# Editor's Briefing

*Euan Lawson*

## ALL TALK AND NO CONTINUITY ACTION

Relationship-based care has been championed by Professor Martin Marshall. He demits office as Chair of the Royal College of General Practitioners this November, and reflects in an editorial on the future and the 70th anniversary of the creation of the College at a time of crisis. This month, we feature articles on continuity, and several others are highly pertinent to relationship-based care. Almost everyone agrees on the importance of continuity yet most politicians are still painfully obsessed with access. This fixation is an acute (on-chronic) political problem, manufactured by the right-leaning media who have relentlessly attacked GPs.

Much time has been spent agonising over GPs reducing their clinical sessions. It needs to be emphasised that this is an entirely rational response in an overheated system; more than anything it is a reaction, a symptom, albeit one that adds to the spiralling workforce challenge. The advent of portfolio careers is lamented by many, sometimes by GPs at the end of their careers and that generational disparity is keenly felt by trainees and new GPs. One of the younger GPs at a recent Royal Society of Medicine meeting spoke plainly about being 'alienated' by the implication that new GPs lack the same resilience as the old guard.

Any old guard has an inherent survivor bias, but no subgroup of GPs is to blame for the workforce crisis or the loss of continuity. The much-cited article by Sandvik *et al*, published in this journal in February 2022, mentions that the Norwegian model involved allocation of a regular GP (RGP), but they also stated:

*'Most RGPs work in small group practices of 3–6 doctors. However, RGPs also do public medical work in nursing homes, prisons, schools, and maternal and child health centres, and are therefore usually present in their practices 3–4 days a week.'*

There is a lot to unpack here, not least the question of practice size.

Hull and colleagues' article on continuity looked at practice size and continuity scores for 126 practices in East London as part of their analysis. There is a clear relationship with smaller practices having better continuity, although the variation also suggests that, in the mid-sizes at least, better continuity is achievable across a wide range. However, it is hard to envisage a system less likely to foster continuity than a single mega-practice where 30–40 GPs are laagered. There may be advantages, not least the raw fact it ensures survival, but much is lost; the collegiality of a thriving partnership cedes to the corporate. Continuity is an umbrous presence ghosting on the fringes. Where is the political drive to prioritise continuity and address structural factors including the implications of larger practices? Ironically, given the general agreement of the importance of relationship-based care, it is all talk and no action.

Euan Lawson,
Editor, *BJGP*

Further notes from the editors and other *BJGP* news can be found at https://bjgplife.com/bjgp

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### Issue highlights

Editorials on inequalities in people with learning disabilities, data, and the role of economic indicators highlight the extraordinary remit of primary care. Qualitative research offers important insight into the patient experience for those with persistent symptoms and how we can support people with pain-related distress. The important topic of treatment burden in people with multimorbidity is explored further. It may be relatively rare but most GPs will live in mild trepidation of the atypical melanoma — we have a Clinical Practice article to help and a thorough Analysis critically explores the management of reflux and the challenge of proton pump inhibitor overuse.

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