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Patients' views on interpersonal continuity in primary care: a sense of security based on four core foundations

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Background. A deep and comprehensive understanding of what patients value about having a personal doctor in primary care is lacking.

Objectives. To acquire a comprehensive understanding of the core values of having a personal doctor in a continuing doctor–patient relationship in primary care among long-term, chronically ill patients.

Method. In this qualitative study, 14 chronically ill patients at three primary health care centres were strategically selected. The centres were selected to include patients with experiences from both long-term and short-term doctors. The patients were asked about their views on having a personal doctor in a continuing doctor–patient relationship in primary care compared with having different short-term doctors. Sixteen health care professionals were interviewed about what chronically ill patients convey to them about having a personal doctor in contrast to seeing different short-term locum doctors. The in-depth interviews were transcribed verbatim and analysed by qualitative content analysis.

Results. The core category, i.e. a universal concept that many patients used to describe the impact of having access to a personal doctor, was a sense of security. This was based on four main categories or core foundations which were: feelings of coherence, confidence in care, a trusting relationship and accessibility. In turn, the four main categories emerged from two to four of subcategories.

Conclusion. The foundations that underpin the value of personal care from the patients' perspective could be based on categories found in this study.

Keywords. Continuity of care, family medicine, general practice, primary care, qualitative study.

Introduction

The 2002 WONCA European definition regarding the discipline and speciality of General Practice/Family Medicine states that the discipline has a unique consultation process, which establishes a relationship over time, through effective communication between doctor and patient and that the discipline is responsible for the provision of longitudinal continuity of care as determined by the needs of the patient.[1]

Today's patients are often assertive, well informed and are increasingly demanding rapid access, choice and value for money. Running counter to such freedom of choice is the enduring preference of many patients for continuity of care, or personal doctoring. Often it is the old, frail and those with comorbidities who express such views, the same groups least able to make use of 'freedom of choice'. One of the major challenges of primary care in the future will be to organize in such a way as to ensure both rapid access to care and to

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BOX 1 *Facts about Swedish primary health care (PHC) and characteristics of short-term locum doctors*

Swedish primary health care	
Responsibility for PHC according to law	20 county councils and regions
System	Different systems, up to local county councils to decide. Geographical responsibility, listing and a mix of these most common
Financing	Taxes + consultation fee 15 €
Total number of general practitioners in 2004	4800
Number of GPs in a practice	Typically 2–6
Form of employment	80% salaried by county councils, 20% private
Average consultation length	20 minutes
Number of inhabitants per GP	1800, range:1500–2300
Percentage of population with access to a personal doctor	40%, range 20–65%
Consultations made in private PHC	25%
Short-term locums	
Number of GPs who have worked as locum doctors at least once during 2004	350 (of which 20% have left their ordinary job)
Background	A majority are specialized family practitioners. Some doctors come from other specialties. A small fraction are registrars or under internship
Duration of employment	Often 1–2 weeks, sometimes more
Reasons for working as locum	Earning extra money Dissatisfaction with existing job Testing out other ways of practising

provide the opportunity of a regular contact with a personal doctor for those who prefer that.

Personal doctoring is especially valued by patients when they have serious medical or psychological problems.[2] A long-term relationship also makes diagnosis and care easier for the doctor, may increase compliance and reduce medical errors.[3–7] Less is known about the effects of lack of personal doctoring.

Studies in Sweden and the UK have shown that ~70% of the population value seeing the same general practitioner over time. For chronically ill and elderly patients the number is even higher.[2,8–10] Yet a deep and comprehensive understanding what underlies having a personal doctor in primary care from patients' point of view is lacking.

