

General practice in the years ahead:

relationships will matter more than ever

COVID-19

In September 2019 the Johns Hopkins Center for Health Security published *Preparedness for A High-Impact Respiratory Pathogen Pandemic*, with ten recommendations to health systems around the world.¹ The report had little traction in western countries. One narrative of the COVID-19 pandemic describes an early, coordinated, community and public-health-based response, with strong political and medical leadership, in several African, eastern, and southern hemisphere countries. In contrast, a slow and confused response, based largely on improving the provision of treatment, rather than dealing with the spread of infection, was seen in many western countries, including the UK. Countries with well-developed, high technology healthcare systems would, hubristically, be able to treat their way out of trouble. The fact that entire national health systems came within a hairsbreadth of total collapse served as a stark reminder of the folly of ignoring 'the science'. Effective vaccines against coronavirus infections are now within reach, but it is vital to strengthen public health and primary care structures to respond more effectively to future, as yet unrecognised, pathogens.

COVID-19 AND GENERAL PRACTICE

General practice, like most sectors of the NHS, was forced to make rapid, radical, and previously almost unimaginable adjustments to working patterns and patient care. Recent commentators have recognised that beyond these crises, and the tragedies of the pandemic, lie opportunities to rethink what constitutes the core of general practice, and must be retained, which new modes of consultation and treatment can best support core activities, and which need to be scaled down or discarded. In a June editorial in the *BJGP*,² Royal College of General Practitioners (RCGP) officers reflected on the dangers to general practice posed by the COVID-19 pandemic and the opportunities

to rethink priorities for the future. More recently, Denis Pereira Gray and colleagues, in a *BMJ* editorial,³ described a 'fork in the road' for general practice and looked forward to a future in which efficiencies, achieved by harnessing new technologies, will permit longer consultations, more face-to-face patient contact, and greater continuity of care. The RCGP is launching a major initiative on relationship-based care, which is regarded as being central to effective general practice, although the College Chair acknowledged in a June 2020 blog post⁴ that 'We've got to get better at making the case for relationship-based care.' Here are some possible ideas and arguments.

ANEURIN BEVAN AND WILLIAM OSLER

Four of the siblings of Aneurin Bevan, the architect of the NHS, died in childhood and it is, perhaps, unsurprising that he is reported as saying that 'I would rather be kept alive in the efficient if cold altruism of a large hospital than expire in a gush of warm sympathy in a small one'.⁵ Whether or not we agree with his assertion, it points up the tension between high-technology medicine, and its continuing political appeal, and the tens of thousands of life-changing encounters that happen every day in the intimacy of general practice consulting rooms, unseen and often disregarded by politicians and policymakers. William Osler, master of clinical method and, of course, not a GP, was more on target: 'It is much more important to know what sort of patient has a disease than what sort of disease a patient has'.⁶

Two separate but related strands of research and scholarship contribute to the evidence base for relationship-based care: the extensive literature on patient-centred care, and the compelling evidence emerging from more recent research on the benefits of continuity of care.

Patient-centred care. Patient-centred care is characterised by information sharing,

respect for patient preferences, and shared decision making. It is care that is accessible, comprehensive, and collaborative, which is aligned with patients' goals, and that respects patients' values, cultural traditions, and socioeconomic conditions.

Across a large research literature, patient-centred care has been shown to be associated with greater concordance with medication and treatment plans following shared decision making, increased patient satisfaction with care, increased wellbeing among both patients and clinicians, more appropriate resource allocation, and cost containment. At a time when recruitment to medicine is problematic, and burnout and disenchantment worryingly common, the benefits to medical staff of a patient-centred, rather than a purely transactional, approach to care should be of particular interest to policymakers and planners.

Continuity of care. Continuity of care can be thought of in a number of ways.⁷ Informational continuity ensures that full patient information is available to make current care appropriate for each individual. Management or organisational continuity describes a consistent and coherent approach to care in response to a patient's changing needs. Relational continuity describes an ongoing therapeutic relationship between a patient and one or more care providers. Continuity has been shown to be associated with remarkable health benefits, including reduced mortality among patients who have greater contact over time with individual doctors.⁷ Other beneficial associations include greater patient satisfaction, better health promotion, increased adherence to medication, and less hospital usage. There is now evidence of a steady erosion in personal continuity of care⁸ that threatens these positive outcomes, so that devising methods of improving continuity should be a priority in service planning. It is worth emphasising that the benefits of patient-centred care are also found in hospital settings, and that some of the benefits of personal continuity are likely to be transferable across care settings.

Relationship-based care. Relationship-based care often incorporates continuity of care but goes beyond it, signifying patient care that is enhanced by a high-quality relationship between doctor and patient, and

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is characterised by trust, mutual respect, and the sharing of power.

