

Holding relationships in general practice:

What are they? How do they work? Are they worth having?

As I write, our coalition government's Health and Social Care Bill has just been published.¹ While not impinging directly on clinical priorities, the Bill is likely to concentrate the minds of all GPs involved in allocation of resources — including clinical time. And time spent on relationships with patients aimed at 'ongoing support without expectation of cure'² may at first sight seem an asset ripe for 'efficiency savings'. In the linked study in this issue of the *BJGP*, Cocksedge *et al* describe the experiences of a selected group of GPs and patients with these holding relationships.² This personal element of care is emphasised repeatedly in the literature.^{3,4,5} How relevant is it to today's context?

SINGLE CONDITION RESEARCH AND MULTIMORBIDITY PRACTICE

For the practising GP, it is a fact of life that patients come with more than one problem. However, when I was getting careers advice as a young researcher a generation ago, the message was loud and clear: 'focus and specialise, be selective!'. Most have followed this advice and one result is that in general practice, as elsewhere, our evidence-based medicine is targeted on guidelines derived from single disease research. Many GPs have pointed out the problems this raises,⁶ but only in the last decade has awareness of the challenge of multimorbidity or comorbidity come centre stage.⁷⁻⁹

Often multimorbidities evolve relatively slowly. Thus a significant feature of a GP's work over time is the multitude of ongoing relationships with patients, each of whom has many problems. Holding relationships are one special, perhaps extreme, example. The term 'holding' is interesting in itself; a subjective term, perhaps implying the dependent or childlike patient of a paternalistic doctor. Cocksedge *et al* suggest a more equal relationship and remind us of the well-established tradition that patients and GPs mutually invest 'in an ongoing relationship built up over time', and that this is 'integral to ... the ideals of contemporary primary care'. But they go on to point out four resulting tensions that may modify the quality of care given:

- the biomedical emphasis of training;
- the problematic challenge of ongoing

complexity (highlighted recently by Smith *et al*¹⁰);

- it is easier to research single consultations, yet relationships are ongoing; and
- policy rewards mono-morbidity according to disease-related protocols.

Healthcare commissioning in a market economy is challenged by multimorbidity, as Moore explained about the decline of the medical generalist in the US: 'the marketplace favors specialism'.¹¹

Cocksedge *et al* describe the inherent conflict between 'inflexible guidelines' within the Quality and Outcomes Framework and other Department of Health policies designed to promote patient involvement and collaborative decision making. These 'competing discourses' have recently been described by Reeve¹² as a clash between 'Scientific Bureaucratic Medicine' and the interpretive aspect of practice, where patients' experiences and priorities are integrated with the practitioner's knowledge of pathology and prognosis.

WHAT, THEN, IS GOING ON WITHIN HOLDING RELATIONSHIPS?

Patients in the Cocksedge *et al* study valued holding relationships strongly; naturally, they did not name them as such, but they described them well and found them special and rewarding. The doctors agreed and also mentioned enhanced job satisfaction. The concept of 'containing' was added by doctors (meaning, attempting to limit progression within modest therapeutic goals) and, importantly, this could minimise inappropriate referrals to specialists.

Doctors also argued the enhanced possibility of changing health-related behaviour. Disadvantages of holding relationships were raised by doctors rather than patients, who mentioned frustrations and the risk of dependence or reduced clinical vigilance.

Altogether this study offers some formal

description of an aspect of practice familiar to most experienced GPs. The authors emphasise that they are restating the value of the doctor-patient relationship at a time when, once again, well intentioned reforms may have the perverse effect of making these relationships less accessible to patients. (Indeed, difficulties with access were the only problems raised by the patients in this study.)

VALUE AND COST

With such potential for good, commissioners and others will wonder how prevalent holding relationships are, and whether they are cost-effective. The GPs studied were either selected by the researchers, or volunteered. This possibly unusual group identified 15-20 patients each, which could comprise 2% of their registered patients. (Just one GP estimated a much higher number.) Although this would be a greater proportion of those with multiple ongoing problems, it is still a small minority; one must ask whether more patients would have liked holding relationships or would benefit from them. Such patients are potentially the most expensive and so 'containment' of unjustified technical interventions could make big savings.

In today's climate, further detailed study of the prevalence of holding relationships and their potential to minimise costs seems urgent. Does quality really improve? Are serious diagnoses made earlier? Are emergency admissions reduced? Holding relationships may yet be resource intensive within the practice. Patient 10 in the linked study² mentioned being invited by the GP to 'come and see me in 2 weeks'. This could imply 25 consultations per year: an unsustainable rate for more than a handful of patients and certainly a threat to practice accessibility for others.

CONDITIONS FOR A SUCCESSFUL HOLDING RELATIONSHIP

For holding relationships to be possible as

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“For holding relationships to be possible as described, patients must have the opportunity of relationship continuity of care.”

described, patients need to see the same clinician for most consultations over time. In other words they must have the opportunity of relationship continuity of care.¹³ But in practices, often in inner cities, where most clinicians are part-time, on short-term contracts, and relatively inexperienced, this may be almost impossible to offer. So another topical question is how can such practices economically and effectively meet the needs of patients such as those reported in this study?

We need to understand how holding relationships evolve. Do the patients have special needs? What factors mediate access? Can anyone have one who wants one? Can clinical criteria be described, or are more covert and personal factors at work? For example, are these the patients who the clinician likes, or conversely are they ones he or she cannot cope with (such as ‘heartsink patients’²)?

There is widespread evidence that relationship continuity is good for both patients and staff.¹⁴ If holding relationships offer particular benefits to a needy group of patients, then good access arrangements to named clinicians is a priority for all those needing holding relationships — including the housebound.

Like much important research, this study raises more questions than it answers, but it has firmly put the issue on the map — and, please note, in these days when academic success is rated by grant income, this work required no new funding!

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Provenance

Commissioned; not externally peer reviewed.

DOI: 10.3399/bjgp11X588240

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