

# How are different types of continuity achieved?

## A mixed methods longitudinal study

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### ABSTRACT

#### Background

In the context of developments in healthcare services that emphasise swift access to care, concern has been expressed about whether and how continuity of care, particularly interpersonal continuity, will continue to be achieved.

#### Aim

To explore how patients regard and use primary care services in relation to continuity of provider and access to care, to identify factors that promote or hinder their success in achieving their preferences, and to describe what this means for how different types of continuity are achieved.

#### Design of study

Longitudinal, mixed methods.

#### Setting

Community in London and Leicester

#### Method

Purposive sample of 31 patients recruited from general practices, walk-in centres and direct advertising. Data collection involved in-depth interviews, consultation record booklets completed over 6 months and general practice records for the year including the study period. Data were analysed qualitatively.

#### Results

Four patterns were identified in the way patients used primary care. These were shaped by their own preferences, by the organisation and culture of their primary care practices, and by their own and their provider's efforts to achieve their preferences. Different configurations of these factors gave rise to different types of continuity. Patients were not always able to achieve the type they wanted. Patients with apparently similar consulting patterns could experience them differently.

#### Conclusion

Within a programme of modernisation, policies that promote a commitment to meeting the preferences of different patients with flexibility and understanding are most likely to provide continued support for interpersonal and other types of continuity of care.

#### Keywords

access to health care; continuity of care; interpersonal relations; mixed methods; physician patient relationship; qualitative research.

### INTRODUCTION

Continuity of care is widely regarded as a defining feature of general practice<sup>1,2</sup> and family medicine.<sup>3,4</sup> Patients consider it important<sup>5,6</sup> and value it highly<sup>7-9</sup> and it has been shown to foster trust and loyalty,<sup>10,11</sup> to increase patient satisfaction and enablement,<sup>12,13</sup> and to enhance quality of care.<sup>14,15</sup> Continuity is a complex concept, however, and recent conceptual work by Haggerty *et al*<sup>16</sup> and Saultz<sup>17</sup> has identified a number of different 'types' of continuity, including informational, management, longitudinal and interpersonal or relational continuity. This work raises questions about how patients value and experience different types of continuity and how each type is achieved and maintained.<sup>18</sup> Understanding these issues is now particularly important as developments designed to promote modern and efficient primary care are increasingly perceived as posing serious threats to some types of continuity.<sup>7,19,20</sup> With a shift in emphasis to swift access to care and continuity defined in terms of access to information, concern has been expressed about whether and how interpersonal continuity in particular will continue to be achieved for those patients who want it.<sup>21</sup>

We present here the findings of a mixed methods longitudinal study of how patients regard and use

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**Submitted:** 6 January 2006; **Editor's response:** 9 May 2006; **final acceptance:** 26 August 2006.

©British Journal of General Practice 2006; 56: 749–755.

## How this fits in

Developments that are designed to improve access to primary care are often seen as posing a potential challenge to continuity of care, particularly continuity with a known provider. Patients differ in the way that they prioritise access and continuity but for many, seeing their 'own' GP remains a primary concern. However, not all those who want to see their 'own' GP succeed in doing so. Those that do succeed have learned to overcome obstacles created by practice policies and have found a GP who responds to their needs with flexibility and understanding.

primary care services in relation to continuity of provider and access to care, of the factors that promote or hinder their success in achieving their preferences and of what this means in terms of how different types of continuity are achieved and maintained.

### METHOD

#### Sample and data collection

This study was part of a larger programme of research.<sup>22</sup> A purposive sample of 28 general practices was recruited to the research programme to provide a variety of practice contexts in terms of size, organisation, 'rurality' and ethnic mix; two NHS walk-in centres and a complementary medicine clinic

were also recruited to extend the range further. Seventy-nine patients were recruited through these organisations, community notice boards and snowball sampling. A maximum variation sampling frame was used to ensure a wide range of participants in terms of sex, age, ethnicity, health status, caring status and employment. Semi-structured interviews were conducted about their preferences, prime considerations and past experience in using primary care. Interviews were audio-recorded and transcribed. Twenty-nine of those who had agreed to be contacted again were recruited to the longitudinal study.

As part of the purposive sampling strategy for the longitudinal study, a further seven patients were recruited to include participants with particular ages, ethnicity, health status and caring responsibilities; these patients were not interviewed.

Participants completed a consultation record booklet each time they consulted a primary care provider, either through their general practice (for example, GP or practice nurse) or via other primary care services (for example, NHS Direct or a pharmacy). Booklets included fixed-choice and open-ended questions about priorities, experiences and satisfaction in relation to each consultation. Participants were asked to continue completing booklets for 6 months.

