An exploration of the value of the personal doctor–patient relationship in general practice

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SUMMARY

Background: *Within the context of general practice, continuity of care creates an opportunity for a personal doctor–patient relationship to develop which has been associated with significant benefits for patients and general practitioners (GPs). Continuity of care is, however, threatened by trends in the organisational development of primary health care in the United Kingdom and its intrinsic role within general practice is currently the subject of debate.*

Aims: *To determine how many patients report having a personal doctor and when this is most valued, to compare the value of a personal doctor–patient relationship with that of convenience, and to relate these findings to a range of patient, GP, and practice variables.*

Design of study: *Cross sectional postal questionnaire study.*

Setting: *Nine hundred and ninety-six randomly selected adult patients from a stratified random sample of 18 practices and 284 GP principals in Oxfordshire.*

Method: *Qualitative interviews with patients and GPs were conducted and used to derive a parallel patient and GP questionnaire. Each patient (100 from each practice) was invited to complete a questionnaire to evaluate their experience and views concerning personal care. All GP principals currently practising in Oxfordshire were sent a similar questionnaire, which also included demographic variables.*

Results: *Overall, 75% of patients reported having at least one personal GP. The number of patients reporting a personal GP in each practice varied from 53% to 92%. Having a personal doctor–patient relationship was highly valued by patients and GPs, in particular for more serious, psychological and family issues when 77–88% of patients and 80–98% of GPs valued a personal relationship more than a convenient appointment. For minor illness it had much less value.*

Conclusions: *Patients and GPs particularly value a personal doctor–patient relationship for more serious or for psychological problems. Whether a patient has a personal GP is associated with their perception of its importance and with factors which create an opportunity for a relationship to evolve.*

Keywords: *continuity of patient care; patient perspective; GP perspective; doctor–patient relationship.*

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Introduction

CONTINUITY of care has traditionally been described as a core feature of good primary health care.[1-3] Within the context of general practice, the opportunity exists for a personal relationship to develop between the patient and doctor.[4,5] This has benefits for both patients and general practitioners (GPs): patient enablement and compliance with medication are improved when the patient feels that they 'know the doctor well',[6,7] seeing their 'personal doctor' increases patient satisfaction,[8] while both the clinical decision-making process and disclosure of psychosocial problems are facilitated when the GP feels that they have good previous knowledge of the patient.[9,10] The doctor–patient interaction itself can be therapeutic,[11] an effect that is likely to be enhanced by feelings of trust and understanding.

Continuity of care may, however, be declining with current trends in the organisational development of primary health care in the United Kingdom: increasing size of practice,[12] sharing workload within the primary health care team, operating a combined list system, rationalisation of 24-hour availability and the introduction of walk-in centres.[13] GPs are increasingly taking on responsibilities outside their practices, such as resource management or teaching, which further reduces their individual availability to patients.[14] Some now question the existence and intrinsic role of continuity within general practice,[15-17] although the principal author's own experience as a GP principal has led her to believe that the personal doctor–patient relationship continues to offer significant benefits, which was the impetus for this research. The aims were to find out which patients report a personal relationship with their doctor and when GPs and patients consider this to be important; in particular, where it is valued more than a convenient appointment.

Method

Sample

Eighteen hundred adult patients were randomly selected from a stratified random sample of 18 Oxfordshire practices; stratification included list size and location — one-third of the sample being from Oxford city and two-thirds from outside the city, to reflect the numerical distribution of the patient population in Oxfordshire (Table 1). With the consent of their GP, each patient (100 from each practice) was invited to complete a postal questionnaire in Spring 1999 to evaluate their experience and views concerning personal care.

All GP principals (*n* = 365) currently practising in Oxfordshire were sent a similar questionnaire, which also included demographic variables. Non-responders were sent a second questionnaire. Additional information on the prac-

HOW THIS FITS IN

What do we know?

The personal doctor–patient relationship has been associated with significant benefits for patients and GPs.

What does this paper add?

Patients and GPs value highly a personal relationship for more serious or psychological problems when both groups perceive it to be more important than convenience. Whether a patient reports having a personal GP is associated with factors which create an opportunity for a relationship to evolve.

tices was collected by telephone enquiry.

