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The power of trusting relationships in primary care

Relationship based care remains a fundamental feature of safe, effective practice

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Every medical specialty prides itself on the tools it uses to ply its trade. Physicians have their stethoscopes, surgeons their scalpels, radiologists their scanners. General practice, **[primary care?]** with its commitment to the humanities, claims a different sort of tool—a trusting relationship with patients. This essential tool is currently under threat because of workload pressures and **[an enduring?]** lack of understanding by policy makers.[1]

This matters. When a GP sees a patient they know and there is mutual trust it's easier to avoid prescribing unnecessary antibiotics and easier to reach agreement with the patient that they don't yet need a scan for their back pain or to see a dermatologist for their rash. And patients are more likely to disclose relevant background information such as a history of sexual abuse or a truthful assessment of their alcohol consumption.

Research evidence supporting the benefits of trusting relationships is growing, and though mostly observational, the findings are consistent.[2] Trusting relationships between patients and their doctors are associated with better patient experience,[3] improved adherence to advice,[4] better health outcomes[5] and lower mortality.[6] They are also associated with higher job satisfaction among general practitioners[7] and benefits to the wider health system, including less frequent use of hospital emergency departments, reduced likelihood of hospital admission, and lower overall healthcare costs.[8]

Given this evidence, if relationships were a drug, guideline developers would likely mandate their use. Instead policy makers and health system leaders tend to treat general practice as if it were a series of unconnected technical transactions. While some primary care interactions are transactional **[such as? repeat prescriptions for stable patients?]** many are not, and harm can occur when complex problems are dealt with in transactional ways.

Ignorance of, or scepticism about, the benefits of relationships reflects wider trends in society. It is now rare for people to have a personal relationship with their bank manager, a growing number of public services have an impersonal front end, and people are encouraged to shop around rather than show loyalty. A transactional mindset may also be exacerbated by greater geographical mobility of patients and health professionals, part-time working, larger scale multidisciplinary primary care organisations, and disease focused payment incentives.

Keeping up

Both the conceptualisation and the delivery of relationship based care need to adapt to ensure that it remains deliverable in the context of these trends. What needs to be done?

First, the concept of relationship based care must be demystified for policy makers and system leaders. The language of "value"—better outcomes at lower cost—is most likely to engage leaders, who then need support to assess the effect of their policies on the ability of frontline clinicians to maintain trusting relationships.

Second, the building of relationships requires time and space. The current environment in general practice is not conducive to this—on average three problems are presented in a 9.8 minute consultation, and GPs are working 11 hour days and seeing or speaking to over 40 patients in that time.[9] Most GPs are working well beyond their capacity to deliver person centred care, and most would not recognise the concept of "unhurried consultations."[10]

Third, early career GPs need reassurance that while the traditional model of longitudinal relations with patients over many years remains powerful, it is possible for clinicians to build trust rapidly. Highly trained generalists, using their knowledge of psychology and sociology, are able to make useful connections with patients even in single consultations. The concept of "speed relationships"[1] will reassure and empower the growing number of practitioners who work part time, on a sessional basis, or who are geographically mobile.

Fourth, we need to understand the implications of triage and remote consulting for relationship based care. Evidence suggests that telephone consultations are often shorter and are characterised by less data gathering, less advice, and less rapport building than in-person consultations.[11] But this evidence was created at a time when face-to-face consultations were the norm, and as both training and experience in remote consulting increase, digital interactions between patients and clinicians may become more substantive and more sophisticated. In addition, effective triage could improve continuity of care by directing patients to a clinician who knows them.

Finally, more than half of all consultations in general practice are delivered by members of the primary healthcare team other than doctors. The multidisciplinary nature of general practice is viewed by some as an impediment to relationship based care, but there are increasing examples of microteam based care in which relationships are held by more than one clinician.[12]

Relationship based care is a fundamental feature of effective general practice and its existence is at risk. The fewer opportunities practitioners and patients have to experience the benefits of trusting relationships, the less they will be valued and the more they will be at risk. No one would consider removing a scalpel from the hand of a surgeon; trusting relationships in general practice must be regarded with equal respect.

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