Patients' records for the year including the study period were obtained from their general practice and general practice managers completed a questionnaire on aspects of their practice.

#### Data analysis

Data were analysed qualitatively, in terms of patients' preferences and priorities regarding seeing the same healthcare professional or gaining swift access to care and whether they were successful in doing so over the period of a year. For each participant, we looked at their preferences and concerns in using primary care as expressed in their interviews; at whom they consulted, how often, and for what problem as recorded in their general practice records over a year; and, for individual consultations, at their priorities regarding whom they saw and how quickly, whether they achieved these, their efforts to do so and any other comments on their consultation, from their booklets. These data were looked at in relation to the organisation and culture of their general practice.

The analysis was conducted by three of the authors and discussed at team meetings.

### RESULTS

#### Sample

Interviews were available for 29 patients; 151 usable

**Table 1. Characteristics of patients (n = 31).**

Characteristic	n (%)
Males	12 (39)
Age (in years)	
18–29	2 (6)
30–59	13 (42)
60–79	13 (42)
≥80	1 (3)
missing data	2 (6)
Ethnicity	
white British	23 (74)
white other (Europe)	2 (6)
Middle East	2 (6)
Asian	1 (3)
missing data	3 (10)
Employment status	
in education	5 (16)
employed	6 (19)
retired	11 (35)
home responsibilities	5 (16)
missing data	4 (13)
Health status (self-rated)	
good or very good	14 (45)
fair	4 (13)
poor or very poor	9 (29)
missing data	4 (13)
Caring responsibilities	
carer	5 (16)
missing data	3 (10)

consultation record booklets were returned by 30 patients; and practice records were provided for 31 patients. The analysis is based on 31 patients for whom at least two of the three sources of information were available (Table 1).

Sixteen general practices completed questionnaires: no information was available about the practices of patients recruited through other sources (Table 2).

### Patterns of service use

Participants regarded and used primary care services in a variety of ways. Four patterns were identified and are described below (Box 1). Although we looked for instances, none of the patients who prioritised swift access failed to receive care within 48 hours.

#### 1. Preference for and success in seeing a named provider

Participants with this pattern of service use included both those who rarely consulted but always chose to see the same GP and those who consulted very frequently and saw the same GP (or practice nurse) for the great majority of their consultations.

Many of these participants were older patients. They identified a particular provider whom they regarded as their 'own' and whom they felt had come to accept a personal responsibility for their care. This personal connection was important to them and experienced as personal care, as Mrs A illustrates:

*'Mrs A regarded a personal relationship with her doctor as important and had invested in building it over many years: "We should all know our bank manager," she said at interview, "and our bank manager should know us. And we should all know our doctor and we made a point of that." During the study she consulted for a range of chronic and acute problems. For example, in booklet 1 she listed the reasons for consulting as "BP [blood pressure] check, pills needed; discuss possibility of wheelchair; wart to be blasted; itchy rash on top of back." In each booklet she indicated that she wanted to see one person in particular, her "own" GP. This she managed to do without apparent effort or problem.'*

(Mrs A, 81-year-old widow. Sixteen consultations in year: 13 with 'own' GP, three with the practice nurse.)

Mrs A's success in seeing her 'own' GP was facilitated by a practice culture that recognised her as Dr L's patient, practice policies that enabled her to book regular appointments with him in advance, and a GP who appeared willing to discuss all problems in any consultation. Not all practices made it so easy

**Table 2. Characteristics of general practices (n = 16).**

Characteristic	n (%)
Practice size (partners)	
1–2	3 (19)
3–5	9 (56)
6–8	4 (25)
Location	
inner city or urban	11 (69)
suburban or town	2 (13)
rural or semi-rural	3 (19)
Personal list operated	
yes	6 (38)
no	10 (63)
Value on personal continuity	
very low or low	1 (6)
medium	7 (44)
high or very high	8 (50)

for patients, however, and where they did not, patients had to work very hard to be able to see their 'own' GP. For example, Mrs B had to overcome a number of obstacles, which she identified as arising from the increasing size of her general practice, policies restricting advance bookings of appointments and the attitude of the receptionist:

*'Mrs B had made a conscious decision a number of years earlier to find a GP she liked and to get to know (and be known by) her, but by the time of the study she was finding it increasingly difficult to get to see her. For example, in booklet 4 she described how she had attended the practice for a routine blood test and while there had tried to book an appointment with her own GP regarding a chest infection she had mentioned in an earlier booklet. "The receptionist told me that there were no appointments for at least 2 weeks and that the diary didn't go beyond that. Eventually, after a discussion, she told me to go home and my GP would telephone; which she did at 10:45 giving me an appointment at 11:15. My GP was very efficient and kind as always." (booklet 4).'*

(Mrs B, 67-year-old retired seamstress. Nineteen consultations in year: 11 with 'own' GP, four with another GP, four with practice nurse.)

