EDITORIAL

In This Issue: Relationships Count for Patients and Doctors Alike

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Ann Fam Med 2010;8:98-99. doi: 10.1370/afm.1098.

THE USEFULNESS OF HOME

The enthusiasm for and adoption of certifying criteria for medical homes, despite little research into the effects of these criteria on both patients and clinicians, raises the concern that this codification of primary care could have unanticipated, negative consequences. A previous article in the *Annals* provides a cautionary note to this discussion.[1] In this issue, Ferrante and colleagues report that, of the medical home principles, continuity and connection with a personal physician trumps technology and organization, at least in the provision of preventive services for patients.[2] At some level, this result is self-evident and has long been a confirmed result of research into the doctor-patient relationship and continuity of care, and the population in this study is decidedly nongeneralizable. On the other hand, however, the study findings are another affirmation of McWhinney's point 35 years ago that the primacy of the person over the technology is what distinguishes family medicine.[3] We are finding that his statement has real consequences for health services as well as clinical outcomes for patients. Whether all the technical tools of the medical home have similar effects awaits more testing.

One can be sure the retail or drop-in clinic with a short list of self-limited illnesses, as described in the study by Ahmed and Fincham,[4] will do little in the realm of preventive services. These clinics mimic fast food in supplying fast medicine cheaply with little coordination with ongoing care. The consumers polled in the study seem to want that. A business school professor once described success as achieved primarily through cost or primarily through quality, and patients, it seems, prefer the former until, of course, something goes wrong.

Soubhi and colleagues urge practices to form open, constructive learning groups for support and education.[5] A good idea. Practices themselves should be an intellectual and emotional home for clinicians. Such a structure would help to deal with managing doubt and attending to the emotional issues of patient care and to offer opportunities to learn more than medical facts from colleagues—to learn how to be better doctors in all senses of that term. This concept also reflects the seminal model, the training-cum-research seminars organized by Michael Balint in the 1950s that invigorated the modern era of general practice education.[6]

This issue also contains the final editorial[7] in a 7-part series designed to articulate generalist approaches to promoting health and high-value health care.[8-13] This editorial addresses how individuals and organizations can gain moral authority to advocate for health.

EMOTIONS AND HEALTH

That a high prevalence of psychosocial symptoms exists in primary care populations should be a surprise to no one, but a screening instrument confirmed the range of problems that exist and was tolerable for both patients and clinicians.[14] There is a growing awareness that depression in primary care populations has more psychiatric comorbidity than originally believed, so an instrument that is both feasible and addresses multiple disorders is increasingly important.

The article by van Tilburg and colleagues[15] demonstrates the high prevalence of gastrointestinal symptoms over time in a population of abused children. The takeaway lesson from their study is that children with a high recurrence of unexplained gastrointestinal complaints should alert us to a history of physical or sexual abuse. We should ask questions sooner perhaps about a child's and a family's history of such abuse.

TESTS AND INSTRUMENTS

Negative results are important to publish. A practice-based study with a rigorous pre-post design and verbatim capture of conversations in the office to evaluate a widely promoted program for increasing patient communication showed no effect of that intervention on either questioning by patients or adherence to advice.[16] Sometimes simple approaches, such as asking about

smoking or drinking behaviors, help a great deal. Sometimes, as in the Ask Me 3 approach, they don't.

Dealing with uncertainty is an issue for all clinicians, but it is an essential skill for primary care clinicians. The push for more certainty through tests led Cals and colleagues[17] to use C-reactive protein assessment as additional sorting agent for clinicians not to prescribe antibiotics, even delayed antibiotics, to patients with lower respiratory tract infections. It seems to have worked, but the test is not readily available in most offices, and we need the cost-benefit analysis of this added information as part of the decision to use it on a wide scale. The good news is that "the interventions had no discernible effect on recovery." Patients do recover from self-limited illnesses.

Shokar and colleagues add to the discussion by describing their experiences with approaching a diverse population of patients with education and information about colorectal cancer screening,[18] finding that there are substantial differences by race, ethnicity, and sex in patient preference but no agreement about a perfect screening process.

We encourage you to join in the online discussion of articles at http://www.AnnFamMed.org.

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