Instrument

Qualitative interviews with patients and GPs were conducted by the principal author to derive preliminary drafts of a parallel patient and GP questionnaire. These were piloted in a different practice (author's own) and minor revisions made.

Patient questionnaire. This had three sections. 'You and your health' included questions concerning consultation frequency and length of registration with the practice. 'You and your GPs' included questions about having a personal GP, priority for seeing such a GP for 13 clinical cameos, and questions on convenience and access. The last section 'Questions about you' included socio-demographic variables.

Measuring the personal doctor–patient relationship. Patients were asked: 'Some people have a GP who is familiar to them, who they feel understands them and their health needs, who knows about their past medical history and with

whom they have an ongoing relationship. They may feel like this about more than one GP. In your practice, do you feel like this about: none of the GPs, one GP, two GPs, or three or more GPs?' We defined patients giving positive replies to this question as reporting 'having a personal GP'.

To learn more about patients' understanding of our definition of a personal GP we included eight questions from the Components of Primary Care Index (CPCI — developed to measure key aspects of primary care delivery in the USA[18]). These were asked in relation to the GP the patient knew best (Table 2).

Convenience. A convenient appointment time was described as one 'to fit in with your normal schedule'.

Access. Patients used a four-point scale to rate how easy it was 'to see whichever GP you want to when you visit this practice' that day, within three days or within one week. There was also a category for 'do not know'.

Clinical cameos. Using a five-point scale, responders were asked 'how important would it be to you to consult a familiar GP (like the one described before)', in each of 13 clinical cameos. These were chosen to be easily understood by patients and represent a typical spectrum of patient problems (Table 3). They were then asked, for the same set of cameos, 'whether you would choose to make an appointment at a convenient time with an unfamiliar GP rather than at a less convenient time with a familiar GP (as described before)'.

GP questionnaire. This was in two sections. 'The GP/patient relationship' was similar to the patient questionnaire but omitting the CPCI questions. The second section, entitled 'Questions about you' included basic details about the practice.

Table 1. Practice characteristics and level of personal care.

Practice list size	Patients who have personal GP (%)	Standard deviation (from study mean)	Degree of administrative support for continuity (1 = most; 4 = least)	Mix of principals	Rural/urban
2140	92	+3.1[a]	1	1 f/t, 1 p/t; 1M, 1F	City
3170	58	-3.0[a]	1	1 f/t; 1M	Town
3340	53	-3.7[a]	2	2 f/t; 1M, 1F	Town
4230	83	+1.2	4	3 f/t; 2M, 1F	City
4270	82	+1.4	4	2 f/t; 2M	Village
5200	78	+0.5	1	3 f/t; 2M, 1F	Town
7260	59	-3.0[a]	4	2 f/t, 3 p/t; 2M, 3F	Town
7770	74	-0.2	2	1 f/t, 4 p/t; 2M, 3F	Village
7950	85	+1.6	2	4 f/t, 2 p/t; 3M, 2F	City
8410	89	+2.1[a]	2	3 f/t, 2 p/t; 3M, 2F	City
8630	73	-0.3	3	5 f/t; 3M, 2F	Town
9020	75	0.0	4	4 f/t; 2M, 2F	Village
11 080	69	-1.1	3	5 f/t, 1 p/t; 4M, 2F	Town
11 910	71	-0.9	1	5 f/t, 2 p/t; 5M, 2F	Town
12 140	65	-1.7	3	5 f/t, 1 p/t; 4M, 2F	City
15 440	68	-1.1	2	7 f/t, 1 p/t; 5M, 3F	City
15 960	86	+1.9	2	6 f/t; 5M, 1F	Town
20 500	90	+2.8[a]	1	9 f/t; 6M, 3F	Town

M = male, F = female; f/t = available 4 days or more, p/t = available for fewer than 4 days. Level of administrative support for continuity: 1 = strict personal list, or fewer than two principals; 2 = strong encouragement from staff; 3 = some encouragement or 'episodic continuity of care'; 4 = free choice of doctor. [a]Significant difference from study mean of 75% (more than two standard deviations).

