

## Relationship continuity:

when and why do primary care patients think it is safer?

### Abstract

#### Background

Doctor–patient continuity is popular with patients and practitioners, and is associated with better outcomes; however, changes in policy and practice organisation have diminished its scope. Although there has been some discussion of safety implications from professionals' perspective, patients' views remain largely unexplored.

#### Aim

To explore patients' understanding of safety in primary care.

#### Design and setting

An interview-based study with patients from general practices in the northwest of England.

#### Method

Patients were recruited from five general practices through patient participation groups and posters in waiting rooms, with further participants recruited through snowballing techniques until no new themes emerged. In-depth interviews were digitally recorded and transcribed. Anonymised transcripts were coded and analysed inductively. Emergent themes were discussed by the team.

#### Results

For patients, relationship continuity was not simply a matter of service quality but an important safety concern that offered greater psychosocial security than consultations with unfamiliar GPs. Relationship continuity enabled the GP to become a repository of information; acquire specialist knowledge of a patient's condition; become familiar with the patient's consulting behaviour; provide holistic care; and foster the development of trust. Patients were also aware of the risks: a false sense of security and lack of a fresh perspective. Their desire for continuity varied with the nature of their concerns, psychological vulnerability, and perception of GPs' qualities and skills. No one supported a return to imposed continuity.

#### Conclusion

Relationship continuity and choice of GP were important safety strategies, neither of which is adequately supported by recent policy changes.

#### Keywords

general practice; patient safety; patients' perceptions; primary care; systems; trust.

### INTRODUCTION

Relationship continuity (a sustained relationship with a specific GP) has been a core feature of primary care, is popular with patients and practitioners, and is associated with better patient outcomes.<sup>1–4</sup> However, changes in healthcare policy and practice organisation — new out-of-hours arrangements, larger practices, more part-time working, the establishment of multidisciplinary teams, greater administrative burdens with the introduction of pay-for-performance, and financial incentives to achieve nationally set speed of access targets — have steadily diminished the scope for personal continuity.<sup>5,6</sup> In light of this, the Royal College of General Practitioners has introduced a *Continuity of Care Toolkit* with advice about how to diagnose and protect patients' capacity to obtain doctor–patient continuity.<sup>7,8</sup> The addition to the English general medical services contract 2014/15 of a requirement for all patients aged >75 years to have a named GP responsible for overseeing their care signals an attempt to reintroduce some personal continuity into a system in which it is rapidly being eroded.<sup>9</sup> Although there has been some discussion of the patient safety implications of continuity from a professional perspective,<sup>2,3,5</sup> patients' views remain largely unexplored. The aim of this study was to explore patients'

understanding of safety in primary care.

### METHOD

#### Recruitment

Patients were recruited from five general practices in the north west of England through practice patient participation groups or posters in waiting rooms. Interested patients were sent information about the project and a consent form. Further participants were recruited using snowballing techniques until no new themes emerged.

#### Interviews

Qualitative interviews lasting 30–120 minutes were digitally recorded and fully transcribed. Because this was an exploratory study, the topics covered were largely introduced by interviewees themselves.

#### Analysis

Anonymised transcripts (identified by number and sex) were coded and analysed inductively using NVivo10 (version 10). Emergent themes were discussed at regular meetings of the research team.

### RESULTS

Thirty-eight people with varied socioeconomic backgrounds (14 males, 24 females; age range 18–78 years,

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## How this fits in

Relationship continuity is linked to better patient outcomes and is popular with patients and GPs, but rarely discussed in terms of patient safety, especially from the perspective of patients. This study examined when and why patients think it is safer to see the same doctor, as well as when and why they consider it to be less safe. Seeing the same doctor has become progressively more difficult with changes in policy and practice organisation. An attempt to counteract this trend has been made with the recent addition to the general medical services contract of a requirement for all patients aged >75 years old to be allocated a named GP. This article discusses the implications in light of the study findings.

