

Priority given by doctors to continuity of care

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SUMMARY. *The attitude of 297 general practitioners in the Wessex region to continuity of care was assessed by postal questionnaire; there were 280 complete replies (94% response). One-third of the doctors were asked to define continuity of care; the remaining two-thirds were asked to rank six priorities of practice organization one of which concerned continuity of care. In addition, all doctors were asked whether they used a personal or combined list. A wide variety of definitions for continuity of care was offered but the majority of doctors (61%) specified care by one doctor. Personal continuity was rated highest by significantly more doctors in large practices (list size of 10 000 or more) than in small practices and doctors in large practices were also more likely to use personal lists.*

Introduction

IN 1969 a working party of the Royal College of General Practitioners defined a general practitioner as one who 'provides personal, primary and continuing medical care to individuals and to families'¹ and this definition was endorsed by the Leeuwenhorst Group of European general practitioners in 1974.² Although not explicit there was a clear suggestion that a patient would normally expect to see the same doctor over a period of time.

In 1976 Aylett reported that 'the majority of general practitioners working in partnerships in Wiltshire no longer organize their practices so that they care for a defined list of patients'³ and by 1982 70% of British general practitioners worked in groups of three or more.⁴

There is an apparent conflict between the College definition of a general practitioner and the modern trend towards group practices. It seemed appropriate, therefore, to ask a sample of general practitioners from a variety of practices to give their definition of continuity of care and also to estimate how important general practitioners feel it is for patients to see the same doctor. This paper reports the response of 280 general practitioners in Southampton and the Wessex region to a short postal questionnaire about continuity of care.

Method

Populations

Two groups of general practitioners were studied. The first group consisted of all doctors in the Wessex region teaching undergraduates attending Southampton University (41 in the pilot study and 205 in the main study). As undergraduate teachers may be atypical the main study included a second group consisting of all 92 doctors in the Southampton district who were not undergraduate teachers.

Questionnaire design

Asking doctors to define continuity of care might bias their answers about its importance in relation to other priorities and so it was necessary to put these two questions to different subgroups of general practitioners using different questionnaires (Figure 1). In version A doctors were asked to define continuity of care and in version B1 doctors were asked to rank six aspects

of primary care in order of priority. One of the six priority items was a specific definition of continuity of care — 'Patients should see the same doctor if possible' — and a second item — 'Agreed practice policies' — suggested a different way of achieving consistency of care. The remaining four items would all tend to reduce the likelihood of a patient seeing the same doctor.

All doctors were asked for details about partnership size and the total number of patients on the practice list in order to see whether these affected their opinions about continuity. The doctors were also asked whether they used combined or personal list systems (Figure 1).

<i>Continuity of care definition</i>	Version A
Please would you write down what you understand by the term 'continuity of care' in general practice.	
<i>Priorities in general practice care</i>	
The following have been said to be important in general practice.	Version B1
Please would you number them in your personal order of importance (1–6) (that is, most important = 1, least important = 6).	
Each of the following have been said to be important in general practice today.	Version B2
Please would you give each item your personal score out of ten <input type="text" value="1–10"/> .	
	Versions B1 and B2
Minimal delay for patients' appointments	<input type="checkbox"/>
Agreed practice policies on drug prescribing and management of common conditions	<input type="checkbox"/>
An equal workload for each partner in a group	<input type="checkbox"/>
Patients should see the same doctor if possible	<input type="checkbox"/>
Delegation of appropriate tasks to paramedical staff	<input type="checkbox"/>
Special clinical interests for individual doctors, for example family planning, diabetes	<input type="checkbox"/>
<i>Question on combined or personal lists (included in all three versions of the questionnaire)</i>	
In normal working hours <i>either</i>	
does your practice run a 'combined list' allowing patients to see any doctor without formality	Yes <input type="checkbox"/>
or	
do you specifically encourage patients to see one doctor (personal list system)?	Yes <input type="checkbox"/>

Figure 1. Versions of the questionnaire used in the study.

