EDITORS' NOTE

Thinking and Practicing Thoughtfully and Thoroughly

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One of the unique characteristics of family medicine is that although we cannot meet every specific need of each patient at each visit we continuously advance the health of the communities that surround our practices. Family physicians aim to improve overall health outcomes across our practice populations, not just individual by individual, nor just for those who arrive in our office for care. We strive to care for individuals who fall through the cracks, for the social circles who surround our patients, such as family members or neighbors; we implement systems to facilitate the broad scope and needed intensity of care; and we build collaborations that assist in population care. Family medicine improves outcomes for everyone, including the unseen. This *JABFM* issue epitomizes many of these distinguishing characteristics of family medicine—what does it take (how)? When? Where? (J Am Board Fam Med 2023;36:527–529.)

Stretching and Implementing Concepts to Change Outcomes in Family Medicine

In an ethics article, Shaughnessy and Cosgrove[1] discuss the importance of developing phronesis (practical wisdom) and its application to family medicine. Phronesis may partially explain the findings of the brief report by Agnoli et al[2] that studied the frequency of urine drug screening of 5690 patients on long-term opioid therapy. These authors rightfully suggest the need for new or different strategies for urine drug screening of this population.

The Integrative Health Learning Collaborative (IHLC) recommended a new format of health record documentation with the Hope Note Toolkit to implement and test moving primary care practices toward whole person care.[3] Although the concept of whole person care is widely accepted in family medicine, this study provides a new creative method to help meet 1 of our discpline's key goals.

Longitudinal care for older patients with multiple problems in the home by a multidisciplinary team and community aging services is an emerging interventional strategy. Woodall et al[4] report the outcomes for patients receiving this combined care for a year.

Health for Women

The United States Preventive Health Services Task Force recommends both breast and lung cancer screening for qualifying women ages 50 to 74. However, many eligible women who undertake mammography do not get lung cancer screening, as reported in this article by Novogrodsky et al.[5] The authors provide data and practical suggestions to improve these disappointing screening rates.

Startling, but not surprising, numbers characterize the findings of Tong et al.[6] Rural areas are usually starved for physicians providing obstetrics services, and the numbers are even worse for the number available who perform C-sections. The reverse for family physicians is emphasized in the findings – that is, family physicians providing these services are disproportionately clustered in these same rural areas. The authors (and *JABFM* editors) encourage more training of family physicians to perform C-sections, which could reduce health inequity and prevent further closure of rural hospital obstetric units.

In a related article, Putnam et al[7] provide data on the care of a large number of pregnant women receiving prenatal care in Community Health Centers. Many of these pregnancies have risk factors for poor outcomes. Separately, interviews with family physicians who do not oppose abortion reveal how abortion care is consistent with comprehensive care and community needs.[8]

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

It Takes a Village

Stewart et al[9] remind us it *is* possible to substantially increase Hepatitis C treatment rates. The authors document the types of struggles for both clinicians and patients through their journey to success. As is clear from their study, multi-layered interventions must often target both the health system and patients. There are also multiple ways to provide weight management in primary care practices.[10]

Social Risk Factors—Screen? Impact of Screening?

We know that language concordance between clinician and patient plus continuity of care can increase health equity for patients living with chronic disease. Hodes et al[11] consider language concordance specifically for Latinx children and their clinicians, and add consideration of care continuity, within the clinical context of asthma treatment. This study included 38,444 children with asthma, adding strength in numbers to their research.

DeMarchis et al[12] summarize the literature on outcomes of screening for social risk factors through a scoping review. After screening more than 6000 articles, the authors found only 42 that met their criteria. Items identified were related to reach, adoption, implementation, and maintenance. Screening for social risk factors has not yet been demonstrated to be simple or effective.

Our Readers Speak

We have more than our usual number of letters to the editor this issue – 3 writers comment on dermoscopy, improving workforce diversity, and income equality. Blum[13] challenges the practicality of dermoscopy as presented in the *JABFM* article written by a consensus group of dermatologists and family physicians. In addition to other comments, he notes that teledermatology (or "teledermoscopy" as a new term he suggests) could be more realistic. On another note, 2 other letters to the editor concern students from groups underrepresented in medicine (URiM) entering family medicine. First, Flowers et al[14] extend the ideas presented by for increasing URiM entering the practice of family medicine. Second, Otiji et al[15] also suggest that increasing representation from underrepresented groups could increase the number of family physicians who would practice in areas of greater income inequality.

Our Patients Speak

Forth et al[16] provide a fascinating, yet telling article, on the relationship between patient identification of their inhalers by nonstandard names and their asthma outcomes.

Whitebird et al[17] describe 4 themes from semi-structured interviews with patients with multiple medical problems who also had care coordinators during the COVID-19 pandemic. Some disliked virtual appointments and suffered from lack of contact with other people.

Etcetera

This issue's Policy Brief[18] concerns primary care physician leadership in top ranked US hospitals. This assessment of the "top hospitals" in the US according to 4 leading rankings reveals only 4 to 7% of represented CEOs are primary care physicians by training. Greater attention to leadership development from primary care residency through health system practice is needed to avoid diminishing primary care's critical role and salutary global benefits.

Medical cannabis is available in Pennsylvania. Bui et al[19] report on interviews with state-recognized clinical providers, finding some rough edges in the program.

In an aptly titled "Physician, Steel Thyself" commentary,[20] Blum relates his personal experience and highlights deliberate disinformation and scams. Multiple types of scams do not just happen to the less-well educated, or just to nonprofessionals. And the scams are increasingly sophisticated. Watch out, physicians (those targeted in this particular scheme), as well as all readers, and consider who is knocking on your door, pinging your computer, or ringing your phone.

To see this article online, please go to: http://jabfm.org/content/36/4/527.full.

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