EDITORIAL

Trust and Relationships Remain at the Heart of Primary Care

Kenneth W. Lin, MD, MPH
Georgetown University Medical Center, Washington, DC

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Trust in medicine is at a low ebb. Although 3 highly effective, safe vaccines against a highly contagious virus that has caused at least 728,000 US deaths have been widely available at no cost (often accompanied by financial incentives) since the spring of 2021, nearly 1 in 5 adults has not received a single dose.[1] A small but vocal minority of health professionals has opposed COVID-19 vaccination; the American Boards of Family Medicine, Internal Medicine, and Pediatrics recently issued a statement threatening to revoke certification of physicians who spread vaccine misinformation.[2] As mass vaccination campaigns have stalled, recommendations from trusted primary care clinicians have become critical to overcoming vaccine hesitancy.[3]

Institutional trust and a few basic communication practices[4] can be sufficient for a patient to connect with a physician during a single encounter, but patients develop more secure expectations of their physicians through repeated interactions over time.[5,6,7] Via trusting relationships, continuity of care is associated with lower costs and improved patient outcomes.[8] This issue of *Annals* includes several papers that explore aspects of trust and relationships in primary care.

Whether to open the "Pandora's box" of psychological issues underlying the ostensible reason for a primary care visit (eg, depression manifesting as back pain) can be a tricky decision for a clinician who is determined to stay on schedule. In a qualitative and quantitative analysis of audio-recorded encounters in HIV specialty clinics, Beach and colleagues question a prior study's finding that attending with empathy to patient emotions shortens visit length.[9] They found that as visit time elapsed, clinicians were less likely to give patients opportunities to elaborate on negative emotions ("provide space") and more likely to respond explicitly to an emotional expression; these less-empathic communication styles were associated with slightly shorter visits. Readers can judge if saving about 2 minutes per visit is worth what was potentially lost in these encounters.

Compared with clinician-patient relationships, the care implications of clinicians' attitudes toward health care organizations have been relatively understudied. Using baseline data from a randomized trial of work-life interventions in 34 primary care clinics, Linzer and colleagues identify 4 features of organizational culture correlated with the combination of high clinician trust in the organization and high patient trust in the clinician: emphasis on quality, emphasis on communication and information, clinician cohesion, and clinician-leader value alignment.[10] Organizations that devote time and energy to optimizing these features may have happier clinicians and more satisfied patients.

Some patients with complex chronic conditions benefit from additional supportive relationships outside of the primary care team. Turner and colleagues explore the characteristics of patients who declined enrollment and trial participants with different levels of engagement in a peer health-coaching program for veterans with type 2 diabetes.[11] Compared with patients who did not enroll, participants reported higher levels of education and greater perceived need for assistance in managing their diabetes; those who engaged in the intervention described their coaches as being more supportive of their autonomy. Although this study's predominantly Black male population limits its generalizability, its findings may help in targeting similar interventions when resources are limited.

Different generations of primary care clinicians may value different kinds of relationships. Two other papers in this issue illustrate the tension between

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CORRESPONDING AUTHOR
Kenneth W. Lin
Georgetown University
3900 Reservoir Rd NW
Washington, DC 29917
KWL4@georgetown.edu

the priorities of independent physicians and those of groups of clinicians employed by a health care organization. In a narrative essay, Loxterkamp observes that living in the same small community as his patients for 3 decades taught him the value of care continuity as defined as a single physician (rather than a "team") caring for a patient through the duration of their illness.[12] By largely abandoning continuity for "the transactional world of episodic care," he suggests that primary care physicians have given up "our trust and belief in the value of relationships." In contrast, Matulis and Barakat describe an informal cases conference for early-career primary care internists and advanced practice clinicians that reduced isolation by creating a virtual community that evoked the hospital doctors' lounge or a pre-COVID communal break room.[13] After the first year, participants reported statistically significant improvements in sense of belonging and enthusiasm about their work.

As a mid-career family physician whose experience straddles those of the recent residency graduate and the doctor contemplating retirement, I appreciate both perspectives. My role models in medical school and residency were the archetypes of Loxterkamp's day, physicians who prized their autonomy and worked around the clock until all the patient care was done. But more than half of today's primary care physicians, like me, are employees of non-physician–owned practices,[14] and our relationships with these organizations are as critical to sustaining our joy in practice as relationships with our patients. There are also advantages to belonging to a large group of health professionals during a pandemic. As I continue promoting COVID-19 vaccines for patients with low levels of trust in the medical system, it helps to know that my practice team and health care organization have my back.

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Key words: trust; primary care issues: clinician-patient communication/relationship; empathy; health care organizational culture; health care teams; peer health coaching; COVID-19

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CORRECTION

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In Loewenberg Weisband Y, Torres L, Paltiel O, Wolff Saggy Y, Calderon-Margalit R, Manor O. Socioeconomic disparity trends in cancer screening among women after introduction of national quality indicators. Ann Fam Med. 2021;19(5):396-404, the author name Yael Wolff Sagy was misspelled. The article has been corrected online (article of record) and therefore differs from the print issue. The corresponding author regrets the error.