#### Box 1. Patterns of service use found.

- ▶ 1. Preference for and success in seeing a named provider
- ▶ 2. Preference for but not successful in seeing a named provider
- ▶ 3. Priority given to and success in obtaining swift access to care
- ▶ 4. Preference for and success in seeing a named provider for some problems; priority given to and success in obtaining swift access to care for others

Despite the obstacles she encountered, Mrs B succeeded in seeing her own GP for the great majority of her consultations. Crucial to this was her own determination and the supportive response from her GP who acted on her sense of responsibility for Mrs B as 'her' patient. Other patients described further strategies including accepting a long wait to see their own GP and learning when to ring for an appointment, whom to speak to and what to say.

## 2. Preference for but not successful in seeing a named provider

These patients identified a healthcare professional whom they considered their 'own' and whom they wanted to see when they consulted, but were generally not successful in doing so.

An example is Mr C who used both his general practice and a community mental health facility. In both cases he made appointments expecting to see his 'own' provider but often found he was seen by someone else:

*'Mr C regarded his relationships with his "own" GP and with the first clinician he saw at the community mental health clinic as important in helping him stay "stable" and in treatment. He booked appointments at the two clinics regularly and always expected to see his own GP at one and his own psychologist at the other. In the last months of the study, however, it was no longer these particular professionals whom he saw. On the first occasion this happened, Mr C noted in his booklet, "I would have preferred my own GP. Partner took GP's place (holiday leave). Fortunately the practice nurse sorted out prescriptions so we didn't have to see alternate GP." When this happened on two further occasions, he indicated considerable dissatisfaction.'*

*'Continuity was even more difficult to sustain in the community clinic, which had a high turn over of staff. He noted in his penultimate booklet: "Five different doctors over the last 8 months is too much for me. It leaves me feeling negative that none of the doctors truly knows me, except for the case notes that they quickly flick through." (booklet 7). Despite his growing frustration and dissatisfaction, he took no action beyond booking further appointments.'*

(Mr C, 42-year-old registered methadone user, unemployed. Practice notes not available; eight consultation record booklets completed over 5 months.)

Patients with this pattern were unhappy with the

care they received. They wanted personalised care and commitment from a healthcare professional whom they knew and trusted and, as Mr C illustrates, neither the use of detailed case notes nor the efforts of other members of the team to maintain a consistent approach to management were perceived as adequate substitutes. However, they took no steps to try to see their 'own' GP and appeared to expect the practices to arrange this for them.

## 3. Priority given to and success in obtaining swift access to care

These patients placed a high value on swift access, often in the context of convenient timing, and succeeded in achieving it. Most were young and employed. They consulted largely (but not exclusively) about minor acute problems and did not mind which GP they saw.

Mr D provides an example of a 'taxi queue' approach, accepting care from the first health professional available:

*'Mr D regarded health care as a technical activity, accepted medical records as an adequate basis for consistent care and was happy to take the next appointment that came up with whoever was available. For example, in booklet 1 he reported a visit to the local A&E department to deal with "sand and grit in face and left eye". He wanted immediate treatment for the problem and did not mind whom he consulted as "anyone qualified to give eye treatment" was acceptable. In the second booklet he reported a visit to his general practice for "pain in upper back". Again he did not mind whom he consulted but wanted to be seen within 2 days and at a suitable time, noting that "I was working late shift at work and required a morning appointment and was given an appointment for the following morning." His concern for a rapid and convenient appointment was readily accommodated by his large urban practice, which operated an appointment system with a high proportion of 48-hour appointments.'*

(Mr D, 36-year-old electrician. Six consultations in year: saw four different GPs; also consulted hospital A&E department.)

For most patients, swift and convenient access to care was achieved at the cost of seeing different healthcare professionals for each consultation. However, this need not necessarily be the case and a small number of patients who prioritised access nonetheless also saw the same GP each time they consulted. Mrs E provides a typical example:

'At interview Mrs E indicated that she did not mind which GP she saw and she reiterated this in all her consultation record booklets except for a next-day follow-up appointment which she wanted with the same GP. For example, in the first booklet she noted swollen glands and cold sores as her reason for consulting and indicated that she did not mind who she consulted but "I wanted to see someone before I went to work". Her small urban practice operated an appointment system which could accommodate this (early appointments bookable in advance, late appointments available the same day) and, at the same time, were able to book her appointments with the same GP.'