Pilot study

A pilot study involving 41 undergraduate teachers suggested that some doctors preferred to score priorities rather than be constrained by ranking. The ranking method had the advantage of forcing a choice between the six items, some of which tended to be mutually exclusive but the scoring method would confirm whether the doctors thought that the so-called priorities were indeed important. Since it was possible to derive a ranking from score data, albeit with the possibility of more tied ranks (when several items were given the same score), it was decided to use both methods. Thus the main study included three versions of the questionnaire A, B1 and B2.

Questionnaire allocation

The three versions of the questionnaire were allocated in rotation using lists of general practitioners (the departmental list of undergraduate teachers and the Hampshire Family Practitioner Committee list of doctors in Southampton and district) (Figure 2). Approximately one-third of the doctors on both lists received each version of the questionnaire.

Analysis of data

The data were analysed by hand. To compare the attitudes of doctors working in large and small practices the results of the scored questionnaire (version B2) were converted into ranks and combined with the results of the directly ranked questionnaire (version B1). Where several items were given the same score (tied values) an average rank was applied and this sometimes resulted in a 'half value'; for example two items placed equal first would each be given a rank of 1.5. Thus there were 11 possible ranks from one to six. The non-parametric Wilcoxon rank sum test was applied to this data to assess the statistical significance of differences between groups of doctors. However, for clarity of presentation in Figure 3 the 'half values' are combined with the next highest 'whole value'.

Results

The overall response rate for the main study was 94% (Figure 2). All 205 general practitioner undergraduate teachers replied

after two reminders; two gave incomplete answers and one preferred to be a non-responder. Only one reminder was sent to the other group of general practitioners to avoid seeming unduly importunate to doctors who had no link with the University. There were no noticeable differences between the replies from either group and so they were combined for analysis.

Combined or personal lists

The replies to this section of the questionnaire (Figure 1) show a striking variation according to practice size. Although the alternatives were not mutually exclusive 242 (89%) of the 273 doctors practising in partnership gave a definite answer (Table 1). In the small practices, with lists of up to 10 000 patients, 43 doctors (32%) reported using personal lists while in the large practices personal lists were used by 101 doctors (72%). This difference was statistically highly significant ($P < 0.001$).

Definition of continuity of care

There were 94 replies to this section of the questionnaire (Figure 1, version A) (91% response). A first reading led to an initial classification. This was tried, amended and retested before the final sorting of different categories.

Sixty-six doctors gave one definition, or if more than one they indicated a preference. Nine doctors labelled one definition as ideal and another as practical — the ideal definition was assumed to be preferred. Thus, in 75 cases (80% of those responding) there was a clearly preferred definition. Of the remainder, 14 doctors gave two definitions and five gave three and it was not possible to decide which definition was preferred.

The 75 preferred definitions fell into three categories (Table 2). Sixty-one per cent of those responding mentioned care by one doctor, either for an episode of illness or for a longer period and 16% specified care by a team, either of partners or with paramedical staff. Other definitions included care of the whole patient, communication with hospitals or within the practice, care of the whole family by one doctor, the concept of consistency and the need for commitment from doctor and patient. One doctor dismissed continuity of care as jargon.

