Gaps, holes and change

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The start of a new year can be a time for reflection of the past and consideration of the future. Whether or not you are a fan of new year resolutions, there is usually something that you want to change. This issue of *Australian Family Physician* considers gaps in practice. Sometimes as general practitioners we know that there is a gap; sometimes our patients know that there is a gap; and sometimes there is a gap but no-one recognises that one exists. Sometimes we go along thinking that what we are doing is evidence based, and then get an unpleasant surprise when asked to justify 'what we always do'!

In general practice, in terms of caring for our patients, we would like to feel that we are on solid ground and moving forward, that we confidently know what to do. Sometimes we know that we are in a hole – perhaps due to limited information to guide us, perhaps because the problem at hand is not suited to our skills. Sometimes we are striding along confidently and we trip and find ourselves in a hole – we can usually get out with only a few scratches and start again. However, when we start again we may be more cautious and look at the ground more carefully. Then we notice the crevices that are running all through the surface and there are larger holes present that we have managed to step over in the past without even realising that we have done so.

General practice is aware of some of the gaps that impact on practice. They can be made explicit when considering guidelines for the management of condition A, and then condition B. However, the complexity of real patients clouds the issue. The patient in front of us may have conditions A, B, C, E and Z. There may be a large hole when considering the evidence for condition A when condition B is also present – let alone with all the other medical and psychosocial issues that are important to that patient. Gaps that fall between specialities may never be identified. Also, relevance of evidence to an individual patient is not considered. For example, is this patient like the 70 people in the trial upon which we base this recommendation?

The more we stare at the ground, the less perfect the surface can look. For example, in recently published acute pain management guidelines,[1] in the section on assessment and management of pain and its treatment, 5 of the 7 key messages are 'recommended best practice based on clinical experience and expert opinion' and the other two key messages are Level III evidence (when evidence is rated from levels I to IV[2]). In other sections the key messages are more supported by evidence, eg. in the area of anticonvulsant drugs where 4 of the 5 key messages are supported by Level I (the highest level) evidence. And whether you will find the information to assist in finding an answer to your question depends on the question; and if there is an answer, how sure can you be that it is evidence based or experience and opinion based? The more you look the more holes you see.

The new year also brings changes to *AFP*. A new research viewpoint series will allow Australian academic GPs to provide examples of how they identify gaps that are important to GPs and what they are doing to try to provide evidence to guide us in our daily practice. Authors will note that we are implementing the use of the International Committee of Medical Journal Editors (ICMJE) conflict of interest form,[3] which is used by many journals. It is hoped the use of this form will lead to a uniform and simplified reporting of conflicts of interest.

We also thank and farewell our 2010 Publication Fellows, Dr Deepa Daniel and Dr Kate Molinari, and welcome our 2011 Fellow, Dr Nyoli Valentine.

This month's focus articles are as diverse as the many gaps in practice. Will there be a GP? Harrison and Britt look at workforce issues. Can you get an appointment? Knight and Lembke help practices identify ways in which they may be able to improve access and stress levels. Are there groups that are not accessing care? Johanson and Hill report on a partnership leading to increased indigenous patient access to private general practice. Is the patient care optimal? Byrnes considers therapeutic inertia and methods to overcome it. And Rutherford discusses a peer review process that has been successfully implemented in a practice.

No matter which gaps appear large in front of you or what things you would like to change, we hope this issue of *AFP* will provide you with food for thought and ideas for solutions.

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