Table 2. Cross tabulations of 'having a personal GP' with questions from 'Components of Primary Care Index'.[18]

CPCI group	Question	Pearson χ^2	Degrees of freedom	Significance
Accumulated knowledge	'This doctor and I have been through a lot together' (n = 827)	205.0	4	<0.001
	'This doctor does not know my medical history very well' (n = 825)	169.2	4	<0.001
	'This doctor clearly understands my health needs' (n = 856)	188.3	4	<0.001
Continuity belief	'I rarely see the same doctor when I go for medical care' (n = 882)	151.2	4	<0.001
	'It is very important to me to see my regular doctor' (n = 917)	111.9	4	<0.001
	'My medical care improves when I see the same doctor that I have seen before' (n = 904)	64.7	4	<0.001
Communication skills	'This doctor always explains things to my satisfaction' (n = 857)	106.4	4	<0.001
	'I don't always feel comfortable asking questions of this doctor' (n = 829)	37.0	4	<0.001

Table 3. Percentage of patients and GPs who rate 'having a personal GP' as very or extremely important and the percentage who valued this more than a convenient time — in each of the 13 clinical cameos. (The clinical cameos were in mixed order in the questionnaires.)

Clinical cameo	Class[a]	Personal GP rated very/extremely important		Personal GP valued more than a convenient time	
		Patients (%)	GPs (%)	Patients (%)	GPs (%)
Incurable cancer	T	87	97	88	98
Lump in breast/testicle	SP	80	53	81	80
Family problem	F	71	84	86	97
Confusion/paranoid illness	P	70	80	81	93
Depression	P	68	80	81	97
A number of illnesses occurring at the same time	MP	67	83	77	98
Stress at work or home	P	63	65	77	94
Regular appointments to control high blood pressure	R	50	43	49	81
Contraceptive advice	C	36	16	52	61
Painful ear	M	16	2	16	15
Painful knee	M	14	4	21	23
Severe cough and cold	M	9	2	20	27
Itchy rash on arm	M	9	2	17	18

[a]T = terminal care; SP = significant pathology; F = family problem; P = psychological problem; MP = multiple problems; R = routine follow-up; C = contraception; M = minor illness.

Practice policies for continuity. Each practice was telephoned to question practice staff about how they arranged appointments with individual doctors. The practices were then ranked on a four-point scale of encouragement of longitudinal continuity (Table 1).

Analysis

Data were analysed using Statistical Package for the Social Sciences (SPSS). We used χ^2 tests for cross tabulations and logistic regression. The response variable in the logistic regressions was 'having a personal GP' (with 0 indicating no personal GP and 1 indicating one or more personal GPs). The explanatory variables were all treated as categorical variables (with indicator contrasts). In Table 4 we present the resulting fitted odds ratios. These compare the odds of having a personal GP in a given category of the explanatory variable with the odds in the reference category. If the data were missing for a particular variable then that patient was

dropped from the analysis.

Results

A total of 284 (78%) GPs and 996 (55%) patients returned their questionnaires. There was an excess of economically inactive and retired patients (40%) in comparison with the 1991 Census (23%) and fewer patients in social class 3. Otherwise the study population was similar, in terms of social class and ethnicity, to the Oxfordshire population. Participating patients were older than non-participants (mean age = 50 years, compared with 40 years) and more likely to be female (60% compared with 40%). To take account of any resultant biases, we have controlled for age and sex in the multivariate analyses.

Patients reported consultation frequency in the past year for themselves or a family member: 10% none, 33% once or twice, 32% three to five times, 16% six to nine times and 8% 10 or more times (n = 990).

Table 4. Logistic regression of reporting care from a personal GP on patient variables (n = 916).

Patient variables	Odds ratio (95% confidence interval)	Significance
Age group (years)		
16–24	1.0	
25–44	1.18 (0.61–2.26)	0.627
45–64	1.21 (0.60–2.43)	0.596
65+	5.70 (2.21–14.74)	<0.001
Consultation frequency		
None	1.0	
1–2 times	1.48 (0.78–2.81)	0.226
3–5 times	4.39 (2.19–8.80)	<0.001
6–9 times	4.47 (1.99–10.06)	<0.001
10+ times	7.21 (2.36–22.05)	<0.001
GP accessibility		
Never easy	1.0	
Sometimes easy	2.43 (1.14–5.18)	0.022
Usually easy	3.40 (1.63–7.09)	0.001
Always easy	9.47 (3.92–22.87)	<0.001
Do not know	1.42 (0.61–3.29)	0.418
Length of registration		
Less than 12 months	1.0	
1–5 years	1.97 (1.05–3.67)	0.034
5–10 years	4.04 (2.00–8.18)	<0.001
More than 10 years	6.87 (3.69–12.80)	<0.001
Value of personal relationship		
Not at all	1.0	
Slightly	3.67 (1.47–9.18)	0.005
Moderately	4.83 (2.28–10.21)	<0.001
Very	13.19 (6.15–28.30)	<0.001
Extremely	16.27 (7.09–37.30)	<0.001