50% aged >50 years) were interviewed (Table 1). Fifteen were recruited through their practice, the remainder through snowballing. In total, participants were registered with 19 rural, small town and city practices across the north of England. Estimated visits to a GP in the previous 12 months ranged from one to 12, with an average of five. Twenty-five people had one or more long-term condition and 12 were carers. Relationship continuity and choice of GP emerged as important safety strategies, neither of which are supported by recent policy changes.

### When do patients think relationship continuity is safer?

Two people preferred to see the same doctor for all consultations; most sought continuity only in certain circumstances and were content to see whoever was available at other times. Four claimed not to mind which doctor they consulted, two of whom had purposely chosen a small practice where they could become familiar with all the doctors; only one person avoided seeing the same person on safety grounds:

*'I actually make a point usually of not asking to see the same person each time ... I'm also a great believer in getting second opinions. None of us are all knowledgeable and second opinions are terribly important.'* (17M)

In recognition of doctors' differing qualities and skills, some people felt safer with one doctor for one type of problem but safer with another for others, and some, like the patient quoted below, had preferred doctors for specific concerns:

*'I see two of them ... the one that is officially my doctor, I came to see him for my mental health problems, and the lady doctor I tend to see for wind problems.'* (12F)

Several people ( $n=10$ ) said there was at least one doctor they would try to avoid, unless the problem was urgent and no one else was available. Patients' desire for continuity varied with the nature of their concerns and their feelings of psychological vulnerability, and changed with their changing needs. It was less important for straightforward, time-limited matters than for more complicated or longer-term problems, sensitive and potentially stigmatising problems, intimate physical procedures, or when patients felt psychologically vulnerable:

*'If I've got a sore throat and I think I've got an infection and I need antibiotics, I wouldn't care which doctor prescribed it, but, if I had another bout of mental illness, I'd prefer to go see one of the two doctors I'd seen before.'* (02M)

*'If, say, I had a chest infection, I'd go in and see anybody. But, if it was my knee, because my particular GP gives me injections every 3 months, so I'd always try and see him.'* (11F)

*'If it's something basic, I'll just take anybody that's there. But if it's something that I feel a bit uncomfortable or stressed about, I may well ask for one of my favourites.'* (24F)

*'It depends: if I have a long-term illness, then I would want to see the same doctor over and over again, but it was a one-off, then I just see any.'* (28M)

*'I think it's a bit pointless seeing somebody who doesn't know the background ... whereas he knows me and I can say what I'm going for. But, if it's an emergency or something completely unrelated [to the long-term condition] ... I'd see anybody.'* (31F)

Although interviewees expressed nostalgia for a past when consultations were longer and doctors knew patients personally, no one wanted a return to enforced continuity. Not all relationships were positive and, in a worst-case scenario, could become toxic, as happened in the following instance:

*'It's almost like he's made it his business to see me ... I've actually now said to the*

**Table 1. Interviewee sociodemographic profile**

Characteristic	<i>n</i>
<b>Marital status</b>	
Single/divorced	11
Married	20
Widowed	4
No information	3
<b>Ethnicity</b>	
White British	31
White other	1
Asian/Asian British	3
Black/Black British	3
<b>Employment status</b>	
Student	1
Unemployed unable to work	9
Employed/self-employed	18
Retired	10
<b>Length of time at practice, years</b>	
<5	3
5-10	6
>10	24
No information	5

practice, "Do not have him see me under any circumstances, because I just don't want him involved in my care". (26F)

The least popular GPs were often those with most availability, with the result that continuity could occur by default:

'[At] my previous practice, there were two doctors, one of whom was lovely, and everybody wanted to see, and the other was grumpy and nobody wanted to see ... you could see him any time.' (M30)

### **Why do patients think relationship continuity is safer?**

*Patient factors.* A common concern was anxiety about the forthcoming consultation stemming from a fear that their reasons for consulting may not be accepted as legitimate and their reception and care compromised as a result. Establishing a relationship with a single GP enabled patients to demonstrate a pattern of responsible consultation over successive visits:

'It's about knowing the individual patients and how they use the service.' (10M)

To patients, feeling safe included feeling confident that they would be given sufficient time, treated with respect, listened to, and have their concerns taken seriously:

'If somebody doesn't approach somebody terribly thoughtfully, it can freeze you so you don't pass on all the necessary symptoms you need to be telling them about and things like that.' (08F)

'It feels good because you feel that you are not being talked down to, you are having a proper conversation ... So it's treating you as having a valid reason to be concerned.' (07F)

'Because I am very heavy, I was worried I would get a lecture about healthy eating every time ...' (24F)

'It's like visiting a lawyer ... you're frightened about the language they speak and it's the same with a lot of people with doctors.' (10M)

'I don't want to be with someone that just palms me off because they haven't got the time ... for someone who comes in projecting as fragile and vulnerable.' (F25)

You could tell from a doctor's body language

that they'd had enough of what you were saying. So, if you did have something, you sort of took that decision: I'll probably have to come back with something else.' (16F)

'[I would like] somebody who explains things and answers questions without it seeming, like, "Why would you be asking?". Some of them have that attitude.' (29F)

Having found a doctor with whom they felt comfortable, patients were reluctant to risk the possibility of a negative reception from an unfamiliar GP. For some, as in the example below, this was a positive choice; for others, it was a case of 'better the devil you know':

'This GP was absolutely brilliant ... he understood where I was coming from ... he's never written me off ... because I've had panic attacks or mental health problems ... he's seen the other side of me, you know, and there's much more to me than just that, and put me in control of my health care, which, for me, was really important.' (26F)

Without this confidence, patients reported delaying or avoiding seeking help, bypassing the surgery altogether and going directly to the hospital emergency department, consulting for some concerns but not others and, once in the surgery, being less candid about lifestyle and circumstances or being unwilling to admit to treatment lapses or failure to follow advice. One person, for example, did not mention his smokers' cough because he knew it was self-inflicted. Another commented:

'No, I'm not honest with them ... because he'll think, "Oh, I won't treat him here, he smokes too much, he drinks too much".' (33M)

Patients claimed they were more likely to be open with and willing to accept uncomfortable information and advice from a familiar and trusted GP:

'If you don't know the other doctors, you can't be as frank with them.' (22F)

'She says, "Well, you can take the tablets and live or don't take them and die, it's up to you" ... and, since then, I've never missed it ... so she went straight to the point, but she's a nice person I think, she'll tell you as it is.' (36M)

Trust could be generated in an initial

consultation if patients believed they were being treated with respect and the doctor was genuinely concerned about their welfare, but deepened over repeat encounters.

**GP qualities.** Most group practices promote team-based continuity through shared electronic records; however, interviewees were convinced of neither the comprehensiveness of records nor GPs reading them sufficiently thoroughly. Seeing the same doctor avoided repeated retellings of their story, with not enough time to relate it in full and important information being misremembered or omitted. To many, a primary function of a familiar GP was to act as a repository of information:

*'I think there are safety implications because they may not have everything on their records or they may just be ... not sure what's happening. It's much easier when you're seeing the same person and they know exactly where you are in a process. Things are more likely to be missed if you don't see the same person. You build up a rapport and you can talk to them more about things and you might say more than you would if it was a different person every time and you may miss something that you don't realise is a safety issue.'* (29F)

*'If you go in and it's somebody different there, you think, "Well, do they know what happened last time? I know it's in the notes, but do they really understand?'"* (24F)

Patients believed that doctors were less prone to mistakes if they knew their full medical histories, including information not recorded in their notes. Several could recount instances when an unfamiliar doctor's lack of knowledge had resulted in inappropriate treatment. Knowledge accumulated over successive consultations enabled the GP to better assess the significance of symptoms and make connections, leading to more rapid diagnosis and treatment tailored to the needs of the individual:

*'You're less likely to get mistakes and more likely to get action quickly if the person knows you and knows [the health history] ... If I presented to a GP who I didn't know ... they may think that I'm coming with something which might clear up or not listen to me because they may not realise that I have so much experience, and think, "We'll give her an appointment in a week's time, see if she's any better", whereas I*