Seeing the same doctor at each consultation, presented as a major feature of primary care, implies continuity over time and is often labelled longitudinal continuity.[11] The concept of continuity in primary care is, however, more complex, including further values than just repeatedly seeing the same person. Choice of doctor, patient-centredness and a good relationship may be similarly important.[2,6,10,12] Patient satisfaction increased significantly when there was a good relationship between doctor and patient.[13]

Already in 1975, Hennen stressed what he called interpersonal continuity, referring to the quality of the relationship, as an important dimension of family practice together with chronological, geographical and interdisciplinary continuity.[14] Interpersonal continuity requires named professionals with whom the patients develop a therapeutic and interpersonal relationship, thereby adding value to the repeated contacts, building trust and respect.[10,15] Also in recent reviews, interpersonal continuity has been emphasized along with continuity of information, team and cross-boundary communication and flexible continuity (adjustments to the needs of the individual), in proposed definitions of continuity.[16,17]

Although interpersonal continuity is repeatedly being emphasized as an important determinant of good care, it is being challenged in current primary care.[7] In Sweden, although all inhabitants should be given the opportunity to choose a personal GP according to the Swedish Health Act, in many parts of the country only a minority has this possibility in practice, while in other parts this is offered to most patients (Box 1).[8,9] In the UK, with a long tradition of patient listing, a proposed new contract suggests that patients will be registered with a practice rather than with a personal GP.[18]

Given the actual situation and announced changes in the organization of primary care, it is important to consider how patients perceive having a personal doctor in primary care and to form a theoretical model to clarify the concept and facilitate further research.[19,20] In this qualitative study, we aimed to acquire a comprehensive understanding of the core values of having a personal doctor in a continuing doctor–patient relationship in primary care among long-term, chronically ill patients. Patients' views were captured by patient interviews and, to deepen the findings, by interviews with primary health care staff about feelings and opinions that chronically ill patients convey to them about having or not having a permanent GP.

Methods

Three Swedish primary health care centres were selected, two in small towns and one in a bigger city.

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TABLE 1 *Patients' age, sex, historical information of having or not having a personal doctor and number of consultations*

	Age (years)	Number of patients in the study			Consultations per patient in primary care during previous year	
		Total	Women	Men	Mean number of consultations with a doctor	Mean number of doctors
Patients with	64 (33–79)	14	9	5		
No personal doctor		6			7	4
Personal doctor for <1 year		3			5	3
Personal doctor for 1–5 years		3			5	3
Personal doctor for >5 years		2			6	1

Centres with at least one position filled with a permanent GP and at least one position filled with short-term locum doctors were chosen. This was done in order to reach patients and staff with experiences from both permanent and short-term locum doctors. The locum doctors were mostly GPs who took on short-term appointments in different health care centres, working for ~1 week in each unit.

A strategic selection of patients was done. To reach patients, we depended on the primary health care centres. Days for interviews were chosen at random in order that the health care personal should not be able to choose patients in advance. An experienced nurse at the health care centre was informed on the day of interview to ask consecutive patients having appointments with permanent or locum doctors for participation when the patients arrived at the centre. The patients should have visited the health care centre for at least 5 years, have any long-term chronic disease and have experienced both periods of having a personal GP and periods of seeing short-term locum doctors. Interviews were performed until saturation was reached. All but one patient agreed to participate. Twelve patients with experience, both from periods of having a personal GP and periods with visits to short-term doctors were interviewed. To add further experiences and deepen the understanding, two patients with experience from only having a personal doctor were included.

Before the individual interviews, each patient was asked to fill in a questionnaire (Table 1). The most common reported diagnoses were diabetes, rheumatoid arthritis, coronary heart disease, depression and lower back pain.

To gain knowledge on what chronically ill patients convey to medical staff, 16 health care professionals were interviewed, chosen by a strategic selection involving different professions, ages and lengths of employment. This was done for triangulation. Three interviewed health care professionals were GPs with permanent positions and long experience, one a short-term locum GP with long experience and one a short-term locum from another discipline and shorter experience. Eleven staff members represented nurses, counsellors and receptionists (Table 2).

TABLE 2 *Age, sex and employment details of interviewed staff*

	Age (years)	Number of staff			Permanent employment	Locums
		Total	Women	Men		
Doctors	53 (35–59)	5	1	4	3	2
Other staff	52 (40–61)	11	10	1	11	
Nurse		7				
Counselor		1				
Assistant nurse		1				
Receptionist		2				

Open individual interviews were performed by the first author. Each interview lasted 30–45 minutes. The patients were informed, that by a personal doctor we meant 'a doctor at the primary health care centre whom you regard as your own doctor and whom you can consult'. This general formulation was used in order to give the respondents a possibility to associate freely. An initial question was posed about the patients' preferences of having a personal doctor or not. The patients were encouraged to elaborate freely about what they found important about seeing a personal doctor. The health care professionals were interviewed about what feelings chronically ill patients convey to them about having a personal doctor or locums.