Extent and meaning of 'having a personal GP'

One personal GP was reported by 57% of patients and two or more by 18%; 25% reported none (*n* = 986). Table 2 shows how patients' responses to our definition of the personal GP were significantly correlated with their responses to the eight CPCI questions.

Perceived value of a personal relationship and factors influencing it

Having a personal GP was rated as 'very important' or 'extremely important' in general by 64% of patients (*n* = 988) and 69% of GPs (*n* = 281). In the cameos involving incurable cancer, lump in the breast/testicle, family, psychological, and multiple problems, patients rated personal care particularly highly; for minor illness it was valued much less highly (Table 3).

The GPs' views were broadly similar to the patients' for all problems except a lump in the breast/testicle. Overall the GPs were less inclined than the patients to use the categories 'not at all important' or 'extremely important ' (see Figure 1 for illustrative examples).

For female patients and with increasing age and consultation frequency, seeing a personal GP was more valued; it was not associated with length of registration, socioeconomic factors or GP accessibility.

Perceived value of a convenient appointment and factors influencing it

A convenient time was less important 'in general' to the patients than having a personal GP had been; 46% of patients rated it as very or extremely important (*n* = 983). The perceived value of convenience was not associated with reported consultation frequency, accessibility, sex or length of registration but was positively associated with being in full-time employment.

Comparison of the value of a personal relationship with the value of convenience (Table 3)

In the clinical cameos concerning more important problems, the overwhelming majority of patients valued having a personal GP more than a convenient appointment. The majority of GPs also felt there were significant advantages for the patient and/or GP if there was a personal relationship in these situations, valuing it even more than the patients for psychological problems. For minor problems, convenience was rated above a personal doctor by patients and GPs. For contraception and hypertension follow-up only, patients and GPs reported differing priorities.

Factors associated with reporting care from a personal GP (Table 4)

These included: longer registration with the practice, more frequent consultations, easier access to the chosen GP, increasing age, and valuing a personal GP. There was no significant association with sex, socioeconomic factors or the importance of convenience.

Sample practices (Table 1)

The proportion of patients reporting having a personal GP ranged from 53% to 92% in the 18 practices. However, after controlling for age and length of registration a personal relationship was recorded significantly more in only three practices, with list sizes ranging from 2140 to 20 500. All three encouraged continuity at level 1 or 2. One of these practices had a relatively deprived population but patient mobility was low here — 77% had been registered for more than 10 years (study average = 57%).

Discussion

Three-quarters of the Oxfordshire patients in this study reported having a personal GP.

When patients feel that they are experiencing a psychological or significant health problem, almost all highly value a personal doctor–patient relationship. In these circumstances, the majority of patients respond that they would prefer to see a personal GP rather than have a convenient appointment time, but when the problem is minor a convenient appointment is more important. In the study overall, there was good agreement between patients and GPs.