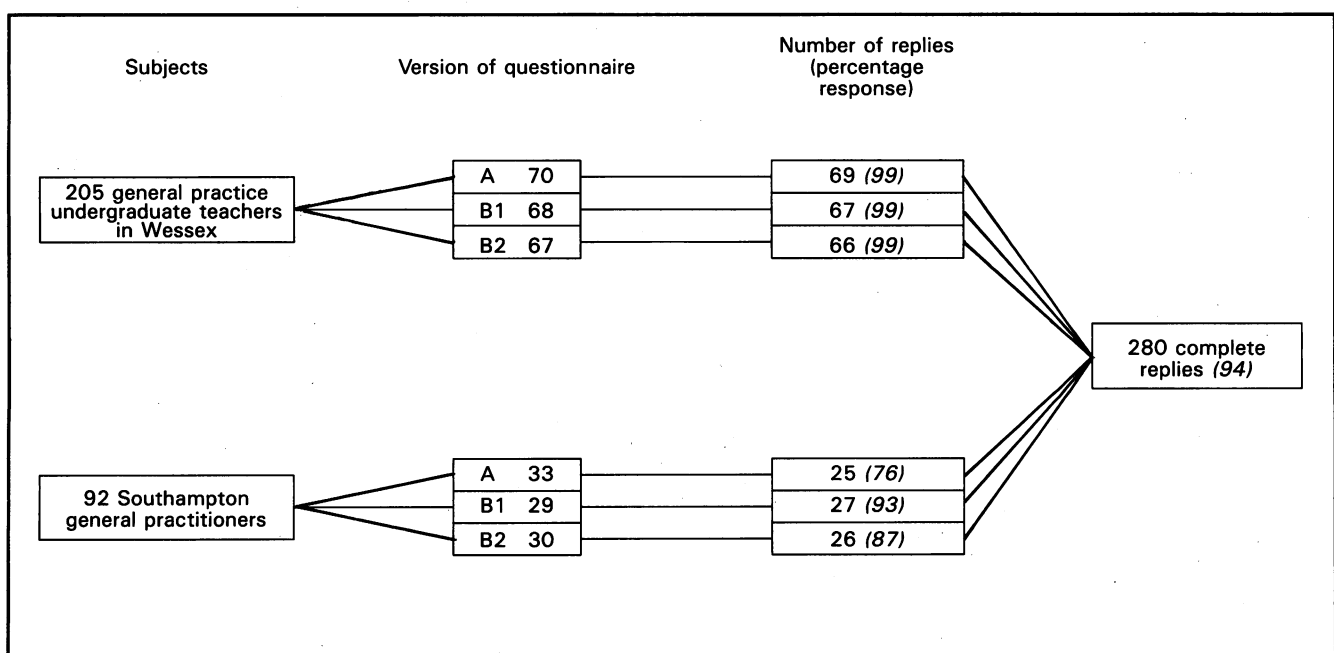


Figure 2. Response to the three versions of the questionnaire for the two groups of doctors.

Table 1. Use of combined or personal lists according to practice size for the 273 doctors practising in partnership. Seven single-handed principals have been excluded.

Type of list	Practice list size		Total number of doctors
	Small <10 000 Number of doctors (%)	Large ≥10 000 Number of doctors (%)	
Combined	77 (58)	21 (15)	98
Personal	43 (32)	101 (72)	144
Not clear	13 (10)	18 (13)	31
Total	133 (100)	140 (100)	273

$\chi^2 = 56.02$, 2 degrees of freedom, $P < 0.001$.

Table 2. Definition of continuity of care by 75 general practitioners in small and large practices.

Definition	Practice list size		Total number of doctors (%)
	Small <10 000	Large ≥10 000	
Care by one doctor for:			
Episode of illness	9	1	10
Long-term	14	13	27
Not specified	5	4	9
Total	28	18	46 (61)
Care by team or partnership	9	3	12 (16)
Other definitions	9	8	17 (23)
Total	46	29	75 (100)

More detailed subdivision of the 46 definitions specifying care by one doctor again suggested a difference between doctors in small and large practices. Table 2 shows that in large practices doctors tended to specify long-term continuity whereas more doctors in small practices were satisfied with continuity over one episode of illness. However, with the small numbers available this difference was not statistically significant ($\chi^2 = 4.59$, 2 degrees of freedom, $P = 0.10$).

Priorities in general practice care

The priorities were ranked in order of preference (Figure 1, version B1) or scored out of 10 (Figure 1, version B2). There was general agreement between the two methods and the order of priorities was the same (Table 3). The mean scores all exceeded five out of 10 suggesting that the doctors considered all the items to be important in general practice. Highest priority was given to 'Minimal delay for patients' appointments' and 'Patients should see the same doctor if possible', showing that personal continuity was thought to be important even when the subject was not specifically prompted.

