Is personal continuity of care compatible with free choice of doctor? Patients' views on seeing the same doctor

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SUMMARY. While much has been written about the benefits of personal continuity of care there has been little research about the views of patients. In this cross sectional study 111 patients from three group practices (one of which ran a personal list system) were interviewed at home within a week of consulting a general practitioner. Patients were selected randomly from a systematic series of consulting sessions and a semi-structured interview was administered. Patients receiving more personal continuity of care were likely to be older, to have booked their most recent appointment further in advance, to desire personal continuity of care, to have an external health locus of control and to have a lower extroversion score. In the practice with a personal list, patients had a high level of continuity of care, were satisfied and showed little interest in having a choice of doctor. In the combined list practices patients valued their choice of doctor but often could not exercise it enough and they were more critical. They made more suggestions for change than those in the practice with a personal list system, mostly about receptionists and appointments.

It is concluded that most patients like to see the same doctor, but they may not be willing to wait two days for this if there is a quicker option. It may be difficult to deliver both personal continuity of care and choice in group practice.

Keywords: continuity of patient care; patient choice of doctor; access to GP; patient waiting time; group practice; patient attitude.

Introduction

PATIENTS used to see the same single-handed doctor for nearly all general practice contacts. Now most are registered with doctors practising in groups[1] and the potential decline in personal continuity has often been regretted on the patient's behalf.[2,3] While there is evidence that satisfaction of both patients and staff is generally associated with higher levels of personal continuity of care,[4,5] little is known about patients' views in the context of group practice where increased choice of doctor may also be an advantage.[6]

Group practices differ in their organization of doctor–patient contacts. Some maintain a strict personal list system where patients normally see their own doctor, but more now operate a combined list system where patients can see any partner. Though every patient is still registered with one named doctor, these practices vary in the meaning they give to this. One advantage for the doctors is the equalization of workload, as patients seeking appointments with fully booked partners can be offered alternatives with less busy colleagues.

Previous studies in four group practices showed big differences in personal continuity of care according to the combined or personal list system used[7] and suggested that the way patients requested appointments reflected their experience of personal continuity of care or, perhaps, the lack of it.[8] Therefore, it seemed important to find out what patients in these practices thought about personal continuity of care. Did patients on personal lists appreciate the high level of continuity of care? Did patients in the combined list practices regard any particular doctor as theirs, whether registered with the doctor or not, and if so could they see this doctor when they wanted; how did they feel about seeing different doctors?

The objectives of the study were to find out: whether patients could identify a usual doctor; patients' ratings of the importance of seeing the same doctor each time (desired continuity); characteristics of patients receiving high or low personal continuity of care; whether those desiring continuity of care were receiving it; patients' reactions to seeing different doctors; patients' awareness of and satisfaction with practice policy on appointments; and how patients had chosen their practice.

Method

The patients came from three of the Southampton group practices involved in earlier studies,[7,8] one with a personal list system (P) and the other two (C1 and C2) with combined lists (P, C1 and C2 correspond to D, A and C respectively, in the earlier studies[7,8]).

Patients were identified by random number from appointment sheets (these were the index consultations). Sessions were chosen in rotation to get an even distribution of doctors and days of the week; special clinics were excluded. During the next week S R approached the patients, by telephone if possible or else by letter, to arrange a home interview. Confidentiality was assured and the doctors were not told which patients were selected. Ethical approval was obtained for both the method of enrolment and the interview. The interviews were carried out between September 1988 and March 1989. Where patients were aged 15 years or less, the parents were interviewed.

The interview was semi-structured. It had been piloted with 20 patients in G F's combined list practice and the questions were found to be relevant and easy to understand, and patients were eager to speak about continuity of care with their doctors.

The interview included the following sections: demographic and social data; health status; pattern of access to the doctors; relationship with the index doctor (and experience at that consultation) and with the usual doctor if different; estimation of reasonable wait for an appointment; importance of seeing the same doctor each time; modified health locus of control scale;[9] Maudsley personality index (short form);[10] and questions clarifying the patient's attitude to personal continuity of care and any suggestions for change in the practice.