The patient factors independently associated with having a personal GP essentially concern whether there has been sufficient opportunity for the patient to develop a relationship with the doctor; with increasing length of registration, consultation frequency, age, and accessibility of the chosen GP, it becomes more likely. Patients who value it are also
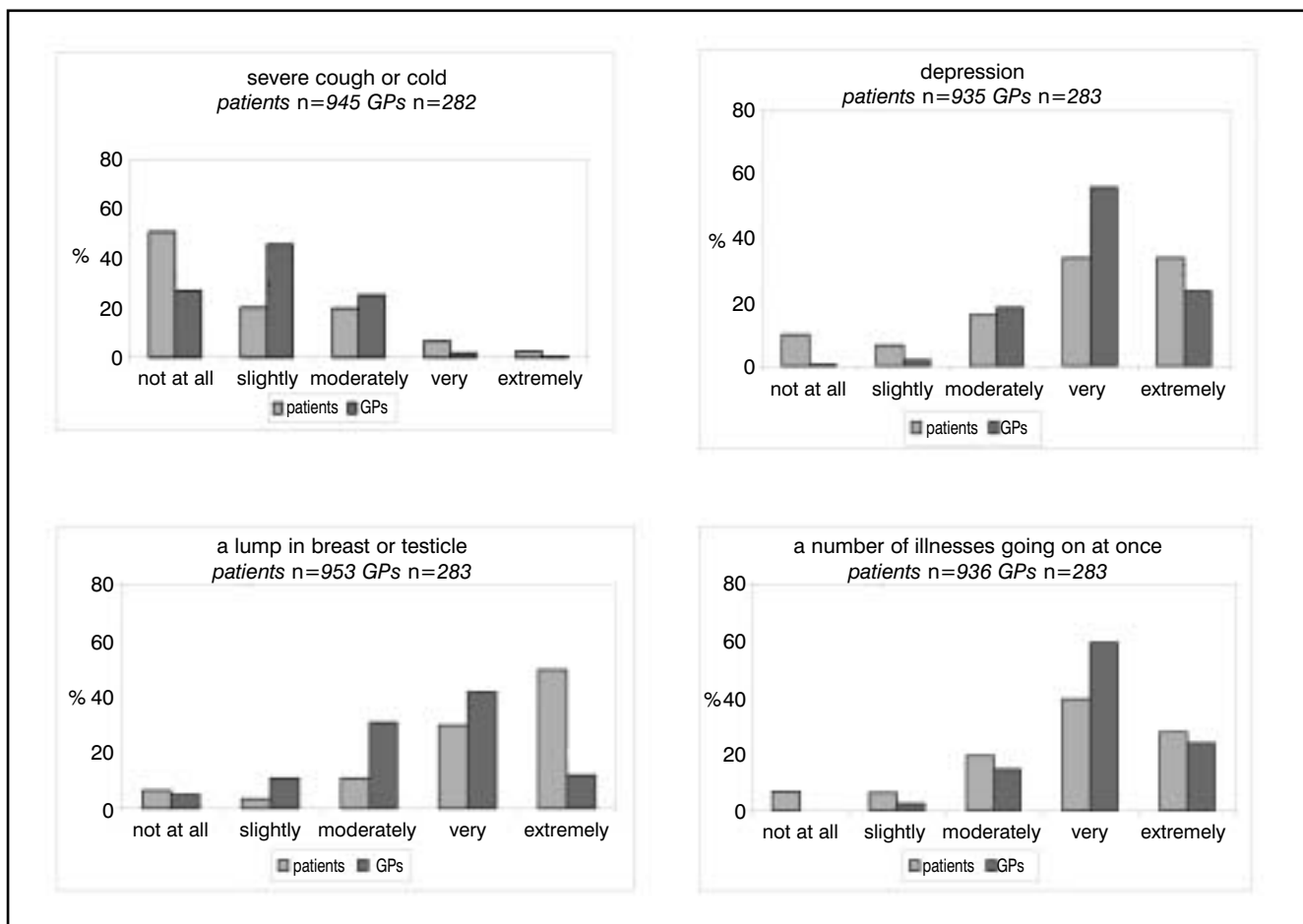
Figure 1. Importance of having a personal GP to patients and GPs: illustrative examples.

more likely to have a personal GP. In contrast, there is no independent association with sex or socioeconomic status, nor is it associated with whether or not the patient valued convenience. The relationship between practice variables and the proportion of patients who report a personal GP is more complex.

Methodology

The response rate to the questionnaires was good from the GPs and satisfactory from the patients. Patients valuing a personal relationship would perhaps be more likely to respond, therefore our interpretation of its overall high rating must be conservative. The excess of retired patients in the study will also have contributed to higher ratings. However, the patient sample was list-based rather than restricted to those consulting to obtain a wider perspective, and therefore included patients who seldom consult. We have shown that these patients were less likely to value a personal doctor, which will have reduced this potential bias. We do consider that responders may be typical in the relative weight given to personal care in the different clinical cameos. The study design limited our findings to patients' perceived, rather than actual, behaviour in prioritising a personal relationship against convenience. This again dictates cautious interpretation of the findings, although marked differences

between the clinical cameos seem to indicate clear preferences. Consultation rates and length of registration were also self-reported.

