Continuity of care in general practice: a survey of patients’ views

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SUMMARY

Background: It is not known how patients value continuity for different health problems. In addition, it is not clear how different types of patients value continuity. It has been argued, for example, that young and healthy individuals have different ideas about continuity from older people with chronic illnesses. More extensive exploration of patients’ views and expectations on personal continuity is important as this may help to organise general practice better in the future.

Aim: To explore patients’ views on continuity of care in general practice and their relations to patient characteristics.

Design of study: Postal questionnaire survey.

Setting: Thirty-five general practices throughout The Netherlands.

Method: A sample of 25 patients from each practice was sent a questionnaire.

Results: The response rate was 644/875 (74%). The percentage of patients feeling that it was important to see their personal doctor varied, from 21% for a splinter in the eye, to 96% for discussing the future when seriously ill. The main reasons for preference of their own general practitioners (GPs) were the GP’s assumed better medical knowledge of the patient and understanding of the personal and family background. Multiple linear regression analysis (GLM) showed that patient characteristics could explain 10% to 12% of the variance in these views on personal continuity.

Conclusion: The importance that patients attach to continuity of care depends on the seriousness of the conditions facing them. Patients in The Netherlands desire a high level of personal care for serious conditions. Patient characteristics, such as age, sex, and frequency of visits to the GP influence views on continuity of care only to a minor extent.

Keywords: patient views; patient perspective; continuity of patient care.

Introduction

There is evidence that continuity of care matters. In the literature, continuity of care mainly comprises the element of personal continuity. Seeing the same doctor may exert its benefit by the doctor’s use of accumulated knowledge about the patient. A feeling of responsibility for patients is believed to support quality of care as well. Recent developments, such as an increase in part-time work, enlargement of practices, general practitioner (GP) specialisation and more extensive out-of-hours services have all put pressure on the personal doctor as the provider of continuity. As a consequence, it has been argued that continuity has served its time and will matter less in the future.

Although identification and discussion of patient beliefs is considered important for quality of healthcare, little is known about patients’ views and expectations regarding continuity. One study found that patients rated personal continuity as less important than their GPs did when considering different aspects of general practice care. Nevertheless, high levels of personal continuity are related to patients having increased trust in physicians, feeling more satisfied with consultations, and more enabled afterwards.

It is not known how patients value continuity for different health problems. Also, it is not very clear how different types of patients value continuity. It has been argued, for example, that young and healthy individuals have different ideas about continuity from older people with chronic illnesses. More extensive exploration of patients’ views and expectations on personal continuity is important, as this may help to organise general practice better in the future.

The main objectives of this study were to assess patients’ views on personal continuity and to determine the extent to which these views are related to patients’ characteristics.

Method

This survey was carried out as part of a project investigating aspects of continuity of care in general practice. A self-designed questionnaire was posted to 875 patients from 35 general practices. The questionnaire incorporated items to elicit views on personal continuity.

Questionnaire design

In the process of questionnaire design, ten semi-structured interviews were conducted to explore patients’ views and expectations of continuity. The interviews suggested that these views were dependent on different situations and circumstances. Therefore, in the questionnaire patients’ views were assessed on the need for continuity in relation to different clinical scenarios. For nine problems requiring con-
This study shows that a vast majority of patients find
in contrast to van den Hoogen, which our study could not confirm. In the United
Schers, S
During normal working hours the responders were
asked to rate the importance of ‘seeing the personal doctor’
using a three-point scale. Patients were also asked their rea-
sons for preferring their own GP; here, responders could tick
a maximum of five out of ten reasons. Finally, general infor-
mation was collected on patients, including their personal
characteristics, number of visits to the GP in the past 12
months, number of years registered with the practice, prac-
tice type, practice area, chronic illness, chronic medicine
use, recent hospital admission, and life events and psycho-
social problems in the past five years. A pilot study was car-
rried out with 20 patients. Following this, changes were made
to produce a final version. Modifications included the simpli-
fication of scales from five points to three points.

Survey sample
The study was based in the practices of 35 GPs spread
throughout The Netherlands. These GPs were members of a
panel of 40 who took part in a recent Delphi study on con-
tinuity of care. In June 2000, each practice assistant was sent
a batch of 25 questionnaires and was asked to post one
questionnaire to each of 25 consecutive patients (aged 18
years or older), who had visited the GP on the first day of
that week. The questionnaires were sent with a letter of rec-
commendation on behalf of the patients’ GPs and a postage-
paid envelope so that completed questionnaires were sent
back to the researchers. After two weeks, a combined ‘thank
you’ and reminder card was sent to all the patients. To
assess possible non-response bias, anonymous baseline
characteristics were collected on all patients.