The two brief psychological questionnaires were included to see whether patients receiving higher or lower levels of personal continuity of care could be differentiated by personality. The modified health locus of control scale assesses whether the

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patient attributes control internally to self or externally either to another person (here the doctor) or to chance or fate. The version used here was adapted for use in the United Kingdom in a study of the consultation skills of general practitioner trainees.[9] Our hypothesis was that having increased personal continuity of care would be associated with external locus of control. Two components of the shortened Maudsley personality inventory[10] were included as a well-validated and contrasting instrument to test the hypotheses that having higher personal continuity of care would be associated with stability on the neurotic–stable subscale and with introversion on the introvert–extrovert subscale.

S R conducted the home interviews and afterwards inspected the clinical records for registration details. Doctors seen at the last 12 recorded consultations were identified by their handwriting. For each patient potentially different doctors included the index doctor seen at the index consultation, the usual doctor named by the patient at interview and the most-recorded doctor identified from the last 12 consultations.

Received continuity of care was defined as the number of consultations with the most recorded doctor divided by the total number and expressed as a percentage, the usual provider continuity (UPC_{12}).[11]

Analysis

In order to express results simply as odds ratios, with 95% confidence intervals, the independent variable UPC_{12} was dichotomized about the median level and associations tested by logistic regression.[12] The median level, which was much higher in the personal list practice, was chosen as the most appropriate baseline for any association with desired continuity of care. McNemar's test was used to assess the null hypothesis that patients would be equally likely to answer yes to each of four questions about their usual doctor as to answer yes to the same questions about the (different) index doctor they had recently seen. Other cross tabulations were analysed using the chi square test.

Results

Patients and their usual and other doctors

Altogether, 128 patients were approached, of whom 111 (87%) agreed to be interviewed, three patients declining or being unavailable from practice P, 10 from practice C1, and four from practice C2. Of the patients not available or declining interview 13 (76%) were women. Most patients declining were in practice C1, though this was not statistically significant. Sixteen participants only had between three and 11 recorded consultations, four from practice P, five from practice C1 and seven from practice C2. The characteristics of participants are shown in Table 1.

All 41 patients in practice P named a usual doctor and this was always the most-recorded doctor (Table 2). In practices C1 and C2 17 of the 70 patients (24%) either named no usual doctor or named one who was not their most-recorded doctor. The difference between personal and combined list practices was statistically significant ($\chi^2 = 99.6$, 1 degree of freedom (df), $P<0.001$) (Table 2). Five of the eight patients naming no usual doctor nevertheless said they were having regular treatment and two were aged over 65 years.

Table 1. Characteristics of participants, by practice.

	Patients in practices with			
	Personal list P	Combined list C1	Combined list C2	All patients
No. of patients interviewed	41	30	40	111
Mean age (years)	44	47	42	44
% women	*66*	*77*	*68*	*69*
% currently married	*59*	*40*	*73*	*59*

Table 2. Usual doctor as named by patient and the doctor most-recorded in last 12 consultations, by practice.

	% of patients in practices with		
	Personal list P (n = 41)	Combined list C1 (n =30)	Combined list C2 (n =40)
Usual GP same as most-recorded GP	*100*	*70*	*80*
Usual GP different from most-recorded GP	*0*	*13*	*13*
No usual GP named	*0*	*17*	*8*

n = number of patients in practice.

Of the 62 patients in practices with combined lists naming a usual doctor 25 (40%) said it was difficult or moderately difficult to see this doctor while 55 (89%) said it was easy to see another doctor. In practice P, two of the 41 patients (5%) found it difficult to see their usual doctor. Twenty five patients (61%) said it was easy to see someone else and 14 patients (34%) could not answer this question. Twenty patients in practices C1 and C2 (29%) said they sometimes wished to avoid a particular doctor, compared with four in practice P (10%).

Patients were asked 'In general how long do you think it is reasonable to wait to see any doctor?... your own doctor?' In practice P the median replies for both questions were two days. In practices C1 and C2 the median was two days for waiting to see the usual doctor but only one day to see any doctor. Nearly all patients naming a usual doctor (93/103) said they would generally be prepared to wait half an hour in the surgery to see their usual doctor rather than see another doctor straight away. Of these 93 patients, 64 (69%) cited their good or close relationship with their usual doctor as the reason while 17 (18%) referred to the doctor's knowledge of their problems.