*know that some action needs taking now.'* (18F)

Relationship continuity was a primary strategy for ensuring information continuity; as one person commented:

*'Otherwise, there is only one person who really knows your case and that's you.'* (18F)

Information continuity is the cornerstone of effective management continuity: timely communication and smooth coordination of care between different services. Patients played a substantial role in helping to ensure management continuity by relaying information between the hospital and GP, checking that letters had been received, and double-checking medication lists. Those with complex medical needs spoke of a collaborative partnership between the GP and patient, dependent on mutual trust, the GP taking an interest in the patient's problems, collaboratively developing combined expertise, open communication, and sharing of information. One person, who had lost the continuity enjoyed in the past when her GP retired, recalled:

*'The old GP rang me on numerous occasions to check if the hospital had sent a request for a prescription alteration. Sometimes he would ring me and check, "Is this right?" or he might check and say, "Why have you been given this, because it's not entirely clear from the letter I've received?" ... and I was sometimes able to clarify things or sometimes he was able to clarify things if he'd had a letter and he would ring me and explain something to me.'* (18F)

### **The dangers of relationship continuity**

Patients wanted the opportunity to choose relationship continuity when and with whom they felt they needed it, in the belief that it was often (although not always) the safest strategy. They also recognised that seeing the same practitioner brought its own safety risks: the danger of both GP and patient becoming overly complacent; perpetuation of an initial failure to diagnose, mistake in diagnosis and/or treatment; lack of a fresh perspective or insight; knowing when to seek a second opinion. This is illustrated in the following exchange between two patients, one of whose cancer had been misdiagnosed as piles:

**P1:** *'It's swings and roundabouts, because what one person can miss another might pick up straight away ...'*

**P2:** *'Well, if you'd seen a locum at some*

point, they'd have gone, "Pfft ... you need to go and get checked, madam".

**P1:** 'Yeah, maybe.'

**Interviewer:** 'Do you want to say a bit more about that instance, when something was missed?'

**P1:** 'Well, no, because she [GP] was a friend as well.' [laughs]

**P2:** 'It's anonymous, it's fine.'

**P1:** 'Let's just say, it wasn't piles, but it took 18 months to find out ... So, partly my fault, partly hers ... I should have gone back to them when [inaudible] And perhaps I might have found it harder to go back if it was somebody strange, I don't know. But it's what ifs, isn't it?' (23F, 24F joint interview)

Second opinions often occurred by chance when a preferred GP was unavailable:

*'It was just a case of getting in to see someone one morning because it was so bad ... it was the best thing that could happen, was for me to turn up and actually see the other doctor ... he diagnosed me within 2 minutes of me walking through the door ... I suppose that's the negative side of it, how long do you go on with a particular person before you say, "Hang on a minute, I'm not sure I've got any confidence in you?" But you don't always realise that until somebody better comes along.'* (29F)

On balance, the benefits of relationship continuity were judged to outweigh the risks. Even bad experiences had not led to questioning of the strategy; most patients had simply transferred their desire for continuity to another GP.

The enhanced safety attributed to relationship continuity was set against experiences of poor care associated with its absence: lack of a coherent diagnostic or treatment strategy; inconsistent information or advice; inappropriate or harmful treatment resulting from insufficient knowledge of the patient's case; failure to appreciate the chronicity, significance, or seriousness of symptoms, or to make a connection between different symptoms for which the patient has made separate visits; persistent misdiagnosis; and being fobbed off with platitudes or pills. In one case, a chronic ear condition had been consistently mismanaged by successive GPs who had also failed to link it with bouts of dizziness and falling. From the patient's perspective, lack of continuity was a major factor in perpetuation of the initial diagnostic error; each GP simply followed the erroneous strategy recorded in the electronic health record (EHR) by

his or her predecessor. Eventually, the patient's condition was diagnosed by a hospital specialist. Not only had the patient experienced debilitating symptoms for a prolonged period and undergone repeated courses of unnecessary antibiotic treatment, but her experience had also left her feeling alienated and depersonalised:

*'You do feel like you're Patient X out of, you know ... you don't feel any sort of personal ... they're professional but ... you don't feel like you matter ... you're just another patient. They don't even look at you, they don't give eye contact or they're just looking at a computer screen.'* (21F)

Lack of patient-doctor continuity was associated with a bureaucratic and impersonal approach to service provision, characterised by short consultations and a superficial, disengaged style, that not only made patients feel less physically secure but entailed a specific form of psychological harm. Interviewees described an industrial process in which patients become commodities to be processed and their individual personhood is denied, as one person commented: *'You are more like a number than a person.'*

## DISCUSSION

### Summary

Although more usually presented as an aspect of service quality, for patients, relationship continuity was an important safety concern that was perceived to offer both greater physical and psychosocial security than consultations with an unfamiliar GP and to promote more open communication. It enabled the GP to:

- act as a repository of information not recorded in the EHR;
- acquire specialist knowledge of a patient's specific condition over time;
- become familiar with the patient and their consulting behaviour and therefore better able to pick up on unspoken matters;
- provide holistic care, with treatment and advice tailored to the needs and capacities of individual patients;
- and foster the development of trust and partnership in navigating services and ensuring information transfer.

Despite these advantages, patients were aware that there were risks, not least a false sense of security and lack of a fresh perspective. Few wanted relationship continuity for all consultations; instead,

patients wanted the opportunity to choose when, for what and with whom they needed it. Patients' desire for continuity varied with the nature of their concerns, their psychological vulnerability and their perceptions of doctors' individual qualities and skills. No one advocated a return to enforced continuity with a practitioner not of their own choosing.

#### **Strengths and limitations**

Only 38 people were interviewed and their views may not represent those of patients more generally. There is no information about those who chose not to take part. However, the sample of patients and practices was geographically and sociodemographically diverse and the findings are consonant with those reported elsewhere.

#### **Comparison with existing literature**

The findings not only echo those of studies highlighting the importance of a psychosocial dimension to safety,<sup>10</sup> but point to the varied and subtle ways in which it can mediate physical safety. They are also consistent with studies specifically concerned with relational continuity,<sup>11,12</sup> although not, as in this study, filtered through the lens of safety. The question most usually posed is, 'For whom is relationship continuity important?', but, to many patients in this study, the more relevant question was, 'When is it important?'. Except for greater weight accorded to psychosocial security, patients' reasons for preferring patient-doctor continuity as a safer option were similar to those of GPs.<sup>1-3</sup> This may help to explain why relationship continuity has been associated with better outcomes than team-based continuity.<sup>1-4</sup> For patients in the study, team-based continuity was no substitute for continuity with the same doctor, when they felt they needed it.<sup>3,12</sup>

#### **Implications for practice**

Despite its therapeutic advantages, relationship continuity appears to be sustained through patient, rather than practitioner, agency and has been discouraged by policy initiatives that prioritise speed of access and promote an alternative team-based approach. This study provides further evidence of the importance to patients of relationship continuity; however, there is uncertainty about the perspectives of GPs and barriers to delivering this that warrants further research.<sup>13</sup>

The new policy of named doctors for patients aged >75 years designates responsibility for management continuity, but offers no guarantee of relationship continuity or even choice of GP, both of which are important safety strategies for patients. Few practices are likely to be able to satisfy all patient choices. The new role provides administrative oversight, but not the relationship continuity and ensuing safety benefits valued by patients, and may do little to counteract the impersonal and superficial style of care of which many complained. As with any change, it is not without risk. Decisions may be taken in the absence of face-to-face discussion and knowledge of the patient acquired in an ongoing relationship; diffusion of responsibility may occur when no one takes action in the belief that the allocated doctor is dealing with the problem; and patients may be allocated a doctor with whom they find it difficult to communicate and/or do not trust to act in their best interests. The initiative is heralded as 'bringing back ... proper family doctors',<sup>9</sup> but, to many patients, for whom management continuity (although essential) cannot substitute for relationship continuity, this might seem a hollow promise.

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#### **Provenance**

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#### **Competing interests**

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