

Holding relationships in primary care:

a qualitative exploration of doctors' and patients' perceptions

Abstract

Background

Ongoing doctor–patient relationships are integral to the patient-centred ideals of UK general practice, particularly for patients with chronic conditions or complex health problems. 'Holding', a doctor–patient relationship defined as establishing and maintaining a trusting, constant, reliable relationship that is concerned with ongoing support without expectation of cure, has previously been suggested as a management strategy for such patients.

Aim

To explore urban GPs' and patients' experiences of the management of chronic illness, with a particular focus on holding relationships.

Design and setting

A qualitative study in urban and suburban areas of north west England.

Method

Participating GPs recruited registered patients with chronic illness with whom they felt they had established a holding relationship. Data were collected by semi-structured interviews and subjected to constant comparative qualitative analysis.

Results

GP responders considered holding to be a small but routine part of their work. Benefits described included providing support to patients but also containing demands on secondary care. Patient responders, all with complex ongoing needs, described the relationship with their GP as a reassuring, positive, and securing partnership. Both GP and patient responders emphasised the importance of pre-existing knowledge of past life-story, and valued holding as a potential tool for changing health-related behaviour. Difficulties with holding work included fears of dependency, and problems of access.

Conclusion

Holding relationships are a routine part of general practice, valued by both GPs and patients. Naming and valuing holding work may legitimise this activity in the management of people with chronic and complex health problems.

Keywords

chronic illness; doctor–patient relations; continuity of care; qualitative research.

INTRODUCTION

An important emphasis in the development of UK general practice since the 1950s has been mutual investment by both doctor and patient in an ongoing relationship built up over time.^{1,2} This has been described as therapeutic,^{3,4} and integral to both patient-centred medicine³ and the ideals of contemporary primary care.⁵ Nevertheless, within this literature there are tensions reported for the doctor–patient relationship and hence for patient care.

Traditionally, doctors have been trained to have an essentially biomedical view of the patient, with a focus in teaching on revealing organic pathology.^{6,7} Such a focus may be unhelpful in managing everyday problems,⁸ particularly in primary care where technical solutions may be unavailable, the boundaries of pathology/illness/normality are often unclear, and symptoms may be diffuse or chronic. When cure is not possible, such a focus offers particular management challenges. Patients with chronic and complex problems have been labelled as 'heartsink'/frequently attending patients, and have been described as having problematic ongoing relationships with their doctors.^{9,10} In considering and managing patients in this way, doctors can feel disempowered and lose their capacity to intervene in a meaningful way.¹¹

The significant literature on the doctor–patient relationship increasingly explores interactional components within

individual encounters, in order to understand their importance, enable teaching, and allow measurement of quality.^{12–14} These approaches focus on specific observable features, reducing emphasis on ongoing and contextual aspects of the doctor–patient relationship.

Policy directives influence doctor–patient interactions. The Quality and Outcomes Framework (QOF) of the General Medical Services contract utilises evidence-based indicators of quality of care.¹⁵ Healthcare practitioners are then required to follow inflexible guidelines and protocols derived from these indicators to achieve targets on which their remuneration is based. This framework has had unintended consequences for doctors and patients, such as reducing continuity of care.¹⁶ In contrast, other NHS initiatives promote patient involvement in care and self-management, with collaborative patient/clinician joint decision making over management preferences.¹⁷ Most recently *Equity and Excellence: Liberating the NHS* emphasises patient-centred practice but puts responsibility for commissioning (and explicit rationing) of services and resources on GPs.¹⁸ The consequences of this latest White paper on doctor–patient relationships and interactions are as yet unknown. These differing policies highlight competing discourses in long-term management,¹⁹ notably between patient autonomy and professional responsibility for delivering evidence-based practice.^{20–22}

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How this fits in

There are many tensions around ongoing GP–patient relationships, both external and within individual encounters, particularly with patients suffering chronic or complex health problems, for whom holding work has previously been identified as a possible, if hard to define, management strategy. This study of ‘holding’ GPs and ‘held’ patients found that holding relationships offered ongoing constant trustworthy support without expectation of cure, and were routine and valued by both parties. Naming and understanding holding work in everyday practice provides alternative management possibilities for clinicians and should be recognised as an integral part of GP work.