Desired and received personal continuity of care

Patients were asked 'How important is it to you to see the same doctor each time you visit the surgery/health centre?' and their responses are shown in Table 3. The 55 patients from all three practices (50%) replying 'very important' were defined as desiring high continuity of care. Altogether, 83 (75%) thought it was either moderately or very important and patients in practice P were significantly more likely to think it was very important (66% versus 40%, $\chi^2 = 5.92$, 1 df, $P<0.05$). Sixteen patients from all three practices (14%) said it was not important at all.

Patients desiring continuity of care were significantly more likely than those not desiring it to be willing to discuss a personal

Table 3. Continuity of care desired by patients, by practice.

	% of patients rating importance in practices with		
Importance of seeing same GP at each visit	Personal list P (n = 41)	Combined list C1 (n =30)	Combined list C2 (n =40)
Very[a]	*66*	*40*	*40*
Moderately	*17*	*27*	*33*
Slightly	*7*	*7*	*10*
Not at all	*7*	*27*	*13*
Depends/no reply	*2*	*0*	*5*

[a]Desired high continuity of care. n = number of patients in practice.

problem with their usual doctor (odds ratio 4.1, 95% confidence interval (CI) 1.6 to 10.5, controlled for age).

High received continuity of care was defined as greater than the median: greater than 90% in practice P, and greater than 58% in both practices C1 and C2. The factors associated with greater continuity of care received by patients are shown in Table 4. The strongest association was with the older age group, where patients aged 45 years or over were 5.8 times as likely as younger patients to receive higher continuity of care, even when their desire for this was taken into account. Controlling for age and desired continuity, patients receiving greater continuity of care were also significantly more likely to have an external locus of control, a low extroversion score and to have booked their index consultation more than two days in advance compared with those receiving less continuity of care. There was no significant association between either received or desired high continuity of care and sex, marital status, social class, school leaving age or reported serious health problem.

Sixteen patients who desired high continuity of care were not receiving it: four patients wanted to see doctors who had recently joined the practice and seven to see those who were working part time. Of the five remaining patients, the three most critical were trying to see established full time partners. One patient in practice C1 had not seen his preferred doctor at all in the last 12 consultations ('I can't see the doctor I want'); he seemed upset but still said he liked having a 'second opinion' in his practice. In practice C2 one patient said 'Antenatal care is excellent because you always see your own doctor' and also alleged 'I've heard a receptionist say "this is a group practice so you will have to see anyone".'

Seeing a different doctor

Of patients in practices C1 and C2 39% had not seen their usual doctor at their recent consultation. For 29 patients in all three practices (26%) the recent (index) consultation had not been with their usual doctor. Four questions on patients' relationship with this index doctor were repeated about their usual doctor. There were significant differences in favour of the usual doctors for three of the four questions (Table 5). These 29 patients were also asked whom they would prefer to consult for the same problem next time. Eighteen (62%) preferred their usual doctor, eight (28%) would return to the index doctor and three (10%) were not sure. Six of those selecting the index doctor mentioned that they were in the middle of a course of treatment or investigations. Two patients described a conflict of loyalties where they would prefer to see their usual general practitioner but they had been asked to make a follow-up appointment with the index general practitioner; neither patient had discussed this conflict at the time with the general practitioner.

Awareness of practice policy and satisfaction

Eighty five per cent of all 111 patients seemed unaware of encouragement to see the same doctor, even in practice P, and in practice C1 47% of the 30 patients voiced scepticism about the existence of any such policy. While most patients said they were generally satisfied with the service, far more of those from the combined list practices offered suggestions for change, most often concerning receptionists and appointments. Of the 41 patients in practice P, 93% were, in general, satisfied with the service from the practice, compared with 83% of patients in practice C1 and 85% in practice C2. Five patients in practice P (12%) made suggestions regarding receptionist or appointment changes and one made another suggestion, compared with 53% and 28% of patients at practices C1 and C2, respectively, making suggestions about receptionist or appointment changes. Eight patients at practice C2 made other suggestions.

In the combined list practices further reservations came from patients receiving less continuity of care. Comments included: 'This practice doesn't make it easy to see the same doctor', 'you have to be quite forceful' 'I would prefer an individual list system', 'our usual doctor is not easy to see but I like the choice here' and 'I would prefer a personal list provided you could be with your own doctor'. In practice C1 two patients remarked that they would not like a personal list system in case they had to be with a doctor with whom they did not get on. In practice P most patients were in favour of the personal list system, but seven would not have minded seeing a different doctor for minor problems and three remarked that while they liked the system it might not suit everybody.