DESIGNING OUR FUTURE

There is now a real opportunity to think more freely about the kind of general practice and primary care we wish to see when professional and civic life emerges from the constraints and miseries of the pandemic. General practice must be conceptualised as being first-contact care that is personal, comprehensive, continuing, and coordinating. Accessibility is central, as are high standards of clinical practice. Respect for patients, whatever their circumstances, should be a given, and should be reflected in the quality of the built environment in which primary care is delivered.

The COVID-19 pandemic accelerated some changes that were bubbling under before it struck, and we now need to look carefully at whether or not these should become enduring components of general practice. Remote consultations have been of great value, but the untested suggestion that they should comprise most patient contacts in primary care — ‘digital by default’ — should be viewed sceptically. It is important to remember that COVID-19 hit us at a time of serious under-recruitment and underinvestment in the NHS, and it is important to do everything we can to redress these significant deficits. It will not be in anyone’s longer-term interest to make workforce plans based on current numbers of doctors and other NHS staff — our per capita numbers of doctors and nurses are among the lowest in the OECD countries.^{9,10} Although skill mix within the primary care team is to be welcomed, the clinical and cost effectiveness of new roles needs to be established before they are embedded in team structures and spending plans. Role substitution, which may have initial financial appeal, could well turn out to be more expensive and less effective than hoped.

Most critically, we must think of imaginative ways of continuing to provide patient-centred care and good levels of individual, informational, or organisational continuity in the face of constrained resources and reduced workforce numbers. Solutions might include careful allocation of clinical time, including calibrating the numbers and lengths of appointments, the use of micro-teams, multiprofessional teams, and locality teams, particularly when part-time and portfolio

working create challenges for personal continuity. Research is needed to determine whether it is possible to create space by using telephone triage and audio/video consultation more widely. Preconsultation assessment and text or email exchanges between doctors and patients, imaginative, patient-led approaches to chronic disease management, and significant reductions in bureaucratic load, partly through more sophisticated automation,¹¹ may all have a place. Research is also needed into the potential benefits of remote monitoring, wearable technologies, and home testing and measurement in chronic disease management, which could also contribute to freeing up space for continuity of care through the provision of more face-to-face consultations.

MAKING THE CASE

Relationship-based care will flourish under conditions that promote personal, organisational, and informational continuity of care. There is a growing consensus that close relationships between patients and doctors is associated with significant health benefits for patients, as well as better use of NHS resources. Critically, continuity within the doctor–patient relationship is also good for the wellbeing of doctors. The flipside is that fragmented care in consultations with patients who GPs never get to know is likely to be bad for both patients and doctors. There are encouraging signs of steadily rising numbers of graduates entering GP training, and the next task is to improve retention of the GP workforce. Creating organisational arrangements in which relationship-based medicine can be practised is likely to be a major step in the right direction. The case for relationship-based care is supported by strong arguments relating to the health of the GP workforce, as well as that of patients, and with better use of NHS resources.

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REFERENCES

1. Johns Hopkins Center for Health Security. *Preparedness for a high-impact respiratory pathogen pandemic*. 2019. https://apps.who.int/gpmb/assets/thematic_papers/tr-6.pdf (accessed 2 Dec 2020).
2. Marshall M, Howe A, Howsam G, *et al*. COVID-19: a danger and an opportunity for the future of general practice. *Br J Gen Pract* 2020; DOI: <https://doi.org/10.3399/bjgp20X709937>.
3. Pereira Gray DJ, Sidaway-Lee K, White E, *et al*. Continuity of care with doctors — a matter of life and death? A systematic review of continuity and mortality. *BMJ Open* 2018; **8(6)**: e021161.
4. Marshall M. We’ve got to get better at making the case for relationship-based care. 2020. <https://www.rcgp.org.uk/about-us/rcgp-blog/a-message-from-your-chair-of-council-26-june-2020.aspx> (accessed 2 Dec 2020).
5. The Minister of Health (Mr Aneurin Bevan). National Health Service Bill. <https://api.parliament.uk/historic-hansard/commons/1946/apr/30/national-health-service-bill> (accessed 2 Dec 2020).
6. John M. From Osler to the cone technique. *HSR Proc Intensive Care Cardiovasc Anesth* 2013; **5(1)**: 57–58.
7. Haggerty JL, Reid RJ, Freeman GK, *et al*. Continuity of care: a multidisciplinary review. *BMJ* 2003; **327(7425)**: 1219–1221.
8. Levene LS, Baker R, Walker N, *et al*. Predicting declines in perceived relationship continuity using practice deprivation scores: a longitudinal study in primary care. *Br J Gen Pract* 2018; DOI: <https://doi.org/10.3399/bjgp18X696209>.
9. OECD. Doctors (indicator). 2020. DOI: 10.1787/4355e1ec-en.
10. OECD. Nurses (indicator). 2020. DOI: 10.1787/283e64de-en.
11. Willis M, Duckworth P, Coulter A, *et al*. Qualitative and quantitative approach to assess the potential for automating administrative tasks in general practice. *BMJ Open* 2020; **10(6)**: e032412.