EDITORS' NOTE

Bread and Butter of Family Medicine: Guidelines, Population Screening, Diagnostic Evaluations, and Practice Models

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This issue of *JABFM* is full of evidence and thoughtful articles on topics central to family medicine. These articles critically examine what family physicians do on a daily basis. Reports in this issue provide new evidence regarding guidelines, screening programs, evaluation procedures, and practice models. Clinical articles report that the sensitivity of mailed Fecal Immunochemical Testing changes with the weather; a dermatoscope and a simple algorithm can help differentiate malignant from benign skin lesions; and that a few almonds can alter blood glucose levels in response to a glucose tolerance test. Readers will find an excellent discussion about whether, and how, the growing number of clinical guidelines should be overseen going forward. We also have a first-hand account of the Inaugural Starfield Summit, a meeting of family medicine leaders working to improve primary care for all. These topics, and plenty of additional new evidence pertinent to the daily practice of family physicians can be found in this issue. (J Am Board Fam Med 2016;29:639–641.)

Knowing and following applicable practice guidelines is a growing factor in how family physicians care for patients. It is import to look critically at these guidelines. For example, currently available guidelines recommend a longer course of antibiotic treatment for all males with urinary tract infections when compared with females. A report from Mospan and Wargo (2016 a) challenges that recommendation, given that they found that a 5-day course of levofloxacin produced the same treatment success rates as a 10-day course. These results are encouraging but it must be noted that this study is a secondary, subgroup analysis of a previously completed trial. Next practice pointer: How much do physicians' professional opinions on the subject influence their clinical decision making? Perhaps more than most physicians realize. Mainous et al[2] eloquently demonstrate how physicians' attitudes toward the concept of prediabetes and their beliefs about barriers to treatment affect their behaviors in the office.

Two excellent commentaries tackle the actual process of creating and publishing guidelines. The number and scope of clinical practice guidelines has burgeoned during the last couple decades and the organizations that create and publish these guidelines continues to grow. The quality and objectiveness of these guidelines vary widely, as does the rigor of the process by which they are created. In a thought-provoking commentary, Shaughnessy et al[3] argue that it is time for oversight of guideline creation. In his commentary on this Article, Dr Wall[4] has a somewhat different take on the best way forward with guideline creation.

A group of articles in this issue evaluates screening for various conditions in primary care. By looking at over 1.1 million mailed Fecal Immunochemical Tests, Doubeni et al[5] found that the sensitivity of the test varies with seasonal temperature changes. The authors discuss some interesting implications of this discovery as it applies to the planning and execution of population-based colorectal cancer screening programs. Grant et al.[6] reports that less than half of Veterans Administration primary care patients with positive screening tests for potential alcohol misuse reported being offered some form of treatment. Younger patients and those reporting a higher screening score on the AUDIT-C (a screening tool for alcohol abuse) were more likely to report being offered help. In a large electronic medical record-based study,

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

Heiden-Rootes et al[7] report that sexual-partnering habits of patients are documented less than half of the time. The authors correctly note that this omission could lead to missed opportunities to identify and screen individuals at high risk for a variety of conditions. They go on to explore the multiple potential reasons for this finding and the complex issue of clinical trust.

This issue has several studies of new and old tools for evaluating patient complaints. Rogers et al[8] report on the performance of a simple dermatoscopic algorithm that can be used to determine the risk of cancer. After brief dermatoscopic training, the Triage Amalgamated Dermascopic Algoithm criteria had a sensitivity of 95% and a specificity of 72%. Those are pretty good numbers for a clinical tool but there are some methodologic weakness to this study. So while these findings will need to be further validated, Triage Amalgamated Dermascopic Algoithm seems to be an excellent tool for family physicians to begin to use.

Patient complaints of fatigue, weight loss, and back pain are commonly encountered by family physicians. So are laboratory abnormalities such as anemia and elevated creatinine. It is therefore not always immediately evident when these signs and symptoms are actually caused by underlying multiple myeloma. What is the effect on staging and survival when the diagnosis of multiple myeloma is delayed? Goldschmidt et al.[9] report a study from the Israel National Cancer Registry to attempt to answer that question.

Every family physician occasionally uses watchful waiting as a clinical tool. In a very interesting study of physician-patient communication, May et al[10] looked at the clinical effect of a variety of communication strategies. The investigators studied resident physicians seeing unannounced standardized patients who were requesting that a clinical test be performed that was unlikely to be useful. The residents used a variety of communication strategies and recommending watchful waiting was associated with significantly less test ordering.

A handful of research articles in this issue examine clinical concerns very familiar to family physicians: chronic opioid use, myalgias from statins, questions about e-cigarettes, and palliative care needs. Problem drug-related behaviors are maladaptive behaviors. Grande et al[11] describe a multifaceted, but relatively simple, long-term opioid management program instituted in an urban safety net clinic. This program may serve as a model for others to implement to help address the growing rate of opioid use and misuse. Bosomworth[12] reviewed existing literature that evaluates statin-induced myopathy in exercising patients and offers several mitigating strategies and some well-reasoned clinical advice.

The use of e-cigarettes and vaping is growing in popularity. In a survey of members of an online consumer panel, 15% of smokers had asked a physician about the use of e-cigarettes. Over half of the smokers who had asked a physician about e-cigarettes reported being advised to use these to help quit smoking.[13] What advice will you give when asked? Nowels et al[14] explore how primary care providers currently address their patients' palliative care needs and report these providers' perceptions about what resources they would need to improve this care.

A fascinating study by Crouch et al[15] demonstrates that giving patients with prediabetes an almond "appetizer" before a glucose tolerance test has a significant effect on the glucose tolerance test results. The idea of "priming the pancreatic pump" could lead to some promising lifestyle interventions for patients with prediabetes, and maybe even diabetics. The challenge now becomes studying whether this experimental finding can be translated into patient's lives and meaningful clinical outcomes. It will be very interesting to see where these findings lead us in the coming years.

A must read for anyone concerned about the future of family medicine is a summary of the highlights of the Inaugral Starfield Summit from a group of past and present Pisacano Scholars.[16] This conference focused on key issues and challenges facing primary care in America today. In this issue, the Summit summary does a great job of painting the picture of where primary care is today, where this group of experts believes it needs to go in the near future, and has a suggested outline of how it can get there.

To facilitate small practices' implementation of Patient Centered Medical Home, CareFirst BlueCross BlueShield of Maryland developed a voluntary PCMH program that did not require formal certification to participate. This program came with limited practice requirements and external incentives. Using a qualitative methodology, Gimm et al.[17] reports multiple stakeholders' views of the successes and challenges of this program.

Patient Advisory Councils (PACs) are encouraged as part of the PCMH model, as defined by the National Committee for Quality Assurance.[18] However, there is currently little evidence to suggest the ideal composition or key functional practices of a successful PAC. Sharma et al[19] studied 8 California PACs identified as high-functioning to consider which PAC best practices would look like. Readers whose practices currently have PACs will want to compare how theirs function to these findings. Readers without PACs will now have a blueprint for starting one.

Researchers may get more access to clinical trial data due to the International Committee of Medical Journal Editors' proposed policy for clinical data sharing (www.icmje.org). Mospan and Wargo (2016 b)[20] share their experience accessing individual, deidentified patient data from a pharmaceutical-sponsored trial. They faced significant challenges analyzing these data even after gaining access, and graciously share their lessons learned.

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