EDITORS' NOTE

Research Addressing the Ongoing Changes in the Practice of Family Medicine

Marjorie A. Bowman, MD, MPA, Dean A. Seehusen, MD, MPH, and Christy J. W. Ledford, PhD

The articles in this issue are divided into 3 categories: 1) increasing our understanding of people's (patients') behaviors; 2) changing how we practice Family Medicine; and 3) rethinking common clinical problems. These categories include multiple topics: nonprescription antibiotic use, recording electronic smoking/vaping, virtual wellness visits, an electronic pharmacist consult service, documenting social determinants of health, medical-legal partnerships, local professionalism, implications of peripheral neuropathy, harm-reduction informed care, decreasing cardiovascular risk, persistent symptoms, and colonoscopy harm. (J Am Board Fam Med 2023;36:383–385.)

People (Patients') Behaviors

Nonprescription antibiotic use is very common and problematic across the world, although we would like to think it is less common in the United States. Laytner et al.[1] interviewed Hispanic primary care patients in Houston, geographic and potentially culturally close to Mexico, and thus with potentially greater access to antibiotics without clinician involvement. The participants readily identified barriers and problematic beliefs that encourage nonprescription use, even when they have health insurance.

Patient use of electronic cigarettes or "vapes" is a health hazard, one that is probably substantially both underreported and under recorded in medical records. Khanna et al.[2] created and implemented a tool called EVAT to record the use of electronic cigarettes or vapes in medical records. This tool was used approximately a million times across many sites in their health care system. It is quite an accomplishment, which could lead to increasing interventions and improving both patients' health and greater understanding of the full health risks of vaping.

Changing How We Think and Practice Family Medicine

Tarn et al.[3] implemented the Virtual Practice-Tailored Annual Wellness Visit intervention in 2021 (during the COVID-19 pandemic) in 3 small community-based practices, showing impressive increases in annual wellness visits, and many other specific preventive services, such as depression and alcohol misuse screening and advance care planning.

Social needs are critical determinants of patient health, but data about social needs have only recently begun to be captured in electronic health records. A representative survey of family physicians showed that 61% document social needs using notes, with fewer using diagnosis codes or electronic forms.[4] This preference for unstructured documentation may make it difficult to connect patients across organizations or for policy makers and planners to identify geographic variation in needs.

Those who have experienced a medical-legal partnership in their practice setting may inherently guess the outcomes and problems identified in this wait-list control randomized trial of referrals to a medical-legal partnership.[5] For others, there may be mixed positive and negative surprises. The authors also introduced the editors to a new category of problems: health-harming legal needs (HHLNs).

"Local professionalism (in everyday practice) is what doctors do of their own accord, in their own locale, to maintain their integrity, honor the past, confront their failings, and elevate the profession–our collective selves."[6] Dr. Loxterkamp provides many thoughts and examples from his practice to further explain this 1-sentence essence of his essay. In a letter to the editor, Drs. Gravel and Erlich[7]

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

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argue against the use of the term "provider" in *JABFM*. As stated in the *JABFM* instruction for authors, we prefer the term "physician" when appropriate, and "clinician" when including other clinical disciplines, rather than "provider" (which could apply to many humans or entities). We agree that the term "provider" is ambiguous.

A large primary care group successfully initiated an electronic pharmacy consult service.[8] The primary communication was within their shared electronic medical record. This report provides insights on frequency and types of pharmacy consults. Satisfaction with the service and implementation of the recommendations were high; cost was not explicitly considered.

Common Clinical Problems, Rethought

Lawler et al.[9] investigate relationships of peripheral neuropathy to mortality in cognitively intact older people. For context, "the dataset, with respect to mortality, includes up to a maximum of 22 calendar years and 10,334 person-years of follow-up." The authors present data on the associations between peripheral neuropathy and other items, including balance, falls, overall health, and mortality. Based on the results, the authors suggest screening and appropriate interventions should be investigated. Hearing loss is amazingly common in hospitalized older patients as reported by Zazove et al.[10] The authors also found multiple correlates. Yet, we suspect that many staff did not recognize the hearing loss, and one must wonder what could go wrong through miscommunication.

Three sites followed 8 common themes in delivering harm reduction-informed care for substance abuse treatment, reflecting the broader movement toward patient-centered care.[11] This article provides ideas on how to overcome some of the barriers imposed by the medical model.

What seem like small changes - but over a large population - can lead to big changes. Linder et al.[12] report that EvidenceNOW practices cared for an estimated 4 million patients ages 40 to 79 who might benefit from interventions for cardiovascular disease risk reduction. Although the amount the practices' interventions reduced patients' 10-year Arteriosclerotic Cardiovascular Disease Risk may seem small, this level of reduction would still prevent 3169 ASCVD events more than 10 years and avoid $150 million in 90-day direct medical costs.

Every practice has some patients with at least 1 persistent symptom diagnosis, that is, a symptom with no specific disease diagnosis. The Chaabouni et al.[13] report from the Netherlands (a primary care system with comprehensive patient databases but a different diagnostic classification scheme) demonstrates that such diagnoses are very common. The types of patients discussed in this report from a practice-based research network would be familiar to many clinicians throughout the world. They found 767 episodes of symptom diagnoses per 1000 patient years, that is, such diagnoses are very common. In fact, there were 1 or more symptoms diagnoses for more than ½ of patients. Prescriptions and referrals for these symptoms were common. There is so much more for us to learn about the human medical condition.

Most studies of harms from colonoscopy include minimal follow-up time. Huffstetler et al.,[14] provide data for 30-day follow-up of colonoscopies from 6 studies, including a total of 467,139 colonoscopies.

To see this article online, please go to: http://jabfm.org/content/36/3/383.full.

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