to *contribute to the health and wealth of the nation*.

And what happens when we seek good-quality primary care? The questions generated by the symptom are answered. We are reassured that we are responding appropriately, doing 'everything possible' (*restoring order*) including: doing nothing; watching and waiting; having tests; and being seen at the hospital.

So, my attempt to summarise the aim of general practice?

To restore order to the chaos of symptoms so people can contribute to the health and wealth of their nation.

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Competing interests

I have no conflicts of interest to declare. I receive funding from the National Institute for Health Research (NIHR) as a Senior Investigator (NIHR 200151) and I have shamelessly espoused the notion of contributing to the health and wealth of the nation from the NIHR.

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Beyond relational continuity

I read with interest the proposed mechanisms that link relational continuity to outcomes.[1] The discussion is comprehensive and the proposed theories plausible. It is important to note, though, that most trial evidence supporting continuity and outcomes examines longitudinal, rather than relational, continuity. These two forms of continuity are obviously related and often conflated, but they are different. Despite this, and the lack of trial evidence supporting causation, relational continuity for patients is primary care, and is almost certainly a 'good thing' that should be maximised wherever possible. However, the current constraints of primary care also make relational continuity difficult to deliver for many practices. We also know that not all patients desire relational continuity or, at times, prioritise timely, convenient access over continuity. While policies that attempt to increase relational continuity of care should be advocated for, we need to accept that many patients do not receive relational continuity. It is interesting that the Royal College of General Practitioners has chosen to promote relationship-based care rather than directly advocating for relational continuity.

Patients who may not want, or be able, to see the same clinician want continuity in its other forms. Continuity encompasses more than seeing the same clinician. Models of continuity such as Haggerty's describe several aspects of continuity, including clinicians having access to appropriate information (informational continuity) and patients being treated in a joined-up coherent manner (management continuity).[2] Patients expect informational and management continuity when being treated in the NHS. Common sense would suggest that a lack of information and a coherent management strategy between clinicians would lead to poor outcomes. However, there is little in-depth research looking at this or how the various forms of continuity, including relational continuity, interact to produce outcomes. While the addition of Sidaway *et al*'s theory to the continuity literature should be welcomed, future research should seek to understand how other forms of continuity influence outcomes. This understanding is needed to optimise outcomes in primary care as it is, rather than how we would like it to be.

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'You don't know what you've got till it's gone': UK primary care on the global stage

The last few weeks have been filled with despair at the lack of understanding of everyday pressures in UK general practice by NHS England and the media. Despite being responsible for delivering a world-leading vaccination programme, managing

record consultation figures,[1] adapting to large-scale roll-out of remote consultations, and providing 90% of NHS consultations,[2] GPs are portrayed as work-shy, out-of-date, non-specialist obstacles to accessing hospital care.

Ironically, despite our own government and NHS leadership failing to value general practice, international healthcare experts are eager to invest in and develop their own primary care infrastructure, aware of the population health benefits, cost-effectiveness, and greater societal benefits this provides. Research from Harvard Medical School shows that increasing US primary care physician numbers increases average community life expectancy significantly more than additional specialist physicians.[3] Advocacy groups such as the Primary Care Development Corporation in New York, US, aim to invest in the national primary care infrastructure to address pervasive gaps in care and healthcare inequity that a non-universal healthcare system reveals. Similarly, China is currently investing in and rapidly expanding its primary care system, after a recent hospital-centric healthcare transformation is limited in its ability to provide comprehensive universal health care to its citizens.[4]

Other nations are aware of the substantial benefits that a high-functioning, well-resourced, and universal primary care system provides, and are actively pursuing strategies to strengthen or establish their primary care systems. It would be nice if our healthcare leaders saw the same.

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GPs' and patients' views on the value of diagnosing anxiety disorders in primary care: a qualitative interview study

This excellent qualitative interview study carried out by Archer *et al*[1] critically assesses GP and patient perspectives on diagnosing anxiety disorders versus ruling anxiety as a symptom. Anxiety can be an extremely debilitating condition and needs to be managed with care. From my clinical experience, the authors' point that patients find a long-term anxiety disorder harder to cope with compared with depression is very convincing.

As a GP, I have fallen prey to using anxiety symptom codes as opposed to diagnostic anxiety disorder codes in my own practice. Many of the GPs' views from this study resonated with my own reasoning for this. Conversely, it was helpful to see that, from the patient perspective, having a proper diagnosis of anxiety helped them to come to terms with and engage with treatment better. Overall, my realisation is that I will need to adjust my practice more to the patient in front of me and always have the diagnosis of anxiety disorders in mind.

One point that the study did not touch upon, but I would find interesting to read about in the future, is the effect of the COVID-19 pandemic on the perspectives of GPs and patients on diagnosis of anxiety disorders. There is no question that the mental health impact of the pandemic has been tremendous[2] and the prevalence of anxiety and depression in the population has changed. Would this consequently affect the views of GPs and patients in this study?

In my day-to-day practice, I have been encountering more and more patients with symptoms pertaining to anxiety disorders. Would the pandemic compel many patients and GPs to shelve these symptoms to be a mere 'side effect' of the pandemic? Would this consequently lead to GPs using anxiety symptom codes more often? Nevertheless, the value of providing accurate diagnoses concerning mental health is more important now than ever.

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Correction

In the research by van der Wardt V *et al*, Promoting physical activity in primary care: a systematic review and meta-analysis. *Br J Gen Pract* 2021; DOI: https://doi.org/10.3399/BJGP.2020.0817, after publication it came to the authors' attention that one further article should have been included in the review and the 12-month follow-up meta-analysis. The paper has been revised to include this paper: Harris T, Kerry SM, Victor CR, *et al.* A primary care nurse-delivered walking intervention in older adults: PACE (pedometer accelerometer consultation evaluation)-Lift cluster randomised controlled trial. *PLoS Med* 2015; **12(2):** e1001783. There are changes to Figures 1 and 3, Table 1, and some text in the Results section. The corrected results did not change the overall findings, discussion, or conclusion. The online version has been corrected.

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