Analysis
The data were entered into the statistical program SPSS 9.0.
Principal components analysis was used to determine
whether calculation of scores was possible for patients’
desire for personal continuity. Consecutively, a sum score
was calculated for the need for personal continuity (seeing
the personal doctor: ‘very important’ — 2 points, ‘important’
— 1 point, and ‘not important’ — 0 points). Multiple linear
regression analysis (general linear model procedure, SAS)
was used to relate sum scores to patient characteristics.

Results
The mean age of the 35 GPs participating in the survey was
48 (range 36-59). Twenty-eight were men and seven were
women. Ten practised in a single-handed practice, 11 in a
two-person practice, and 14 in a group practice or health
centre. Six practices were situated in the countryside, 18 in
the commuter belt, and 11 in a city.

A total of 875 questionnaires were sent out and 644 usable
replies were received (74%). Older patients, and patients
with chronic illness and more frequent attendance had high-
er response rates (Table 1).

Personal continuity
For most of the presented situations more than 75% of the
responders felt that it was important to see their personal GP
For minor problems, such as a splinter in the eye or a
sprained ankle, only a minority of patients considered it
important to see their personal GP. A majority of patients
thought that it was very important to see their personal doc-
tor for family problems and for discussing the future when
seriously ill (Table 2). Patients preferred their personal doc-
tor chiefly because he was believed to have the best med-
ical and personal knowledge of the patient. Also, the per-
ception was that better communication was possible with
the patient’s personal GP (Table 3).

Relations with patient characteristics
Principal components’ analysis showed that a one-factor
model could explain 63% of the observed variance; all items
loaded high (>0.6) on this component, which justified the
making of a sum score.

Only a few significant relations were found between the
mean sum score and patient or practice characteristics.
Having children and having experienced a serious life event
in the past five years was related to a greater need for per-
sonal continuity. No significant relationships were found with
age, sex, marital status, chronic illness, psychosocial prob-
lems, practice area and practice type. A model containing all
variables explained 10% of the observed variance (Table 5).

Discussion
This study has shown that patients’ desire for personal care
depends on the reason for encounter. In the Netherlands,
Jung found that a majority of patients (64%) considered it
important or very important to see their own GP on each
visit.14 This study shows that a vast majority of patients find
it important to see their own GP mainly for serious medical
conditions and emotional problems. Very recently, Kearly et
al found that, in the United Kingdom, patients valued a per-
sonal relationship with their GPs when consulting for more
serious or for psychological problems.20

It was surprising that views on personal continuity are hard-
ly related to patients’ characteristics. In Sweden, Hagman
found that patients considered continuity less important
than health professionals did.2 In Ireland, Murphy observed
that urban people value personal continuity more than rural
people,21 which our study could not confirm. In the United
States, in a hospital study on various aspects of medical
care, Fletcher found that younger people gave a lower rank
to personal continuity than older people.23 In contrast to
these findings, this study showed that younger patients val-
ued personal continuity more than older people, although not significantly. Patients with more frequent attendance appeared to expect a higher level of personal continuity, but the difference was not significant in the regression analysis. A broad range of patient characteristics accounted for only a small amount of the variance between responders. Apparently, other factors determine the valued importance of personal continuity. More personal characteristics, such as coping behaviour, trust, and dependency may be of influence in this field. Qualitative research would provide a useful approach to identify these factors. Patients are known to distinguish between clinical scenarios as regards their preference to see the usual doctor versus a trainee, or a specialist. This survey shows that

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Table 1. Response rates. Numbers and percentages responding within subgroups (overall response = 644/873).

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Number of responses/surveys sent</th>
<th>Percentage within characteristic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age&lt;sup&gt;b&lt;/sup&gt;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18–40</td>
<td>182/284</td>
<td>64</td>
</tr>
<tr>
<td>41–60</td>
<td>270/349</td>
<td>77</td>
</tr>
<tr>
<td>61–80</td>
<td>170/210</td>
<td>81</td>
</tr>
<tr>
<td>&gt;80</td>
<td>20/24</td>
<td>83</td>
</tr>
<tr>
<td>Sex</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>399/533</td>
<td>75</td>
</tr>
<tr>
<td>Male</td>
<td>243/338</td>
<td>72</td>
</tr>
<tr>
<td>Chronic illness&lt;sup&gt;b&lt;/sup&gt;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>255/314</td>
<td>81</td>
</tr>
<tr>
<td>No</td>
<td>380/548</td>
<td>70</td>
</tr>
<tr>
<td>Number of contacts with GP in the last 12 months (including last visit)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1–2 times</td>
<td>122/177</td>
<td>69</td>
</tr>
<tr>
<td>3–4 times</td>
<td>154/221</td>
<td>70</td>
</tr>
<tr>
<td>5–10 times</td>
<td>244/310</td>
<td>79</td>
</tr>
<tr>
<td>&gt;10 times</td>
<td>121/162</td>
<td>75</td>
</tr>
</tbody>
</table>

<sup>a</sup>Owing to missing values the count of sent questionnaires was 865–871 and responses 635–642. <sup>b</sup>p<0.001 (χ², df = 1 and 3); <sup>c</sup>p = 0.046 (χ², df = 3). (Significant difference between responders and non-responders.)

