EDITORS' NOTE

# Must-Read Family Medicine Research—Glucosamine/Chondroitin Supplements and Mortality, Telomere Length and the Doctor-Patient Relationship, Reducing Opioid Use, and More

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**This issue of the *Journal* contains some exceptional research articles. A few are truly "must-reads," including a fascinating look at the relationship between having a usual source of care and telomere length. Glucosamine/chrondroitin supplementation seems to be helpful for more than just arthritis pain. There is a very practical advice on keeping patients discharged from the emergency department out of the hospital and on reducing patient requests for inappropriate antibiotics. This issue also features 5 articles addressing how family physicians can combat the opioid epidemic. Three articles highlight research on diabetes and another 3 on breast cancer. Payment reform, dermoscopy, and telemedicine are among many other topics covered. (J Am Board Fam Med 2020;33:823–826.)**

Two potential keys to a longer life? Definitely 2 must reads for family physicians. First, continuity has always been considered foundational to the practice of family medicine and has been associated with many positive health outcomes, including lower mortality. Baltrus et al[1] used National Health and Nutrition Examination Survey (NHANES) data to evaluate the relationship between having a usual source of care and leukocyte telomere length (LTL). LTL is associated with chronic stress and aging. This very interesting study provides us with one plausible biological mechanism to explain the well-established benefits of continuity.

Taking their cue from preliminary research on the topic, King and Xiang[2] used another large publicly available database to evaluate the effects of glucosamine/chondroitin on overall and cardiovascular mortality. Their results are not only consistent with the preliminary research, the beneficial effects suggested are quite surprising. These findings may make everyone rethink their position on these supplements.

There is growing concern that the COVID-19 pandemic will only make another health care crisis in America—the opioid addiction epidemic—worse.[3] It would seem that treating opioid use disorder will continue to grow as a proportion of what family physicians do on a daily basis. Justesen et al[4] report on factors associated with patient retention in a medication-assisted treatment program based in a family medicine residency clinic. We also know that opioid prescriptions for acute pain can start patients down the path to long-term opioid use. Onishi et al[5] examined which patient characteristics are associated with an expectation that opioids will be prescribed for acute pain. The findings set the stage for future research on interventions that reduce such expectations. In an effort to improve and standardized the opioid prescribing practices within their family medicine clinic, investigators at the University of North Carolina created a Controlled Medication Advisory Board.[6] The results over a 4-year time frame are encouraging. The authors provide several excellent tools to facilitate recreating such a board at other institutions. Meanwhile, Lai et al[7] are designing an opioid taper tool to help family physicians safely reduce their patients' morphine milligram equivalents per day in accordance with recent guidelines. Lastly, Boggiano et al[8] demonstrate how important receiving high-quality education on the treatment of opioid-use disorder (OUD) during residency is for future practice patterns regarding OUD.

There has been a lot written on the pros and cons of mammography in average-risk women. Less is known about how the ongoing debate surrounding when, and how often, to recommend mammography is viewed by family physicians. A team of researchers from Canada used some novel methodology to explore

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family physicians' perspectives on the topic.[9] In 2019, The United States Preventive Services Task Force recommended the 7-Question Family History Screening (FHS-7) tool to identify asymptomatic women who should be offered genetic counseling related to *BRCA*-related cancer risk. A surprising percentage of women in one urban academic medical center completing the FHS-7 met referral criteria.[10] The results prompt the investigators to question whether the FHS-7 is the right tool for the job. For many reasons, breast cancer survivors have a higher risk of cardiovascular disease than women without a history of breast cancer. Among women followed in primary care at the Medical University of South Carolina, breast cancer survivors were also more likely to be screened and treated for cardiovascular disease risk factors.[11] It is likely that these patients' increased health awareness is part of the reason. It is also likely that having a usual source of care contributes.

As the number of patients family physicians care for with diabetes continues to grow, preventing diabetes complications is becoming a key component of clinical practice. Because diabetes treatment is predicated on lifestyle change, communication between the patient and their family physician is of utmost importance. A team out of the University of Florida explored the prevention of complications and cost savings of 1 strategy.[12] It is not news that among patients with diabetes, depression is associated with worse glycemic control. In an ambitious study looking at most patients with diabetes living in Minnesota over the course of 8 years, an interesting interaction with living a rural town was found.[13] This study is further evidence that the underlying causes, as well as the best treatments, are linked with patients' social relationships and support structures. A research team from the University of Maryland–College Park report the results of their internet survey of patients with diabetes, exploring patient knowledge of the relationship between diabetes and periodontal disease.[14] This is must-read research if you do not regularly recommend dental appointments to your patients with diabetes.

Patients with Down Syndrome are living longer so family physicians see this population as older adults. Fitzpatrick et al[15] used a large national database of patients with Down Syndrome to conduct a retrospective cohort study spanning 20 years. Their findings related to cardiovascular risk factors and heart disease in patients with Down Syndrome are quite interesting and challenge prevailing perceptions. Adults with communications difficulties are another population known to have worse health outcomes. Stransky et al[16] examined over 33,000 responses to another national survey (the National Health Interview Survey Voice, Speech, and Language Supplement) to identify behavioral health symptoms and diagnoses associated with communication difficulties.

Family medicine leaders have been calling for payment reform for a long time. The Medicare Access and CHIP Reauthorization Act (MACRA) is one government answer to those calls. How well are practices planning for the changes required by MACRA? In particular, how are smaller practices doing? A qualitative study of small and medium practices in Virginia highlights some unintended consequences of such reform measures.[17]

Keeping low-acuity patients out of the hospital is more important now than ever. Close, reliable followup after Emergency Department visits can help prevent avoidable hospitalization. Nanavati et al.[18] report on a novel, low-tech, low-cost method that worked for them. This method, or a variation of it, could work in almost any family medicine clinic. While electronic medical records have not fulfilled all the expectations many had 20 years ago, there are many ways in which this technology can improve clinical care. Mulhem[19] adds to that list with a well-conducted study of a Hepatitis C screening reminder embedded in the electronic medical record. Patient portals also help provide care outside of the traditional clinic visit. El-Toukhy et al.[20] explored factors associated with use, or lack of use, of patient portals and their various functions.

Family physicians are frequently faced with requests for antibiotics for inappropriate indications. What types of messages about the harms of prescribing nonindicated medications are most effective at reducing such requests? The messages in typical antibiotic stewardship campaigns may need to change.[21] Making a strong argument for team-based care, investigators in West Virginia report on an analysis of a chronic obstructive pulmonary disease clinic staffed by an interdisciplinary team.[22]

Most practicing family physicians are providing care for children, but it seems that the percentage is falling. The Robert Graham Center used data from family physicians registering to take the American Board of Family Medicine Certification Examination to quantify the trend in the years 2014 to 2018.[23]

In recent years, dermoscopy has been shown to be an easy to use and effective tool for the detection of skin

cancer when put in the hands of family physicians.[24] What has the uptake of this tool been and how do family physicians feel about using dermoscopy in their clinics?[25] Randall[26] provides an update on the current indications for tonsillectomy and adenoidectomy.

Fenton et al[27] analyzed the inter-rater reliability of the peer review ratings of abstracts to 2 large academic family medicine conferences. The results were disappointing, but perhaps not surprising. Considering these conferences are important events for the development of junior faculty and the sharing of new information in the specialty, this is a real problem. Hopefully, these findings will trigger some creative rethinking of how abstracts are selected. The authors have generously started this process.

*To see this article online, please go to: http://jabfm.org/content/33/6/823.full.*

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