Data presented as means give no indication of the spread of opinion and this varied for the six items. The biggest contrast was found between the ranking of 'Equal workload' and 'Delega-

tion'; there was a wide spread of opinion about 'Equal workload' while 'Delegation' was given a middle ranking by the majority of respondents.

When the results were analysed according to practice size there were again some differences of opinion between doctors in large and small practices. The biggest difference concerned the importance of patients seeing the same doctor; this is shown in Figure 3, where the score data from version B2 of the questionnaire have been converted into ranks and combined with data from version B1. Doctors in large practices gave more priority to the importance of seeing the same doctor ($P < 0.001$; Wilcoxon rank sum test, two tail, using normal approximation with continuity correction and allowing for extensive ties). Smaller differences were observed for other items; doctors in small practices gave higher priority to minimal delay for appointments and also to equal workload between partners than doctors in large practices.

Table 3. Mean rankings and scores given to priorities in general practice care by 186 general practitioners.

	Rank ^a ($n = 94$) ^d	Score ^b ($n = 92$)	Combined rank ^c ($n = 186$)
Minimal delay	2.28	7.91	2.56
Patients to see same doctor	2.51	7.89	2.63
Equal workload	3.57	7.49	3.34
Delegation	3.68	7.37	3.48
Agreed policies	4.00	6.07	4.24
Special interests	4.86	5.63	4.73

^aHighest rank = 1, lowest rank = 6. ^bMaximum = 10, minimum = 1. ^cScore data converted into ranks and combined with rank data. ^d n = number of doctors.

Discussion

These results confirm that continuity of care has a variety of meanings for general practitioners and therefore it must always be specifically defined before research or even discussion can be profitable.⁵ However, definitions including the term 'Care by one doctor' were the most common (Table 2) and when presented with the statement 'Patients should see the same doctor if possible' among five other statements about practice organization, general practitioners tended to rank this statement near the top of the list.

The difference between general practitioners in large and small practices, apparent in all parts of the study, was unexpected. The break between small and large practices was arbitrarily decided to be 10000 patients on the practice list. (Earlier analysis had shown smooth trends in the following variables when the practice list size varied from 5000 patients to 12500 or more.) Doctors from large practices were more likely to run a personal list (Table 1), to define continuity of care as care from one doctor over a period of time (Table 2) and to rate 'Patients seeing the same doctor' as the most important of the six priorities (Figure 3). This would appear to conflict with Aylett's interpretation of trends from the findings of the Wiltshire study³ which suggested that group practices were becoming less likely to run personal lists and also with the finding of Cartwright and Anderson that single-handed doctors were more likely to think that

