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