(Mrs E, 51-year-old office manager. Seven consultations in year: all seven with one GP.)

While these participants regularly saw the same GP, they appeared unaware of this, or unconcerned about it, and did not appear to experience it as continuity of care.

Neither Mr D nor Mrs E looked for a continuing relationship with any particular provider and neither felt they were missing anything as a result of not having one. However, several patients who prioritised speed and convenience of appointments and who saw a number of different GPs quickly expressed dissatisfaction with the care they received. An example is Mr F:

'At interview he stated he did not want to be restricted to a single GP of his own (although he identified three he preferred), and indicated that "transport problems" would also make it difficult to stay with one GP. In his booklets he noted that the speed or timing of the appointment was most important to him. For example, in booklet 1 he wanted to see someone that day and any of range of people would do, to "get my inhaler changed, trouble with breathing, and to see again if I could get my small finger, left hand, sorted out." However, at the end of his last booklet he indicated that he was less than satisfied with the consultation and that the GP he had seen would not be his first choice next time. He closed by adding, "I tend to feel like I am on a conveyor belt in a rush to get rid of me".'

(Mr F, 55-year-old man, on long-term incapacity benefit). Nineteen consultations in year: 11 with four different GPs, eight with four different nurses.)

As Mr F illustrates, patients' priorities may be shaped by practical constraints and achieving them may not always meet their needs.

#### **4. Preference for and success in seeing a named provider for some problems; priority given to and success in obtaining swift access to care for others**

Participants with this pattern include young parents who made an effort to see their 'own' GP for their own problems but who looked for quick access to any appropriate provider for their children; and patients who made an effort to see their 'own' GP for chronic health problems but gave a greater priority to quick or convenient access when they experienced minor acute problems. This could give rise to a large number of consultations with many different practitioners, as Mrs G illustrates:

'At interview, Mrs G indicated that over the years she had come to regard Dr Y as her "own" GP and preferred to see him whenever she consulted except when she had "women's problems" when she preferred to see the female partner, Dr X. She had discussed this with Dr Y who was happy with the arrangement. The general practice records also indicated that, although Mrs G saw a number of different providers for specific problems, Dr Y reviewed all her problems each time he saw her (and was the only GP who did).'

'The many concerns and their changing salience which shaped her complex pattern of consulting were evident in her consultation record booklets. For example, in booklet 6 she reported making an appointment for her husband to see "our own GP because he knows our family circumstances really well" and had succeeded as she had made it well in advance "for the day my husband was off work as he cannot take time off at present due to work pressure." By contrast, three consecutive booklets showed that, in seeking help for her son's sore throat and voice loss she had first asked for and seen her "own" GP for a same-day appointment, then several days later had rung NHS Direct who had advised her to see a pharmacist which she did before finally contacting her practice again. At this point she did not mind whom she consulted for a same-day appointment and saw the trainee GP with her own GP in attendance.'

(Mrs G, 38-year-old mother, off work on sickness benefit. Fourteen consultations in year: five consultations with 'own' GP, three consultations with female partner, one consultation with each of four other GPs and two practice nurses. Consultation record booklets also show that she accompanied her son and husband in consulting primary care providers on other



occasions, though these consultations were not recorded in her own practice records.)

Continuity of care was facilitated by the commitment of Dr Y, and the support of a large inner-city practice, which had a flexible appointment system, placed a high value on personal continuity, encouraged patients to see the same GP for continuing problems and asked patients which GP they wanted to see.

Despite the complex pattern of consulting which resulted, these patients and their 'own' GPs seemed able to accept the contribution of other providers, while still maintaining their mutual commitment to their relationship as the primary one.

## DISCUSSION

### *Summary of main findings*

Patients regarded and used primary care in a variety of ways in relation to continuity of provider and access to care. Their use was shaped by their own preferences, by the organisation and culture of their primary care practices, and by their own and their provider's efforts to achieve their preferences. Different configurations of these factors gave rise to different types of continuity. Patients were not always able to achieve the type they wanted. Patients with apparently similar consulting patterns could experience them differently.

### *Strengths and limitations of the study*

Participants were recruited to the study from a wide range of primary care contexts and included those with diverse social and demographic characteristics. Multiple types of data were collected from different sources, which meant that the details of specific consultations could be placed in a broader context, and information from the patient could be compared with medical records provided by the practice. Patients were followed longitudinally, which enabled us to look in detail at how different types of continuity of care were achieved and maintained over an extended period.