The tensions outlined above impact on everyday primary care interactions, particularly in long-term management of, and relationship with, people with complex chronic problems. However such doctor–patient relationships are framed within these tensions, it is important to understand and account for how patients and professionals experience them, and how they conceptualise the resulting interactive work. Holding work has been defined as establishing and maintaining a trusting reliable constant doctor–patient relationship, providing ongoing support without expectation of cure, and has been identified as a possible management strategy for such patients.^{23,24} This paper presents a qualitative study that explored GPs’ and patients’ experiences of managing chronic illness in primary care, particularly focusing on holding work.

METHOD

Study design

Urban and suburban GPs with over 5 years’ experience were recruited to the study (5 years allowed comparison with previous work with practitioners in semi-rural areas who described established long-term doctor–patient relationships).²⁴ Each GP participant was interviewed and asked to identify and contact one or two patients with ongoing or chronic illness with whom they considered they were undertaking holding work. These patients were then interviewed by a different researcher.

Recruitment and sampling

In north west England, six GPs were invited by two of the researchers to participate in a study about managing people with chronic

illness, and five other participants volunteered, following an email to all members (approximately 20) of a suburban GP trainer group. Responders to the initial email contact received invitations and information sheets followed by email/telephone contact to obtain initial verbal consent. Semi-structured interviews were conducted, with written consent, at responders’ practices.

Patients were recruited by the GP who had been interviewed. After initial contact by the GP, and giving verbal consent to be approached by the researchers, patients were sent an invitation letter, information sheet, and reply-paid envelope. Once this had been returned, patients were contacted by telephone to obtain initial verbal consent. Semi-structured interviews took place with one researcher, in either responders’ homes or their GP surgery. Every patient invited by their GP agreed to participate.

Data collection and analysis

Data were collected in 2009. Audiotaped semi-structured interviews were transcribed verbatim, with consent. Interview topic guides were developed by the authors through discussion, taking account of previous holding work and the literature referred to above. The GP interview topic guide explored doctors’ understanding of holding as a concept in primary care, their views on their ongoing doctor–patient relationships, and the risks and benefits of these. Patient interview topics included exploration of views about their GP practice and their usual doctor, their understanding of their ongoing doctor–patient relationship, and their doctor’s role within it. Questions allowed discussion about the topic guide but enabled broader dialogue to develop. Transcripts were coded, indexed, and analysed according to the constant comparative method of Strauss and Corbin.²⁵ Initial transcript analysis was undertaken independently by the authors, and categories were agreed through discussion allowing interview schedule modification as new themes emerged. Recruitment continued until category saturation was reached. Tapes were wiped after transcription, and transcripts were anonymised.

RESULTS

Eleven GPs and 14 patients were interviewed (Tables 1 and 2). The main themes presented in this paper include: holding — an acknowledged doctor–patient relationship; the value of holding; dangers of holding; barriers to holding; and

Table 1. Demographic details of the participating GPs

Identification	Sex	Years as a GP	Ethnicity	Practice list size	Practice setting
D1	Female	15	White	4500	Urban
D2	Female	23	White	5800	Urban
D3	Female	40	White	N/A	Urban
D4	Female	5	White	5000	Urban
D5	Male	22	White	6200	Urban
D6	Male	17	White	13 250	Suburban
D7	Female	34	White	13 250	Suburban
D8	Female	13	White	7000	Suburban
D9	Female	13	White	9700	Suburban
D10	Male	18	White	9700	Suburban
D11	Female	25	White	6500	Urban

judgments on the other. Transcript data are identified by Dr (doctor) or Pt (patient) and interview number.

