

## COMMENTARY

## Guest Family Physician Commentaries

*H. Andrew Selinger, MD***Information Chaos**

Beasley et al<sup>1</sup> enumerate very important aspects of the daily life—delivering clinical care—of the primary care clinician. Delivering clinical care requires daily immersion in our patient's medical records (paper or electronic), dealing with hundreds and hundreds of issues per week when one includes office visits, prescription refills, and telephone triage. As these authors so rightly point out, our obligation is to assimilate many disparate pieces of information to arrive at a cogent decision for each and every medical record that we touch.

We must sort through and cope with information overload, underload, scatter, conflict, and erroneous information. As the delivery of health care has become more fragmented, this challenge has intensified. In addition, ancillary issues occupy more and more of the clinician's attention: reimbursement documentation requirements, litigation anxiety, a new set of patient expectations, patients' increasing portion of the cost of care, internet-based self-diagnosis/treatment, and the need to be responsive to patient self-reported satisfaction surveys.

The authors rightly point out that the interplay between these clinical practice demands and the information necessary to service these demands can result, at times, in mental overload and can impair the situational awareness of the clinician, resulting in the risk of cognitive tunneling—overlooking patient cues and information. This indeed may di-

minish the quality of the care we deliver, which is quite the opposite of the intended effect.

Practically speaking, addressing these important issues will require input from all the members of the ambulatory office staff. Realignment of the workflow and the work processes is necessary to implement some of the proposed solutions the authors provide. Improved preparation for the patient visit; better information management, ie, “pushing” relevant information to the clinician at the time of the patient visit; and reallocation of patient care duties to manage time constraints and interruptions require each member of the office staff to work to the limits of his or her licensure to create a team-based approach to patient care. All this will stress the resources of a typical independent primary care practice, yet these are the inevitable challenges we face going forward. We need local, state, and national medical societies to support their member clinicians with detailed roadmaps to address and navigate these challenges.

**Urine Cultures**

The treatment of the uncomplicated urinary tract infection is one of the most frequent reasons for primary care visits. The practical application of this discussion is to offer guidance to the practicing clinician regarding the utility of ordering a urine culture at the time of initial treatment. The literature is clear that, as a standard practice, concomitant urine culture testing is of little value. We have been trained that to do so is unnecessary and an overutilization of resources. Johnson et al<sup>2</sup> seem to validate that conclusion. Unfortunately, current practice among the physician population studied demonstrates different behavior: 57% of treating physicians ordered a urine culture in addition to a urinalysis when treating. There was no difference in the frequency of follow-up office visits between the culture/no culture groups and there was no difference in persistent symptoms or change of antibiotic between the culture/no culture groups. Johnson et al<sup>2</sup> correctly recommend that routine

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See Related Articles on Pages 647, 693, 745.

urine culture ordering is not cost-effective and should be avoided. An additional valuable note is the low (5%) antibiotic resistance rate identified and the reference only to trimethoprim/sulfamethoxazole as the implied antibiotic of first choice. Thus, having a urine culture conferred no benefit on the clinical outcome for the patient.

### Intellectual Disabilities and Mammography

For practicing clinicians in primary care, this article serves to increase our awareness of health care disparities among disadvantaged populations, specifically those with intellectual disabilities. These individuals experience higher mortality when disabled by more pronounced impairment and by adaptive difficulty. In primary care we are becoming increasingly sensitized to providing population-based care through the use of clinical metrics tied to pay-for-performance arrangements. In most areas of the country, this incentive model has not yet appeared for this population.

Wilkinson et al<sup>3</sup> present evidence that the following factors are associated with women who receive lower rates of mammography: requiring less than 24-hour residential support; having a guardian who is legally responsible for the client; higher level of impairment of daily living; examination time (a more “labor-intensive” office visit); limited wait times (a patient who needs to be seen quickly); and a requirement for sedation.

The patient-centered medical home model is the current organizational structure being deployed throughout the country specifically to address this type of need. The authors highlight that one approach is to shift the responsibility to the health care provider. However, they then acknowledge that many women with intellectual disabilities and other vulnerabilities who reside semi-independently in the community do not receive consistent primary care. Potential areas of improvement at the system level include broadening health coordination to be available to more clients and improved education of guardians about screening and health recommendations. This article illustrates the value of health systems research in providing direction to funding the initiatives that will improve health care coordination and improve the delivery of primary care services to vulnerable populations.

### References

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