How patients chose their practice

In all three practices the most common reason for choice of practice, given by 37 patients (33%), was that other members of the family were already registered; eight other patients had previously been registered with the same practice themselves. Other reasons included proximity of practice (24 patients, 22%) and recommendation by a friend or neighbour (18 patients, 16%). New patients were usually registered with the general practi-

Table 4. Association of five variables with high received continuity of care (UPC_{12})[a] in patients attending three practices with combined or personal lists.

Variable	Baseline group X	Comparison group Y	Odds ratio (95% CI) Y/X	Adjusting for
Age (years) (*n* = 54/54)	0–44	45–81	5.8 (2.4 to 14.1)	Desired high continuity
Desired high continuity (*n* = 53/55)	No	Yes	2.7 (1.1 to 6.6)	Age group
Days appointment booked in advance (*n* = 60/48)	0–2	3+	3.2 (1.3 to 8.2)	Age group and desired high continuity
Health locus of control[b] (*n* = 46/50)	Internal	External	4.3 (1.6 to 11.3)	Age group and desired high continuity
MPI extroversion score[c] (*n* = 63/44)	High (4–6)	Low (0–3)	4.1 (1.5 to 10.9)	Age group and desired high continuity

n = number of respondents in baseline/comparison group. [a]High received continuity = higher than the median: UPC_{12} >58% in combined list practices and >90% in the personal list practice. [b]Excludes 10 patients with tied scores (internal = external) and two not replying. [c]Maudsley personality inventory (part); excludes one patient not replying.

Table 5. Relationship with index and usual doctors for 29 patients whose index consultation had not been with their usual doctor.

	Number of patients answering yes about:			
	Both GPs	Usual but not index GP	Index but not usual GP	Neither GP
GP has helped with serious problem[a]	3	8	1	15*
Have good relationship with GP [b]	8	16	1	1***
Easy to talk to GP [b]	21	4	1	0
Can discuss personal problem with GP [c]	2	12	0	9***

[a]Data missing for two patients. [b]Data missing for three patients. [c]Data missing for six patients. McNemar's test comparing preference for usual or index doctor: *$P<0.05$, ***$P<0.001$.

tioner with the smallest list. This was a formality in practices C1 and C2 where they could consult any doctor. In practice P a request to register with a specific general practitioner would normally be granted. It was thus surprising that none of the eight patients choosing their practice because of a particular doctor was in practice P. However, two patients from practice P had requested registration with the one woman doctor.

Discussion

This study shows a marked contrast in experiences and attitudes of patients in a group practice with a personal list system and in practices with combined lists. Some differences were anticipated, for example patients in the practice with a personal list both received and valued more personal continuity of care while choice was appreciated by their counterparts in the practices with combined lists, in that they appreciated the ease with which they could make an appointment with another doctor. However, two other important findings were lack of interest shown by patients in the practice with a personal list in seeing different doctors and the frustration resulting from patients' perceived inability to exercise choice in the practices with combined lists.

Most patients identified a usual doctor, even in the combined list practices, but the eight patients not naming one were not all young and fit as might have been expected. Access to the usual doctor was often perceived to be difficult in the practices with combined lists. One reason for this may have been that the distribution of usual doctors was uneven, with those most often named also having been noted as most requested in our earlier study of receptionists.[8] On the other hand the availability of earlier appointments with less familiar doctors may have raised patients' expectations for being seen quickly in these practices.

Patients in practice P were more likely to think it very important to see the same doctor each time (desired continuity) than those in practices C1 and C2; they seemed committed to the idea of having a personal doctor and few expressed interest in consulting other partners. Many of the 61% of patients who said that it was easy for them to see other doctors in the group added revealingly that this might only apply when their doctor was ill or otherwise absent and 14 (34%) could not answer, the question being outside their experience.

In the practices with combined lists patients seemed committed in varying degrees to both continuity and choice of doctor, perhaps reflecting the variety of contact they actually received; only 61% had seen their usual doctor at their recent consultation.