The interviews were recorded on audiotape and transcribed verbatim after each interview. Notes were continuously made on preliminary ideas and reflections. New interviews were performed until further data collection did not provide any additional information. The interviews were analysed using a technique inspired by Grounded Theory, a qualitative content analysis described by Kvale.[21,22] This involved

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concentration of respondents' statements into smaller meaningful units, which could then be grouped into subcategories under conceptual themes with unique headings. From subcategories expressing related concepts, larger units emerged which were termed categories. Early in the process of analysis, one category emerged as the core category. A process of interactive analysis and revision was adopted whereby provisional coding was modified in the light of newly gathered data. The analyser (IvB) is a health care professional, but does not have in-depth knowledge of primary health care. Co-assessment was done by experienced GPs (GE, PH, BM). Triangulation was done by analysing the interviews with the doctors and other staff on what patients convey to them.

Results

Thirteen of the fourteen patients strongly preferred encounters with a personal doctor, while one patient with experience from permanent and locum GPs, who had a mild chronic disease with few necessary check-ups, did not stress the importance of a personal doctor as much.

From the qualitative analysis, one core category emerged, which was 'a sense of security'. This in turn was based on four main categories: (i) coherence; (ii) confidence in care; (iii) a trusting relationship and (iv) accessibility. Each of the categories was in turn built-up from two to four of subcategories (Fig. 1).

A sense of security

The core category, the universal concept that many patients used to describe what impact access to a personal doctor had, was a sense of security. When it could not be arranged for the patients to see the same doctor, 10 out of the 12 patients with experience of both personal and short-term locum doctors, conveyed that this generated feelings of insecurity and anxiety.

> 'It's important to have a personal doctor. And especially, when you are an elderly person with many diagnoses. A personal doctor knows about the patient's situation. Then you get a feeling of security'. (Patient)

> 'Then I met doctor number three, and I asked myself: Do they know anything about my troubles and what I've told them before? Indeed they've got my patient record and all that stuff on computers, but you still feel insecure. That's how it is; you don't feel quite secure, I think.' (Patient)

A number of patients without access to a personal doctor gave an impression of resignation, faced with the fact that they would have to keep on seeing short-term locums in the future. Both GPs and locum doctors emphasized the need for security among patients suffering from long standing illnesses.

> 'It's about security, you know. They are extremely thankful that they've got a contact'. (GP with permanent position)

Locums conveyed that many patients asked them if they were going to stay or not.

> 'The patients ask me, for how long will you be here? And I say: just this week. They sigh and say that, yes, it feels tough!' (Short-term locum doctor)

Staff members held continuity to be a prerequisite for chronically ill patients to experience security. They had noticed that patients lacking a personal doctor became

