EDITORIAL

In This Issue: Continuity, Relationships, and the Illusion of a Steady State

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This issue of *Annals*, the last I will be introducing as Editor, is about relationships.

A study of more than one million Medicare patients seen by 6,551 primary care physicians finds that multiple measures of continuity of care are associated with lower health care expenditure and hospitalization rates.[1] An editorial describes continuity as presence, trust, reliability, responsibility, and endurance, and decries its diminishment.[2]

I wonder what it means when both patient and clinician are willing and able to make deposits over time into the relationship "bank" for which continuity is one marker? What interest is accrued besides less health care cost and hospitalization? What else is bought when a withdrawal needs to be made? How and why does the account sometimes seem to replenish itself like a deep well? What are the important aspects of care for which continuity is just a marker? I wonder how a new generation of patients and clinicians and systems will look below the surface of continuity to find ways of investing in relationships even when continuity is not possible.

On the flipside of continuity, an interesting pattern of associations with *losing* a usual source of care is seen in a nationally representative study of older adults. Loss is less likely among those with at least 4 chronic conditions and with Medicaid or supplemental insurance, and more likely among those made vulnerable by depressive symptoms, unmet transportation needs, or moving to a new residence.[3]

A family medicine resident in a "clinic-first" training program shares how an emphasis on continuity of care developed in him a sense of responsibility for caring for his patients, noting that "relationships are the cornerstone of our learning."[4]

Three research briefs in this issue address different angles on access to care and the possibility of relationship development.

A study in which investigators phoned family physicians' offices in British Columbia requesting an initial appointment finds that patients identifying as having recently been discharged from prison were half as likely to get an appointment.[5]

In an academic health care system in Cleveland, Margolius et al find that access to appointments is lower for patients of physicians with less time scheduled in the office, but is not associated with larger panel sizes.[6]

Shires et al assess the willingness of Midwestern US primary care clinicians to provide routine care to transgender patients, and identify factors associated with this willingness.[7]

An essay by Keuroghlian et al sheds further light on issues faced by people who do not conform to traditional gender norms and elucidates the use of inclusive, nonbinary language in patient care.[8]

In a cluster-randomized trial in 15 practices, a relationship with a performance coach is found to increase the rate of provision of multiple components of the Ottawa Model for Smoking Cessation. No effect is seen in cessation outcomes.[9]

Point-of-care urine testing for cotinine has potential to promote smoking cessation during pregnancy, particularly in light of denial of tobacco use among a high percentage of pregnant smokers. Gold et al find that although clinicians are concerned about the effect of testing on the clinician-patient relationship, pregnant and postpartum women on Medicaid have generally favorable views about sensitively used prenatal urine screening for tobacco use.[10]

In a large national probability online sample of people aged 65 and older presented with a hypothetical patient with limited life expectancy, more than one-half would not want to discuss with their doctor how long they would live, if they were that paitent. Since many guidelines include life expectancy in clinical decision making, this finding shocks us into needing to better understand patient preferences.[11] It would be interesting to replicate the study in clinical samples in which an ongoing relationship is present.

A population-based practice-based research network study by Mangin et al defines the phenomenon of "legacy prescribing"—drugs that are most appropriately prescribed for an intermediate term but that are continued for a longer term. The finding of high rates

of legacy prescribing for 3 common drug classes identifies a powerful lever point for interventions to reduce the patient health risks and costs of polypharmacy.[12]

A randomized clinical trial of a novel intervention for knee osteoarthritis—clinic-based patellar mobilization therapy—is found to be efficacious when combined with home-based vastus medialis oblique muscle exercise. Pain, stiffness, and self-report and externally assessed physical function all are favorably affected.[13]

Hudson et al assess over-the-counter pulse oximetry machines and find that they provide comparable results to medical use oximeters for people with an oxygen saturation of >90%, and thus seem reliable for ruling out hypoxemia.[14]

The *Annals* feature on Innovations in Primary Care in this issue contains a fresh extension of the genogram method to map health system connections to improve patient transitions from hospital to primary care.[15]

A Perspectives editorial by Mainous discusses strategies to disseminate research findings to the general public, in an era in which science and facts often are discredited as "fake news."[16] The blatant misuse of news and facts for political ends, and the sometimes divided powerlessness of opposing political voices in today's environment, are a wakeup call that makes the interactive and contextualized communication of valid science more important than ever. It's also a reminder of the importance of being part of the broader conversations, not only in our field, but with different individuals and groups in our larger society.

We welcome you to join the online discussion for each of these and previously published articles at http://www.AnnFamMed.org.

In the early months of launching the *Annals of Family Medicine* in 2002, as new tasks and opportunities kept emerging, Editorial Coordinator Robin Gotler and I would periodically assure each other, "We must be at steady state now." Fortunately, we never reached steady state. The opportunities still seem fresh and growing and beyond fully knowable. With the *Annals* in a strong, and yet still developing, state, I have chosen to step away from the role of Editor at the end of the year. Bill Phillips, who has served as Senior Associate Editor from the beginning, will take over leading the editorial team as Editor. The Board of the *Annals*' sponsoring organizations has launched a search for a permanent Editor, and hopes to complete that very soon.

In the May 2018 issue of *Annals*[17] I had the chance to reflect on how family medicine and primary care can be a force for integration in a fragmented world. I got to thank the many contributors to *Annals* and the sponsoring organizations for coming together to create an ongoing conversation that includes, but transcends, the interests of any single individual or organization. This conversation, to paraphrase the *Annals*' mission statement: is dedicated to advancing knowledge essential to understanding and improving health and primary care, and to supporting a learning community of those who generate and use information about health and generalist health care.

Thank you for the privilege of being part of this conversation, as Editor. I have confidence that our learning community will continue to be part of the larger conversations and actions needed to nurture healthy individuals, healthy, equitable communities, and an inclusive society.

To read or post commentaries in response to this article, see it online at http://www.AnnFamMed.org/content/16/6/486.

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