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Table 2. Percentage of patients stating that seeing the personal doctor is important, or very important (n = 644).

<table>
<thead>
<tr>
<th>Situations</th>
<th>Importance of seeing personal doctor&lt;sup&gt;a&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Important or very important</td>
</tr>
<tr>
<td></td>
<td>Numbers</td>
</tr>
<tr>
<td>Splinter in the eye</td>
<td>126/608</td>
</tr>
<tr>
<td>Sprained ankle</td>
<td>142/607</td>
</tr>
<tr>
<td>Regular blood pressure check</td>
<td>227/610</td>
</tr>
<tr>
<td>Problems at work</td>
<td>435/575</td>
</tr>
<tr>
<td>Sudden, severe breast pain</td>
<td>493/624</td>
</tr>
<tr>
<td>Unexpected blood in stools</td>
<td>511/621</td>
</tr>
<tr>
<td>Family problems</td>
<td>515/591</td>
</tr>
<tr>
<td>Anxiety about a-specific abdominal symptoms</td>
<td>566/618</td>
</tr>
<tr>
<td>Discussing future when seriously ill</td>
<td>591/617</td>
</tr>
</tbody>
</table>

<sup>a</sup>On a three-point scale: ‘not important’, ‘important’, and ‘very important’.

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Table 3. Reasons for general preference for own GP (n = 644).

<table>
<thead>
<tr>
<th>Reason</th>
<th>Numbers</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knows better what my medical condition is</td>
<td>489/644</td>
<td>76</td>
</tr>
<tr>
<td>Knows my personal and family background better</td>
<td>470/644</td>
<td>73</td>
</tr>
<tr>
<td>Is easier to talk to</td>
<td>290/644</td>
<td>45</td>
</tr>
<tr>
<td>Understands me better</td>
<td>206/644</td>
<td>32</td>
</tr>
<tr>
<td>Knows my opinion about treatment</td>
<td>155/644</td>
<td>24</td>
</tr>
<tr>
<td>Knows better what I expect from him</td>
<td>155/644</td>
<td>24</td>
</tr>
<tr>
<td>Is more interested in me as a person</td>
<td>142/644</td>
<td>22</td>
</tr>
<tr>
<td>Can solve my problems better</td>
<td>77/644</td>
<td>12</td>
</tr>
<tr>
<td>Will make greater efforts for me than other doctors</td>
<td>45/644</td>
<td>7</td>
</tr>
<tr>
<td>Will take offence if I visit another doctor</td>
<td>6/644</td>
<td>1</td>
</tr>
</tbody>
</table>
these differences for various scenarios are considerable. For serious problems, patients want to see their own doctors; for minor ailments, this matters much less. These results agree very strongly with recent data from the UK.20

This study had some limitations. The survey carried out focused on a patient sample that had visited the GP recently, because it was assumed that this group was of greatest interest as regards possible implications for service provision, and would be able to give the most valid information. In the group, patients with frequent attendance were relatively over-represented, and patients who did not attend were not present. Nevertheless, it was found that only a very limited relationship existed between the number of visits in the past 12 months and outcome, and therefore the survey also included a considerable number of patients that had visited their GP only once in the past year. Therefore, bias on this point was limited. The practice assistant was asked to send the questionnaires using the appointment book, thereby preventing any selection by the GPs. Although response rates of over 70% are considered to minimise bias,14 there were more responders in the older age groups and in the group with chronic illness. This may have caused some bias but, considering the result that outcome was related only very slightly to patient characteristics, the chance of bias is reduced.

What can be learnt from this survey? First, in a changing society with apparent emphasis on turbulence and short-lived interpersonal contacts, most patients within general practice continue to value a personal doctor for serious and emotional problems, regardless of age, sex, place of residence, and present circumstances. Secondly, patients appear to value personal continuity because they think that this will be beneficial to their health. Prior knowledge of the medical condition, as well as knowledge of the personal and family background, is considered important by patients.

References


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