Does Family Medicine Need Another Journal?

Using “Family Medicine” as a search term generates 82 journals in the National Library of Medicine (NLM) catalog. After eliminating journals that have little to do with Family Medicine, journals that are discontinued, and journals that are duplicates, there remain about 40 current Family Medicine journals that are indexed in NLM’s Medline.

It is estimated that there are about 14,000 biomedical journals in publication with about 40% of them, or 5,800, approved for inclusion and indexed in Medline (1). Family Medicine journals therefore represent less than 1% of indexed journals, or about 40 out of 5,800. The irony is that the proportion of all health system encounters that occur in primary care ranges from about half (United States) to more than 9 out of 10 (United Kingdom) (2,3). So, in effect, while primary care clinicians provide the majority of health care services around the world, they are asked to do so with less than 1% of the indexed knowledge base. We have a long way to go.

One barrier to research by and for family doctors is the difficulty in getting published in indexed journals. Some might contend that Family Medicine does not produce enough quality research to warrant more journals. This seems a bit like the proverbial chicken and egg question: should more publication outlets come first or should significant research results come first? Without a reasonable probability that one’s research will be published, why bother to conduct the research? Therefore, an important priority for our discipline should be to establish more journals that achieve indexed status.

There are other barriers to research besides ease of publication. The daily work of family doctors suggests that they prefer patient care over research, since that is what they do most of the time. Some of their preference may reflect a sense of greater satisfaction helping patients rather than performing research. On the other hand, some of their preference may reflect the economic necessity of having to maintain a financially viable practice. For many family doctors, participating in research means earning less income or working longer hours or adding more complexity to their lives than they are willing to take on.

As a result, most clinical research is done by sub-specialists working in academic health centers. Many of those researchers see patients only a session or two a week. They design research protocols to address issues of interest to them. To simplify the analysis, their studies often limit research subjects to those without multiple morbidities. To speed up the research, many studies are modeled along the same lines as medication studies: 12 week double blind cross over placebo controlled trials. Their research team is able to assure follow up visits and correct pill counts. They can secure significant time and funding for their efforts because they are supported by academic infrastructures that value research. Yet, when it comes to the health of all people, we may be in a situation where the wrong people are asking the wrong questions on the wrong patients in the wrong setting.
Although their studies were separated by 40 years, White and Green and colleagues came to similar conclusions when they looked at a typical United States community of 1000 adults followed over a month (4,5). During that time period, about 800 of the 1000 developed symptoms (cough, fracture, allergies, depression, etc.), 217 sought consultation with a doctor (slightly more than half of those were to primary care doctors), 13 were seen in emergency departments, 8 were admitted to a community hospital, and less than 1 was hospitalized at an academic health center. Given that the vast majority of published studies are conducted in academic health centers, one must conclude that the resulting literature is not necessarily relevant to the care of most people.

More surprising is that the current literature may not have much accuracy or durability for anyone, even those in academic health centers. Ionnaides showed that fewer than half of the most frequently cited studies produce results that are accurate or durable (6). Frustratingly, early research findings quickly get converted into clinical practice guidelines, which take on regulatory and financial importance when they are reduced to performance measures.

A case in point is glycated hemoglobin. For a number of years, the literature advised that a patient’s glycated hemoglobin should be kept below 7%. Many in the primary care community felt that was too low, especially for older patients and those with multiple morbidities. In the past several years, 3 studies addressed this issue by including more typical patients with type 2 diabetes mellitus – those who are middle aged with other morbidities such as high blood pressure, dyslipidemia, etc (7-9). Among these patients, there was a higher mortality rate for those with glycated hemoglobin levels less than 7%. Frustratingly, once the target of less than 7% was set, it has proved difficult to change it and allow less intensive glucose control.

Imagine how different things might be if it were easy for family doctors to do research. When needed, there would be methodologists available to assist in framing the research, statisticians to assist in analysis, support teams to help conduct the research, and financial support for the time away from patient care.

In fact, imagine for a moment that every family doctor participated in research – some as principal investigators, some as sources of data, and so on. Further imagine that all the family doctors were able to reach out to other family doctors around the world to participate in their research and to quickly share their findings. While these may seem like impossible dreams today, electronic health records, practice-based research networks, and mobile telephony are likely to make this a reality in the next 2-3 decades.

The upshot of all this would be many more research findings that are more likely to reflect the typical patient in the typical setting. The number of subjects studied, drawn from the billions cared for by family doctors, could provide greater confidence that the study is a better reflection of actual practice and most patients.

Once all of this research has been conducted and written up, there must be a place to publish it. Thus, to go back to my opening question, we definitely need more journals in Family Medicine. The Eurasian Journal of Family Medicine will be unique because it will cover a broad geographic expanse and focus on studies drawn from practice networks. This should excite all of us. I hope this journal will become an indexed publication, publishing compelling research which changes practice and improves patients’ outcomes.
References


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