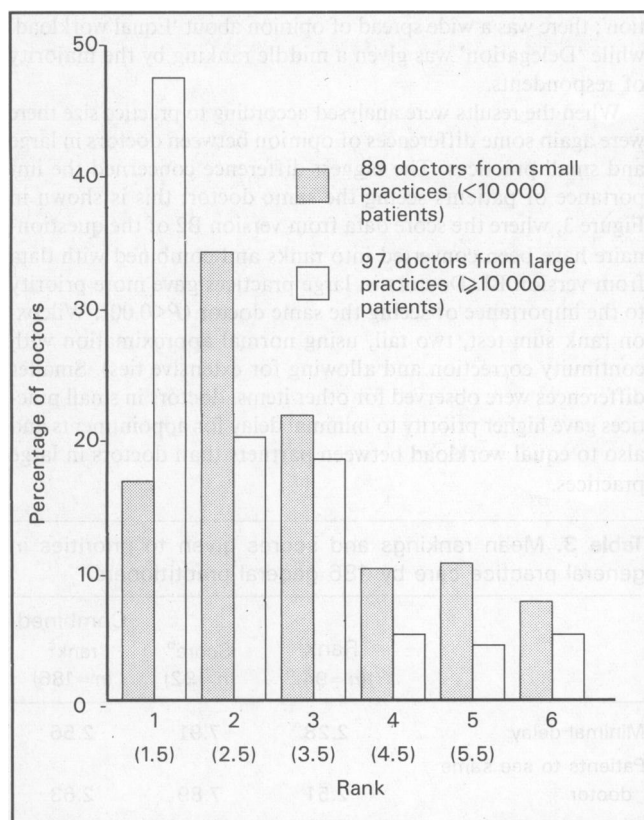


Figure 3. Distribution of ranks given to the importance of patients seeing the same doctor by size of practice of the doctor.

continuity of care was important.⁶ However, there were only seven single-handed doctors in the present study and Cartwright and Anderson did provide some evidence that doctors in large partnerships value continuity of care more than those in small partnerships. Doctors in small practices may feel they give good or even superior continuity of care without insisting that the patient sees the same doctor. One doctor in a two-partner practice remarked that they encouraged patients to see both partners 'since we are then both aware of all the patients and their problems — useful for example when one doctor is away on holiday'.

Rather than claiming that doctors in large practices value personal continuity more highly it may be that they see the potential lack of personal continuity as a problem which can be avoided by encouraging patients to stay on a personal list. Personal continuity may be an important source of satisfaction to general practitioners. Patients may, in turn, benefit from this satisfaction, as well as from the greater consistency of care likely with personal lists. The statement 'Agreed practice policies on drug prescribing and management of common conditions' attracted relatively little support from the doctors in this study, suggesting that consistency is not being consciously attempted except by personal continuity. It does not follow that patients necessarily want to see the same doctor and indeed freedom of choice without the formality of re-registration may be one of the unsung advantages of group practice.

The challenge facing general practitioners, particularly in large practices, is to deliver care which is both personal and consistent while preserving the freedom of choice of patients.

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Acknowledgements

This study was made possible by the enthusiastic cooperation of more than 300 of my colleagues in general practice in the Wessex region. I thank Mrs Fran Ross for her help in preparing and distributing questionnaires, Dr Clive Osmond for statistical advice and Dr David Pendleton and all my academic colleagues for their constructive criticism.

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Antisocial behaviour in children

Children with behaviour perceived as antisocial, or who are adjudicated as delinquent, comprise the largest single category of both treated and untreated emotionally disturbed youth. Compared to normal or neurotic children, their life quality and adult prognosis are poor. Knowledge of the independent correlates of antisocial behaviour helps to identify populations of youth in certain neighbourhoods, classes, and races which are at high risk for it. This information is useful in planning community or school-based interventions, but much less is known about why or how an individual youth from a favourable or unfavourable background becomes, or does not become antisocial, and what can help to predict, mitigate, or prevent the development of such behaviour in a young person. Psychosocial correlates of antisocial behaviour can identify families or communities at high risk for it, but cannot identify particular children within these families or communities where there is antisocial behaviour. This study of 71 sibling pairs, discordant for antisocial behaviour and service contact, suggests that factors inherent to the child are important in identifying which particular child in a family is more at risk for antisocial behaviours. Perhaps antisocial behaviour should be viewed as a threshold phenomenon; different reactivity patterns in the child will be converted into persistent antisocial behaviour under differing psychosocial circumstances. Under this hypothesis, the role for psychological factors, such as marital discord or parental discipline in the aetiology of antisocial behaviour, is not so much a causative one, as a failure to contain abnormal reactivity patterns in the child successfully. Although the interventions will be directed mainly at the psychosocial factors, the authors will be able to specify these interventions more precisely and carry them out with more finesse if they have increased knowledge about inside-the-child factors.

Source: Reitsma-Street M, Offord DS, Finch T. Pairs of same-sexed siblings discordant for antisocial behaviour. *Br J Psychiatry* 1985; **146**: 415-423.