Holding — an acknowledged doctor–patient relationship

All doctors reported that they currently had holding relationships with patients. Most saw holding as a routine and significant ‘bread and butter’ (Dr11) part of GP work – ‘I think it comes with the territory’ (Dr5):

‘It’s what we do a lot of the time ... you aren’t making progress as it were, you’re just being a person for them to keep touch with ... they just come in to see you to say, “how are you doing?”. It’s not that they’re getting any worse or better and you’re not making any dramatic changes.’ (Dr8)

A minority of responders saw holding as a more specific relationship with people with long-term problems, applying ‘to all

chronic disease patients’ (Dr3). Although one GP (Dr6) felt that he had over 100 such relationships, most considered holding to be specific to only a small number of patients, generally 12–20 per doctor.

Patients did not directly describe holding, but the majority stated that they had an ongoing relationship with one particular GP, which they felt was special and different from encounters with other GPs:

‘Nothing could change this relationship, because it has stood the test of time. The only person that I have known longer than Dr Z is my partner.’ (Pt9)

They also identified significant components of their ongoing relationship, including feeling secure:

‘When I’ve seen him ... I’m thinking he is securing me. I feel better.’ (Pt5)

Both patients and GPs described holding in terms of partnership – ‘negotiation and joint decision making’ (Dr8); ‘we work though it together’ (Pt8). For GPs, this allowed chronic and complex issues within primary care to be managed and contained:

‘I think it’s a partnership in that the consistency that we have together and the mutual respect and tolerance and honesty between us produces that partnership existence.’ (Dr6)

‘Well in a sense I hold onto her knowing that she’s my burden, if you like, my problem, my patient and I don’t refer her on, I don’t over-medicate, over-investigate, over-refer the

Table 2. Details of participating patients

Patient number	Sex	Age, years	Main chronic illness	Ethnicity	Occupation	Years known the GP for
1	Male	85	Coronary heart disease	White British	Retired manager	5
2	Male	65	Parkinson’s disease	White Australian	Rabbi	3
3	Female	59	Fibromyalgia	White British	Retired estate agent	5
4	Female	69	Chronic back pain	White British	Retired cleaner	6
5	Male	77	Stroke	White British	Retired builder	10
6	Female	51	Chronic pain	White British	Retired nurse	11
7	Female	43	Bipolar disorder	White British	Career adviser	14
8	Female	69	Generalised anxiety disorder	White British	Retired book binder	20
9	Male	52	Depression	Black British	Tunnel miner	20
10	Male	39	Alcoholism	White British	Builder	20
11	Female	51	Depression	White British	Retired healthcare assistant	N/A
12	Female	77	Stroke	White British	Retired cook	8
13	Female	71	Arthritis	White British	Retired cleaner	10
14	Female	56	Depression	White British	Hairdresser	N/A

N/A = data unavailable.

patient. I carry that burden in a way. For good or for bad.' (Dr5)

'Containing' patients with long-term illnesses — seen both in terms of preventing the progression of a patient's condition and of limiting their management to primary care, aiming to reduce use of secondary-care resources — was described as an effective management strategy. The skills for such holding were noted as listening, monitoring, and understanding that little apparent clinical achievement was a positive outcome:

'I think the skill is not to do anything rather than be proactive.' (Dr8)

'I don't try and change the world, I don't analyse it too much, I try and react to the problem that comes on the day.' (Dr10)

Patients had a similar view:

'... just to listen mainly. A lot of the time with me it is just getting it out of my head. That's 90% of the problem gone then, just because I have let someone else know ...' (Pt10)

Most GPs noted that maintaining a holding relationship was a doctor's role and reported that they possessed the necessary skills required to provide patients with holistic care and manage people with complex medical and psychosocial problems.

