EDITORS' NOTE

The Words We Use, the Procedures We Do, and How We Change (Medical Care Information for Family Physicians)

In this September/October issue, we have another fine collection of articles that are pertinent to the practice of family medicine: articles about doctor–patient communication,[1,2] those that should inform the national debate on health reform and the needs of medical homes,[3–6] articles about office procedures,[7–9], those based in community health centers,[4,10] articles that use qualitative research methods,[5,11] and 2 commentaries related to palliative care (one from a medical student[12] and one from an experienced family physician working in palliative care[13]).

Use of Specific Terms in the Doctor–Patient Relationship

Weight Versus Fat

What words should we use when discussing a patient's excess weight? It seems that "weight" is preferred by patients and more often used by physicians, followed by "excess weight," with many variations of this.[1] The term "fat," with various added descriptors or variations, was clearly the least preferred; we suspect that it is thought to be demeaning.

Prehypertension

The diagnosis of hypertension, even when the patient has no symptoms, is associated with patients reporting increased sick time and missing more work during the year. However, what if patients are told they have "prehypertension" based on relevant blood pressure values? Will it make them "sicker" or, alternatively, embrace necessary lifestyle changes? It turns out that the term prehypertension does not seem to lead to negative or, unfortunately, positive consequences.[2]

Conflict of interest: The authors are editors of the *JABFM*.

Procedures in the Family Medicine Office

Nerve Conduction Tests

Shephard[7] reports on a case series of point-of-care nerve conduction tests completed in an internal medicine office. Most of the tests were abnormal, and most confirmed the diagnosis that was applied before the test. The physicians who received the reports found them helpful, and a significant minority of patients experienced changes in specific care plans.

Dry Needling

Kalichman and Vulfsons[8] review the currently available information about the office use of dry needling for pain. Many readers, perhaps, are not familiar with that term. It refers to the technique of using acupuncture needles to stimulate points in muscles that are the source of much pain. Compared with acupuncture, dry needling is based more on Western theories. Studies to date have suggested reasonable levels of success, and the technique requires less formal education than acupuncture.

Laryngoscopy

Wilkins et al[9] present a case series of almost 300 laryngoscopies performed in a family medicine office. Based on previous experience with various other types of scope procedures done by family physicians, it is not surprising that these were safely accomplished. One quarter of patients were referred to otorhinolargynlogy, and 1% had cancer.

Information on Many Aspects of Medical Homes

Health Information Exchange

Fontaine et al[3] provide an in-depth review to identify the advantages and disadvantages of health information exchange (HIE) in primary care. HIE across health entities can increase the availability of information, such as laboratory or radiograph results, and may create some efficiencies while mak-

ing other processes more difficult. Experiencing a massive amount of HIE in the large University of Pennsylvania Health System, I (MAB) would note that the goal of such exchange should probably not be cost savings, because that will be elusive; instead HIE should focus on improving patient outcomes. We should also remember that more information, and the ease of information exchange, can increase expectations of things like timeliness and completeness. Yes, the laboratory test result that is immediately available from that other health entity seems to cost less than would repeating it, but it costs money to get that test result where it needs to be at the exact time it is useful.

Monetary Incentives for Prevention

Gavagan et al[4] report negative results of monetary incentives to improve preventive care in community health centers; there was minimal gain in those randomized to receive monetary incentives. However, the incentive was only 3% to 4% of the total potential income of each provider. It is like the effect of medical school debt on specialty choice: it makes minimal or no difference until it becomes too large to ignore. In this case, I (MAB) suspect greater dollars would be needed to change the systems that would make prevention more likely, particularly given how much effort is required to make sustainable practice change.[5,6,14]

Providing Investigational Drugs When Patients Need Them

Talk about a patient-centered medical home! In a sign of major commitment to meeting patient needs, Weiser et al[10] took steps to offer needed, but investigational, medications for patients who had the human immunodeficiency virus in their community health center. By discussing their processes the authors help us to understand it is not as daunting a process as many family physicians may think, but it does take significant effort.

It Takes Two (to Increase Likelihood That Change Will Happen)

Gallagher et al[5] look at how having 2 different people (one physician and one nonphysician) leading together initiatives for medical home change for individual offices makes a difference.

Sustainability of Practice Change

Nease et al[6] address the sustainability of practice improvements that were initiated with great effort at individual practices, a needed skill for long-term practice change. What was sustained and how? In general, items of lower cost and effort are more readily sustained.

Practical Clinical Advice

Survivors of Childhood Cancer

The article by Haddy and Haddy[15] has wonderful practical significance; it provides many specific recommendations for the care of patients after childhood cancers and their associated treatments. This is an excellent follow-up to a report recently in the *Journal of the American Board of Family Medicine* by Schwartz et al.[16] Adult survivors of childhood cancer reported significantly more health problems than healthy controls (5.6 vs 2.6 problems; $P < .001$); specifically, problems with growth, thyroid, kidney, immunologic, heart, and fertility functions were noted 4 times more often among adult survivors of childhood cancer than were reported by the comparison group.

Remember the Uncommon in the Common

Our brief reports this month are reminders of the care needed when observing patients and their symptoms and signs to find the true diagnosis. For example, family physicians commonly hear that depression can be secondary to medical illnesses, but usually this is thought of as depression after an illness such as a heart attack. Hurst[17] presents a case of depression secondary to primary hyperparathyroidism, which has many easily overlooked and common symptoms. In the second case, Lohiya et al[18] present an easily overlooked fistula that developed in a patient with a percutaneous endoscopic gastrostomy tube, where the only symptom was intermittent diarrhea.

Klotz et al[19] provide information that suggests that the source of disease from infection with *Bartonella henselae* is probably not just from cat scratches; it may have a variety of sources. We probably need to test for it more often in patients who maintain a consistent clinical picture but have no exposure to cats.

Finally, given all the instruments available to assess geriatric-age patients, it seems that we

should have one that is good enough. Yet, as reported by Naik et al,[11] based on focus group discussion, professionals who regularly assess vulnerability among older people pointed out the inadequacies of current instruments, which suggests that in-home assessments are better than in-office assessments.

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