To a great extent, those most desiring high continuity of care were getting it, though in the practices with combined lists a potential gap remained between high continuity of care received (defined as better than 58%) and considering it very important to see the same doctor on every surgery visit. Personal continuity of care was received significantly more by patients who were older, had booked an appointment further in advance, were less likely to feel in control of their own health or to have a high extroversion score, but there was no significant association with the reporting of a serious health problem. In other words, personal continuity of care was linked to willingness to wait, perhaps either because of patience or because of fear of the unfamiliar. The desire for high continuity of care was significantly correlated with willingness to discuss personal problems with the usual doctor, and patients willing to wait half an hour for their usual doctor cited their relationship with their doctor rather than his/her knowledge of their problems, suggesting that continuity was wanted more for interpersonal than for medical–technical reasons.

Patients' views on consulting doctors other than their usual doctors suggested different priorities in the three practices. These also emerged later in discussion at practice meetings where results of this and other studies were fed back.[7,8] In the practice with the personal list doctors voiced their high priority for personal care; they and their patients tended to view a consultation with a different doctor as an unusual and temporary experience, ongoing care being passed back to the usual doctor as soon as possible. In the practices with combined lists the doctors were committed to personal care in a less exclusive way and they all gave more emphasis to the importance of the whole practice team. Some felt that seeing the same doctor was a matter of patient choice. The study found that their patients did indeed value the freedom to choose but could then find it difficult to negotiate their choice with receptionists. It was interesting that some patients experienced a conflict of loyalties when invited to make a follow-up appointment by a different (index) doctor. Clearly some patients could find themselves being followed up by a new doctor without having wanted to change.

Rather than generalize these results to other practices with similar list systems it is more appropriate to regard them as an illustration of the range of patients' views about the potential strengths and weaknesses of these two systems which have been the subject of a number of opinions over the years.[13] Because, to a large extent, patients' views reflected their experience one must wonder how the patients chose their practices and how much the practices moulded the patients? There was no evidence that the patients had chosen to register by the list systems or even that they were aware of these policies. There were more women than men in this study because women consult more,[14] however, sex was not associated with continuity of care, either desired or received.

The personal list system seemed more easily understood by patients than the combined list system and operated smoothly, avoiding some of the barriers to access which have been associated with larger practices.[15] Yet it demanded a high level of priority from doctors and inhibited choice for the patients, although most seemed unaware of what they might be missing. Advocates of consumer power may suspect that the apparent high satisfaction with continuity of care is the product of an underlying need to believe in one's own doctor, combined with lack of an alternative. Such advocates might be pleased to hear about the better informed, more articulate consumers in the practices with com-

bined lists but dismayed at the difficulties they reported in exercising their choice. They may also wonder how to help those less able to negotiate the system when feeling unwell or those who would prefer to be guided to the same doctor without having to fight for this. It seems that to abandon the concept of the registered doctor may leave some patients with insufficient leverage for the personal care that they desire.

Whether practices should encourage more personal continuity of care for patients who do not recognize that it might help them is a different issue. The findings of this study are consistent both with those of Hjortdahl and Laerum, that patients reported much higher satisfaction if they saw their personal doctor,[5] and those of Smith and Armstrong, that 'usually the same doctor seeing you' was among the three most highly rated criteria of good health care identified by patients.[16] However, both the current findings and our previous observation study of receptionists booking appointments[8] also suggest that many patients are not prepared to wait long to see their usual doctor. The option of a shorter wait (here one rather than two days) may often be sufficient to tempt patients to see a different doctor in practices with combined lists.

It is difficult for patients and doctors to agree about the urgency of problems that may seem relatively minor in a medical sense.[17] Doctors in group practices may be reluctant to make themselves individually, as opposed to collectively, available at one day's notice or less. This makes it hard to deliver both continuity and choice of care. To get better personal continuity of care either patient choice must be restricted by a personal list system (in which negotiation between patient and both doctor and receptionist is necessarily less complex), or doctors must become individually more available even in practices with combined lists. Neither solution is easy or cheap; it may be that delay, as in other parts of the National Health Service, is the inevitable rationing mechanism in a service which is free at the point of delivery.

If satisfaction is the main benefit of personal continuity of care most patients are competent to judge for themselves how long they can wait to obtain it. Before the profession can properly advise patients that it is in their best interests to see their usual doctor, even if this means waiting longer, better evidence is needed of any resulting positive health outcomes.

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