The value of holding

Some patients undoubtedly valued their relationship with their doctor very highly, attributing this in part to sharing current and past hardships, including child abuse, domestic violence, and bereavement, which had helped them cope with these issues:

'She will listen to me when I talk. But I think that's all she can do, like she says your past is very very sad, but that's all gone now.' (Pt4)

Others valued simply feeling better after a consultation, receiving support and reassurance, or a 'morale boost' (Pt3):

'I suppose she gives me confidence to deal with it ... "you can do this" "you can sort this out". I come out feeling more positive.' (Pt3)

'I always leave there feeling positive ... We speak on a level ... We'll work round things and head in a positive direction. Even if that is just come and see me in 2 weeks and look

after yourself till then.' (Pt10)

All GP participants valued offering ongoing holding doctor-patient relationships, several attributing to them job interest and satisfaction along with patients' gratitude, positive feedback, and health gain:

'I think it's what we do best and what is most satisfying ... acute things are in and out and it's the ones that come back and without necessarily seeing improvement in the illness ... you can see improvements in coping skills and things and that's important.' (Dr11)

For their patients, GPs perceived value from holding in emotional and social support, reassurance, and having accumulated knowledge about patients' narratives or stories.

Through this knowledge accumulated over time, trust and consultation efficiency were thought to be improved without the need for active changes in medical care:

'I think she knows that I understand her, I understand her history if you like, the narrative, her story.' (Dr5)

'I think I provide support, sort of emotional support, stability in her life, trust. And I try to understand her symptoms and the impact they're having on her life ... it's the knowing of the patient and the patient having the sense that you know about them. That's what a lot of patients value.' (Dr9)

This was echoed by patients, who valued their doctor as a source of support and information:

'If you can find a GP within a practice who you can relate to ... and you have got some continuity, that is excellent. Because you do build up a relationship ... The familiarity is nice. You are not walking in and having to start from afresh on each visit. And that is really good ... Obviously it is very important if you can build up a relationship if you have got ongoing problems in particular.' (Pt3)

Dangers of holding

Some GPs expressed concern about dependency as a potential danger with patients in holding relationships, but their accounts suggested that this was not an issue in everyday practice. Of more concern was the possibility of missing new symptoms in holding patients, which might be attributed to an existing chronic problem:

'I don't think that that kind of relationship is without risk for the patient. I think the trouble is if you've got someone who's complex and you think you know them well, they can sometimes come up with something new and you might miss it because you think you know all about them.' (Dr7)

'When you know someone over years sometimes you perhaps don't look at things objectively.' (Dr9)

Some doctors suggested consultations with 'holding' patients were a personal challenge, needing communication skills more than medical knowledge. These accounts reveal frustration that sometimes time-consuming consultations achieved apparently little:

'You do feel as if you're almost banging your head against a brick wall sometimes to get her to comply and take on board what you're actually saying.' (Dr8)

'Am I getting frustrated and is my frustration impacting on the care I can give her?' (Dr9)

Barriers to holding

Nearly all GP responders believed that recent changes in primary care have affected their relationships with holding patients. Fragmentation in primary and secondary care was proposed as a barrier to holding, possibly affecting quality of patient care. Government initiatives emphasising measuring performance indicators against targets were felt by many responders to have diverted attention from managing holding patients, in part by increased workload:

'The bad part of QOF is that it can be quite easy to concentrate on QOF, and not the patient in front of you.' (Dr1)

'You could say it's improved measured care, but each of these things has taken away part of that listening time.' (Dr6)

For patients, all of whom were keen not to waste their doctors' time and were prepared to wait to see their preferred GP, the chief barriers to maintaining support were appointment and telephone systems:

'It's hard to get appointments to see her ... you are on the phone and it is engaged.' (Pt6)

These barriers were reduced by systems

allowing easy regular contact, particularly by some doctors booking their patients' appointments as a follow-up tool.