However, the sample size is small and the follow-up period limited to a year. While the patterns described are likely to be enduring at the population level, at an individual level we found examples of patients who showed signs of changing the way that they used services in the context of their evolving experience and circumstances. A longer study period with a larger sample would have allowed a fuller exploration of how and why some patients alter the way they use primary care services.

### *Comparison with existing literature*

All the types of continuity described by Haggerty et

al<sup>16</sup> and Saulz<sup>17</sup> were found in our study and our analysis allows a further consideration of the distinctions and relationships among them.

In the UK, where patients register with a general practice, informational continuity is institutionalised in medical records. For at least some of our participants (for example, Mr D), access to medical records was seen as a sufficient basis for good medical care. However, this might be better regarded as the context or foundation for continuity of care, as Saultz suggests, since patients themselves did not appear to experience it as continuity of care. Its limitations are also reflected in the frustration with their care expressed by some participants (for example, Mr F) who relied on it.

Similarly, in the one example of management continuity in the study, Mr C regarded the efforts of known members of his general practice and the mental health team to maintain a consistent approach to his care as a poor substitute for continuing care from his 'own' providers.

Several participants (for example, Mrs E) received care from a single GP over the study year but without preferring or 'choosing' to do so. These patients received what Saultz referred to as longitudinal care: care from the same doctor over time but without an ongoing personal relationship between patient and provider. This was continuity produced by the way practices operated and was not recognised or experienced as such by patients. The attitudes of patients in this group support the distinction Saultz made: where patients are indifferent to which doctor they see, continuity of provider over time does not constitute interpersonal continuity.

By contrast, patients (for example, Mrs A) who both valued and achieved continuing care from their 'own' GP experienced this as personal care. These patients received what Saultz described as interpersonal continuity, distinguished from 'lower' forms of continuity by a sense of personal trust and responsibility. This type of continuity required commitment and effort from patient and doctor alike and appeared to produce a mutually rewarding relationship.

Two patterns found in this study help to address questions raised by Saultz as to how long and under what circumstances interpersonal continuity can survive when a patient does not see the same provider. Patients (for example, Mrs G) who saw a preferred GP for some conditions and looked for swift access for others, nonetheless succeeded in maintaining a relationship with their 'own' GP, which suggests that interpersonal continuity need not be exclusive. Where patient and doctor regard each other as their 'own' and see each other regularly, their personal relationship can withstand a good deal of

selective and instrumental use of other services and practitioners. However, the experience of patients who preferred to see their own GP but were unable to do so suggests that some indication of mutual loyalty is needed to sustain interpersonal continuity over the longer term. As the example of Mr C illustrates, patients who do not receive continuity may include those with social and psychological problems and those who have difficulties in forming satisfactory personal relationships.<sup>23</sup> It is these patients in particular for whom commitment from their 'own' doctor, supported by receptionists carrying out practice policies, may be most necessary (although most difficult to sustain) if the interpersonal continuity they desire is to be achieved.<sup>21</sup>

### Implications for policy and clinical practice

The place of continuity of care in today's increasingly complex primary care services is under debate. Underlying this debate are simplistic models of access to care<sup>24</sup> and unjustified assumptions about access to information as a sufficient basis for continuity of care. Our findings, like those of Rubin and colleagues,<sup>25</sup> suggest that while patients may prefer shorter waiting times, convenience of appointment may be more important to some and an appointment with their 'own' provider more important to others. Flexibility is necessary to take account of the preferences and priorities of different patients, particularly when they experience barriers to obtaining the type of continuity they seek. Policymakers should seek ways to reward GPs' commitment to responding to patients' preferences and choices in this respect and adopt policies that promote flexibility rather than introduce uniformity. GPs can then give less attention to debating the respective merits of continuity and access, and more to fostering commitment to meeting the preferences of different patients with flexibility and understanding.

### Funding

The study was funded by a grant from the NHS Service Delivery and Organisation National Research and Development Programme (SDO/13b/2001)

### Ethics committee

Ethics approval was obtained from Leicestershire Research Ethics Committee (LREC6443) and Riverside Research Ethics Committee (RREC 2833 and RREC 3747)

### Competing interests

The authors have stated that there are none

### Acknowledgements

We acknowledge with thanks the assistance of Janet Low, Janet Vaux, Liu Yang and Eileen Hutton in aspects of the study. We also thank the participating general practices and all those patients who shared their views and experience with us and completed consultation record booklets for half a year.

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