EDITORIAL

In This Issue: Minding the Gaps

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Medical practice is an exercise in gaps. We work with gaps in access, evidence, and communication. Our patients have enzyme deficiencies, absence spells, and anion gaps. We diagnose paucities, -penias, and lacunae. Medical research has its deviations, differences, and intervals. Health care itself suffers inequities, disparities, and barriers.

We read in our journals—and patients read in the news—about practice gaps, how often doctors fall short in delivering care recommended by authoritative guidelines. In this issue of *Annals of Family Medicine*, Schafer and team report a practice gap in behavioral screening and counseling practices of family physicians, particularly for alcohol misuse.[1] Gaps in following prescribing guidelines can put patients at risk, particularly older adults suffering already with multimorbidity and polypharmacy. A team from Dublin, however, reminds us that closing this gap requires attention not only to guidelines but also to the lived experiences of patients. The team, led by Cahir, finds that older adults can have difficulty even identifying adverse effects of the drugs we prescribe.[2]

Those of us who have senior moments find ourselves searching for a fugitive name or mislaid task. But we all search for hope in addressing the personal and public health tragedy of dementia. Streit and colleagues conducted a cohort study in the Netherlands of patients aged 75 years or older treated for hypertension for a year. They found that lower systolic blood pressure is associated with less cognitive decline without loss of daily functioning or quality of life and that the effect was strongest in patients with complex health problems.[3]

No medicines are more critical and more challenging to manage than opioids. West and colleagues share an Innovation to address the opioid overdose crisis by working with local police departments in Oregon to design an approach to prescribing naloxone for patients on high doses of opioids.[4]

Gaps can occur in care and communication when patients move from primary care to specialist care for consultation. With electronic consultations, de Man and an international team working in Ottawa, Canada, found that primary care clinicians follow the recommendations of their specialty colleagues in 82% of eConsults.[5] Gaps in continuity undermine a pillar of primary care. Studying family doctors in Canada, Hedden and team document the trend of fewer practices providing out-of-office services, despite financial incentives that recognize the value of continuity.[6]

Identifying and closing communication gaps creates opportunities for better care and better health. Testing strategies to reduce unnecessary prescribing of antibiotics for respiratory tract infections, an international team led by Little found that Internet training of clinicians in communication had a sustained positive impact over time but training in C-Reactive Protein point-of-care-testing did not.[7]

Technology can empower patients and communities and improve care: apps for gaps.

In another Innovation, Duffy and team report on a clinical decision support app that can empower lay community health workers to manage diabetes in rural Guatemala.[8] Grant and colleagues tested an information technology tool in waiting rooms at Kaiser in California and found it improved communications during the clinical visit but did not reduce gaps in clinical care.[9] Clinical skills trump technology but may not be sufficient for optimal patient care.

Also in this issue, Ebell and colleagues in Georgia report a systematic review that revealed only a third of patients with suspected acute rhinosinusitis have bacterial infection and identified three clinical indicators as the best predictors: clinical impression, foul breath, and pain in teeth.[10]

Kimball and team share an Innovation to describe how their primary care team embedded an AmeriCorps volunteer as a legal navigator and patient advocate in their immigrant and refugee health program in Boston.[11]

Doctor-patient communication is a familiar path and is sometimes a two-way street. It is the route to building trust and relationship in continuity over time. Doctor Thompson Buum reflects on how sharing her personal experience with breast cancer with her patients has changed her approach to professionalism, personal privacy, and patient care.[12]

Gaps in life profoundly affect human health. We recognize poverty as a social determinant of health

and care for both the have-nots and the have-gots. Mother Teresa recognized that, "Loneliness and the feeling of being unwanted is the most terrible poverty."[13] Mullen and her team studied over a thousand patients in two diverse practice-based networks in the United States and found that 20% reported being lonely. Loneliness was associated with lower health status and more frequent visits to primary care and urgent/emergency care and hospitalizations.[14] Working with members of that team, Tong studied communities in Colorado and Virginia and found that patients who live in areas with greater problems with unemployment, access to care, poverty, and transportation also face heavier burdens of loneliness.[15]

The admonition, "Mind the gap," long familiar to London commuters, has become a common caution to all travelers. As we explore the frontiers of family medicine, our new science might be gapology. Holding hands with our patients, we must jump across the gaps in clinical guidelines, evidence-based care, and efficient clinical protocols.

Health care most often goes wrong at the transitions; between prescription and adherence, between inpatient and outpatient, between convenience and comprehensive care. These are the gaps that test our commitment to the patients, families, and communities we serve.

Family physicians share a mission to fill the gaps by caring for folks in a way that is integrative and introspective, comprehensive, and compleat. What other medical professional embarks on so foolish a quest? Others seek more comfortable niches that limit expertise, expectations, and exposure to inadequacy. It is in the interstices of health and illness, in the uncertainties between diagnoses, and in the tensions between healing roles that primary care clinicians expose the audacity of their hopes.

These articles, like all research, point to further gaps, unanswered questions, and challenges in practice. Please join our online discussion at http://AnnFamMed.org.

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