Judgements on the other

Patients noted that initially establishing ongoing relationship and building up trust needed time. Once established, it was seen as extremely significant — verging on friendship:

'Dr Z [names GP] has been there for me every step of the way. You know he really is, I've just got to say he is my friend.' (Pt8)

'But I would like to think of him as a friend, not just a doctor ... As far as I'm concerned if I was to die tomorrow my life has been enriched by meeting Dr Z and having his friendship.' (Pt9)

Key attributes given to GPs by these patients were having time to listen and being interested in them as people within their local context (noted to be particularly reassuring), while aiming to solve problems together:

'He always has time to talk or listen. He's never shaken his head and told me to go away.' (Pt10)

Many responders said that their doctor was honest and straight talking, describing negotiation when decisions about medication, referral, or investigation had to be made:

'He would say it exactly as it is to me.' (Pt8)

'He can be firm when he wants to be firm. Even if I don't want to hear it he will turn round and tell me.' (Pt9)

Most described their doctor as someone who goes 'the extra mile' (Pt9), giving 'more than really the job description demands' (Pt3). Importantly, limits were also noted:

'They are not God are they ... If I go in and I'm not very well, I expect a miracle and they don't happen do they?' (Pt12)

Several GPs suggested that 'holding' offered stable support to emotionally needy patients. Others emphasised encouraging patients to develop an active role in relation to their illness along with responsibility for their own health. This was postulated to improve health outcomes:

'She's a bit passive in some ways, and so I've

tried to engage her more in an active relationship with her illness.' Dr2

'I suppose she hasn't got anybody else. I think if she had a stable family background or whatever, she'd probably go to someone in the family ... I'm somebody more neutral really.' (Dr11)

DISCUSSION

Summary

Holding relationships emerged from all GP responders' accounts as routine work. Most suggested that they had 15–20 patients each in this category, with chronic or complex healthcare needs, for whom holding work was an explicit containing management strategy. Patient responders did not use the term 'holding' but were almost all clear that their relationship with their doctor, perceived by their doctor as a holding relationship, was special, different from encounters with other health professionals, supportive, and trusting. Although keen not to waste doctors' time, they reported benefits from this of feeling more secure, confident, and positive, particularly valuing time offered for listening, interest in them as individuals, and a sense of partnership with their doctors. Additionally, doctors and patients valued the shared narrative and pre-existing knowledge of a patient's past life-story — helpful in everyday consultations — offered by the continuity of a holding relationship. GPs noted that establishing this required listening time and skills, both within individual consultations and over ongoing interactions, but offered the possibility of attempting to change patients' illness behaviour.

Other GP responders described fear of possible dangers in holding work. These were firstly of patients becoming dependent on their GP and, secondly, of missing medical problems due to diminished clinical vigilance that might result from seeing a patient regularly.

Strengths and limitations

Qualitative methodology enabled collection of rich data not available through other methods. Interviewing both 'holding' doctors and 'held' patients allowed parallel perspectives, particularly patients' accounts, to be brought into view. Urban/suburban geographical sampling complemented previous work,²⁴ as did limiting GP responders to those who had been in practice for over 5 years. Sampling included a variety of GPs and patients of different ages. Having a team of

researchers for each arm of the study (doctor, patient) increased data collection and the trustworthiness of analysis.²⁶

All GPs were known personally to one of two researchers, and it may be that they shared the assumptions made that holding is an important part of general practice, by agreeing to participate in the study. However, neither holding nor doctor–patient relationships were mentioned in the original invitation letter, the study information sheet, or at the start of the interview topic guide, all of which focused on exploring GPs' and patients' experience of chronic illness. It is possible that interviews with GPs who were randomly sampled (perhaps particularly from non-training practices) would generate different data. All GP responders were white British in this small study. Patient participants were mostly also white British, limiting the value of the study for people of other cultural and linguistic backgrounds. Patients were all selected by their GPs as being in holding doctor–patient relationships, which will have influenced their interview accounts.²⁷ Patient responders had all been registered with their practices for between 3 and 20 years, and it is not known how patients who move practices frequently might respond.

Having medical students as interviewers will also influence the data collected,²⁸ as will all researchers being clinicians, and may have limited the scope and richness of the data; involvement of researchers from different research backgrounds might improve the trustworthiness of data collection and analysis.²⁶ All the study conclusions are inherently limited, as qualitative interviews explore what people say they do, not necessarily what they actually do.

