Out of Hours

Future-proofing relationship-based care:

a priority for general practice

Trish Greenhalgh asked the College Annual Scientific Meeting in October how we can preserve the therapeutic doctor–patient relationships that are at the centre of general practice.

I began my talk by describing (with consent) two patients whom I had seen in my surgery the previous week. One I had known for many years; the other was newly registered. Both had multiple chronic conditions that had affected them physically, cognitively, emotionally, and economically. Through a brief analysis of these 'cases', I illustrated how effective care in general practice is delivered through, and enhanced by, a strong therapeutic relationship.

KNOWING OUR PATIENTS

We know in our bones (as a result of everything our patients have taught us over the years) that *knowing* our patients is not merely a matter of adding up the test results or filling in the QOF template. *Managing* our patients is not merely about making the occasional evidence-based decision and playing every member of the multidisciplinary team to their strengths. It is also, of course, about following the story of the person in context: the individual nested in the family, nested in the community — and as we all know, it's more often about addressing the complex needs of the individual who lacks a family and is excluded from his or her community for whatever reason.

Relationship-based care also allows us to consider, for example, the patient's fibroid uterus in the context of her weak bladder, in the context of her diuretic therapy, in the context of the limited treatments at our disposal, given the many side effects she has had from other blood pressure medications over the years. Leaving aside all the social aspects of a long-term clinical relationship, it is this same ongoing relationship that allows us to synthesise a person's complex clinical conditions into a deep, holistic knowing of our patient that informs our intuitive judgements to a remarkable degree, a phenomenon I don't think has ever been adequately researched.

Cum scientia caritas. Our College motto: '*loving care with expert knowledge*'. I suggest that the reason we feel so strongly about relationship-based care is that it is a defining feature of good professional practice — of what philosopher Alasdair MacIntyre terms '*medicine's internal goods*'. How, then, can we future-proof relationship-based care?

> *"We owe it to tomorrow's patients as well as tomorrow's doctors to take a stand on the inexorable retreat of medical education from the messy, non-standardisable reality of illness and suffering."*

WHAT IT MEANS TO BE A GOOD GP

First, I believe that, like Bevan's NHS, relationship-based care will persist for as long as there are people willing to fight for it. And this means articulating the counter-narrative to the neoliberal discourse of choice and competition. We need to spell out, in the time-honoured tradition of our Royal College, what it means to be a good GP and why relationship-based general practice matters. And we need to do this not only in the pages of the *British Journal of General Practice*, but also in the spaces where broad-based civic engagement happens: blogging sites, social media, debating forums, the Institute of Ideas — and, perhaps even, the *Daily Mail*. Our patients will, of course, be our greatest allies here because, survey after survey has shown that seeing one's *own* doctor is preferable to seeing *any* doctor.

Secondly, we need to stem the haemorrhaging of experienced GPs from our profession under the euphemism of 'early retirement'. The very doctors who have the most experience of delivering relationship-based care, from whom students and trainees have much to learn, are the ones being driven most rapidly from our ranks by the technocratic logic that has come to characterise the professional standards agenda. In the past year or so, many of us have won our revalidation spurs by waging a gallant fight against the twin forces of bureaucracy and clunky computer technology. But how many excellent GPs do we know who decided to throw in the towel 1 or 2 (and in some cases 5 or 10) years early, rather than do battle with the system? To retain only those GPs with the inclination and stamina to play the managerialist revalidation game is an alarmingly powerful form of professional Darwinism.

Thirdly, we need to challenge the colonisation of medical education by the unreal: the simulated patient, the silicon body part, the standardised scenario, the objective and structured — but entirely fictitious — clinical examination. I know the value of skills labs in helping students learn to take a blood pressure or catheterise a manikin. And I know that a structured approach makes both teaching and assessment more consistent and reproducible. But I also know that what honed my own professional virtues was early and prolonged contact with real patients suffering from real illnesses, real anxieties, and real social situations — and shadowing experienced doctors caring for those patients. In my view, medical schools have overused and abused the technologies of the unreal in a misguided pursuit of the spurious psychometric goals of reliability and reproducibility — and at the expense of the far more crucial goal of validity. To what extent is the ability to strut a stellar performance at a 10-minute OSCE station a *valid* measure of the ability to develop and sustain meaningful, committed therapeutic relationships with real patients over weeks and months and years? We owe it to tomorrow's patients as well as tomorrow's doctors to take a stand on the inexorable retreat of medical education from the messy, non-standardisable reality of illness and suffering. Finally, and perhaps most importantly, relationship-based care rests on an increasingly precarious foundation: the structure, staffing, and reward systems of general practice, where registered patients are offered life-long, personalised, comprehensive care that is free at the point of need.

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DOI: 10.3399/bjgp14X682357

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