We used an extended definition of a personal GP to ensure that patients understood the question. Responses to the eight CPCI questions[18] suggested that patients interpreted the definition with its several aspects as intended. For example, associations of these responses were particularly strong for whether the patient and GP had 'been through a lot together', whether the GP had a clear understanding of the patient's health needs and knew the patient's medical history well, and whether the patient saw the same doctor when going for medical care.

Comparison with other work

Our definition of a personal GP incorporates concepts from other studies; the doctor being 'known',[6,7] having accumulated knowledge and understanding of the patient[9,10] together with a commitment over time.[19] Patients were able to report more than one personal GP in a practice and it is noteworthy that 18% did so. We assessed the patients' perception of whether they had a personal GP, rather than the number of contacts with the same doctor, because we were measuring the existence of a relationship rather than counting contacts that may have variable importance to the

patient.

Other studies have shown that the proportion of patients who 'know the doctor well' decreases as the total list size increases[6] and that smaller practices tend to offer more continuity.[14] In this study, one practice with a very large list achieved a very high patient reported rate of personal care, reminding us that size need not inhibit this quality in the presence of appropriate organisational policy. Here the GPs ran strict personal lists; it would seem unlikely that this level could have been achieved without some degree of encouragement from the practice.

Strict personal lists did not, however, guarantee an enhanced level of personal care as two other such practices did not report significantly higher levels (Table 1), which was unexpected as personal lists have been associated with improved continuity.[14] Furthermore, some practices offering patients an entirely free choice of doctor achieved similar levels of reported personal care to those that were encouraging patients to see one particular GP. It is likely that reducing choice for patients too much may decrease the chance of finding a doctor with whom they feel at ease. It will also reduce the possibility of having more than one personal GP, which may be very helpful with increased part-time working.

Implications for service provision

Value of a personal relationship and convenience. These results add strong support to those advocating personal doctoring in the recent BMA debate 'My doctor or any doctor?'.[15] Those who argue that 'continuity of record' could replace 'continuity of care' discount the value of 'accumulated knowledge' or of 'an ongoing relationship'; these were, in fact, the aspects of our definition that were most strongly correlated with the CPCI questions (Table 2).

Personal care was more highly valued than convenience by the great majority of patients and GPs for more important problems. The current political emphasis on fast access and convenience may be more of a priority for patients in full-time employment and for the management of minor illness only. It may reduce the opportunities that patients and GPs have to develop a personal relationship — fixing 'what's right' instead of 'what's wrong' with UK general practice, as suggested by three international observers of our NHS.[20] Better access to the chosen GP was, however, associated with more reported personal care in this study, indicating a need to establish the right balance between continuity and accessibility. We are not advocating 'compulsory personal care', which may not be appropriate, but we are wanting to enable patients to choose it.

Facilitating personal doctor–patient relationships. There was a wide range in the number of patients who reported a personal relationship in the practices studied. We have shown that multiple factors, which relate to the practice, the patients, and the GPs, all influence whether a patient has a personal doctor; these would need to be taken into account in planning any financial incentives for providing personal care.

Further research questions

Further research is needed to clarify the relationship between the characteristics of the practice and the degree of continuity of provider sufficient to create the opportunity for personal care. Issues concerning accessibility, including 'through-the-week' availability of the doctor and sharing of the 'personal GP' relationship also require further exploration. It appears to be possible to have a personal doctor without strict adherence to personal lists, which can potentially restrict patient choice and lead to conflicts with other demands on the modern GP. However, by definition it clearly requires a degree of commitment to continuity by patients, doctors, and practices.

The priority given to personal care in different clinical cameos warrants further exploration; for example, of actual patient behaviour in an inner-city setting and with different problems. While GPs' and patients' views were mainly similar, several differences did occur, perhaps suggesting different estimation of the importance or emotional content of these consultations. This indicates the need for more dialogue between GP and patient, to promote a shared understanding of the times when a personal relationship is most important.

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