Comparison with existing literature

This study, building on previous work,²⁴ establishes holding work in the doctor–patient relationship in primary care. Almost all GPs interviewed in this study and previously²⁴ recognised holding as a significant but small part of their routine work in managing patients with chronic illness and ongoing healthcare needs — generally not more than 20 people per GP at any one time.

This study restates the work of Cartwright and Anderson, who asked patients 'do you consider your doctor to be something of a personal friend or is your relationship pretty much a businesslike one?'.²⁹ Just over one-third of people questioned suggested the former. Over 20 years later, patients in the

present study described the same important relationship. The study responders' accounts demonstrate the value given to holding work by patients and doctors alike, both describing partnership within this work — a General Medical Council recommendation.³⁰ Such ongoing relational work would appear to be a mutual investment,^{1,2} with therapeutic potential,^{3,4} inherently patient centred, taking account of patients' perspectives, and sharing control of interactions.³¹ It echoes the concept of the 'doctor as drug' suggested by Balint,¹ but contrasts with biomedical and organic diagnosis/treatment approaches to medical practice⁶⁻⁸ by offering clinical encounters that support and maintain rather than cure. The skills needed for this ongoing work are not so much those of diagnosis and treatment, as those of listening, honesty, and ongoing accessibility; more pastoral than clinical,²⁴ listening than treating. That some patient responders accounted for this supportive 'caring not curing' relational work as verging on friendship emphasises both its importance and its distance from traditional diagnostic biomedical approaches. Previous literature, however, suggests that this can be a source of frustration and disempowerment for GPs.⁹⁻¹¹

As holding work offers ongoing supportive care without expectation of cure, it is not easily measurable, challenging both component-based models of the consultation,¹²⁻¹⁴ and policy based on evidence of effectiveness.¹⁵ However, holding provides a mechanism for the role of the GP as 'the heart sink of the NHS, absorbing both risk and workload'.³²

Implications for practice and research

Further study would determine whether holding work is as important as the authors feel it is, through direct observation or recording of consultations. In addition, the question of whether this concept is affected by cultural issues requires exploration, through a similar study of GPs and patients of non-white background. Determining whether holding work should be rewarded under the QOF¹⁵ is vital in order to bring holding into view — the challenge of

'measuring' such relationships has been discussed by Greenhalgh and Heath.³³ The effect on this aspect of GP work of the move to GP-led commissioning, and the explicit role GPs will have in restricting resources is ripe for investigation.

This study is not presenting something new. The authors believe they are restating what many GPs already know. This is not a limitation of this study, as it is vital, with GP roles changing (GP-led commissioning; explicit rationing of services), to restate the importance of the doctor-patient relationship, particularly in people with ongoing, complex healthcare needs. Holding work offers a possible management tool in these potentially difficult relationships. Altering doctors' perceptions of such ongoing relationships with people who have chronic or complex healthcare needs from frustrating lack of progress to positively valued holding work — keeping someone ticking over through support, trust, and listening over time without expectation of cure — may be a significant and empowering therapeutic step for both doctor and patient.

Holding work, however, implies that relational continuity — of both doctor and patient — is important (G Freeman, personal communication, 2010). There is a need to influence policy makers' perceptions, to enable allocation of value away from biomedical indicators towards essentially unmeasurable aspects of primary care, such as doctor-patient relationships over time. Naming and valuing such perceptual revisioning may provide alternative management strategies for both individual clinicians and policy makers alike.

Training of GPs about holding work, along with research into teaching holding, would allow preparation for future practice working with patients with chronic or complex health needs.

How holding, and the sustainability of ongoing GP-patient relationships, will survive current policy developments¹⁸ is unknown. Acknowledging the value of holding and, possibly, rewarding it as a legitimate and important GP role, would be a start.

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Competing interests

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