EDITORS' NOTE

Research Representing the Changing Landscape of Family Medicine

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Family medicine continues to evolve in response to new technologies, new theories, and new problems to address. This issue of JABFM includes studies on the integration of artificial intelligence into primary care, thoughts on how medicine can address climate change, and some novel approaches to important issues in family medicine. Studies on medication assisted therapy, continuity of care, and periodontitis are among the original research in this issue. In addition, research on screening for social needs, updated guidelines, and case reports are included. (J Am Board Fam Med 2023;36:207–209.)

New Perspectives on Family Medicine

The age of artificial intelligence in medicine has begun and will likely revolutionize primary care, and in general, medical practice. Two reports describe AI within primary care in Canada. The first looks at the systems level of AI implementation across the country[1] while the other looks at clinician and staff level perspectives regarding AI.[2]

Providing preventive services is 1 of the most important functions of a family physician. However, it does not have the immediacy or urgency of other medical issues. Mold, DeWalt, and Duffy[3] reframe preventive care in a way that many readers will find helpful. Another group of authors (Phillips, Uygur, and Egnew)[4] propose a novel Comprehensive Clinical Model of Suffering framework. The authors offer this framework to help clinicians understand their patients better, open productive dialog and, ultimately, enhance healing.

How can clinicians impact climate change? We hear this question more frequently. A brief report suggests a simple action with impact: the choice of inhalers for patients with pulmonary disease.[5] JABFM has issued a call for articles on climate change to advance the science of climate change and its implications for primary care: www.jabfm.org/content/climate-and-health.

Screening for Social Needs

Screening for social needs is becoming standard in primary care. A team of investigators in Oregon studied the acceptability of social need screening among patients.[6] They were particularly interested in determining whether the mode of patient encounter (in-person vs telehealth) influenced the acceptability. In another study, researchers explore how to screen for food insecurity and then address positive screens.[7] A multi-method report describes facilitators and barriers to food insecurity screening within a safety net clinic in Los Angeles County.

Updated Guidelines

The National Comprehensive Cancer Network recently updated its recommendations for genetic testing of patients diagnosed with cancer, greatly expanding the number of patients who qualify for genetic testing. Dr. Sorscher summarizes the evidence behind the recommendations and their implications for family medicine.[8] The FDA has also delivered new guidance, specifically important recommendations focusing on racial and ethnic diversity in clinical trials. Adashi and Cohen review the new guidelines and what they mean for the future of clinical research.[9]

Providing Primary Care

Medication-Assisted Treatment (MAT) for opioid use disorder (OUD) is within the scope of care of primary care clinicians. Indeed, to address the large number of Americans with OUD, primary care

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clinicians must be part of the solution. Providing training to help clinicians become more confident with MAT is a necessary first step. Gardner-Buckshaw et al. report on 1 such training program in Ohio.[10] Separately, Onishi et al. explored the relationship between patients' beliefs about opioids and their tendency to catastrophize their pain.[11]

The ICAN Discussion Aid was designed to help clinicians better individualize patient care. The investigators reviewed data on more than 600 patients who had completed the ICAN Discussion Aid and identified several factors associated with number of reported health burdens.[12]

A tremendous amount of care is provided by home health care workers (HHW). How often, and in what ways, do those HHWs interact with the medical system? A report from New York explores this question and presents some interesting opportunities to strengthen this link.[13]

The COVID-19 pandemic changed health care delivery in many ways. A report from the Veteran's Health Administration examines how diabetes medication adherence changed during the pandemic and which patient populations were impacted the most.[14] Williams et al. report on the association of cancelled family medicine outpatient appointments and subsequent emergency department visits and hospitalization.[15] They evaluated these associations both before and during the early phases of the COVID-19 pandemic.

Highlighting the Importance of Continuity

Family physicians inherently understand that continuity improves health outcomes, especially for people living with chronic conditions. Gaglioti et al. created a novel measure that allows quantification of the positive outcomes of continuity on chronic ambulatory care-sensitive conditions using data on emergency department visits and hospitalizations.[16] The findings are impressive, even for those of us who already value continuity.

Research Using Big Data

Using National Ambulatory Medical Care Survey data, Mainous et al. explored how often obesity was acknowledged and addressed in the primary care setting.[17] The authors also looked at the impact of continuity of care on these actions.

The role of periodontitis in chronic systemic inflammation has received attention in recent years. O'Dwyer et al. report the association of periodontitis and multimorbidity using NHANES data.[18]

Unusual Illness Presentations

Coccidioidomycosis is well known as a fungal infection of the lungs throughout the Southwestern United States. Infection beyond the pulmonary system is less commonly seen. An unusual case offers the opportunity to review this lesser-known presentation.[19]

To see this article online, please go to: http://jabfm.org/content/36/2/207.full.

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