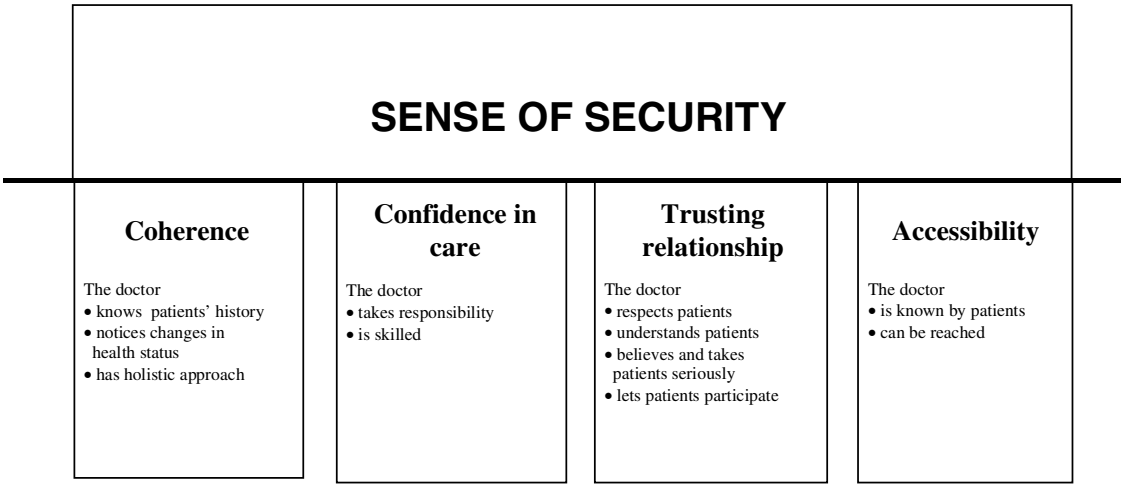

FIGURE 1 *A theoretical model for the patients' perception of the core values of having a personal doctor in primary care. An overall sense of security emerged, which was based on four main categories: feelings of coherence, confidence in care, a trusting relationship and good accessibility. Each category was in turn built-up by subcategories which involved different aspects concerning the doctor-patient interaction.*

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worried about which doctor they would see the next time.

> 'One doctor tells them this, and perhaps... the patient then comes back in a fortnight and another doctor tells them that. This isn't good and it's because that lack of security that patients experience.' (Nurse)

Four main categories emerged as the basis for a sense of security. Every patient expressed feelings that fell into at least three of the four main categories that emerged as the basis for the sense of security, feelings of (i) coherence; (ii) confidence in care; (iii) a trusting relationship and (iv) accessibility (Fig. 1).

Coherence

The main category coherence was built on three subcategories. It seemed essential to the patients that the doctor (i) knows about the patient's disease history; (ii) notices changes in health status and (iii) has a holistic approach.

Knowing the history. Patients often looked upon their encounters with the primary doctor as a set of intertwined events. They pointed out that doctors should be familiar with these events and about the patient's own, unique medical story. They felt that a personal GP acquires this familiarity in time.

During the interviews, patients with experiences from short-term locum doctors often strongly complained about the frustration of repeatedly having to tell their stories to new doctors.

> 'When you're sick, you are expected to rattle off your background data to a new doctor every time, like when you're on a long sick leave... as I have been. You feel insecure and vulnerable... you don't know how you will be met. You surely know that when you have a personal doctor.' (Patient)

> 'When I see my personal doctor, I meet a person who knows who I am, just that. And who knows about my disease.' (Patient)

Some patients had met short-term locums who had not informed themselves in advance about what had been done earlier, but tried to pick up information from the patient's record during the consultation. Patients often reported on being forced to take too big a responsibility for their care and having to inform short-term doctors about things the doctor ought to know.

> 'It's important not to have to explain and explain to a new doctor each time.' (Patient)

> 'I sometimes even have to tell short-term doctors what to prescribe. They don't even know what I'm on.' (Patient)

Patients reported that dependency for one's health and life on their chronic disease being correctly assessed repeatedly by unknown persons during short encounters based on records that the patient did not know the coverage of, created anxiety and insecurity.

> 'It's really a relay race with people's health.' (Patient)

Also the short-term doctors themselves were aware of the shortcomings of such encounters with chronically ill patients.

> 'I have to ask about so many things because I haven't seen the patient before and I've got only 15 minutes. It's hard. But... above all, patients find it hard to tell me about everything.' (Short-term locum doctor)

Noticing changes. Patients wanted a doctor to notice changes in their health status.

> 'Then I feel I have talked to this doctor before and he will notice differences about how I feel. A new person never does that.' (Patient)

GPs also stressed the importance for chronically ill and elderly patients to have a personal doctor who will notice changes.

> '... after all, as a personal doctor I will notice changes and I can ask myself, why this change?' (Permanent GP)

A holistic approach. Many patients pointed out that their chronic disease or disablement involved their whole person, physically, mentally and socially, as well as their relatives. They regarded visits to the doctor as parts of their lives, in which their diseases were integrated. The patients felt that it is important for their health care that the doctor is informed about their life situation, to create a feeling of coherence.

> 'Most short-term doctors have too little time; they haven't got time enough to understand your personality. It creates misunderstandings.' (Patient)

Confidence in care

The main category confidence in primary health care was built on two subcategories. It seemed essential that (i) the doctor takes on responsibility and coordinates care and (ii) that the doctor is skilled.

Responsibility. Patients emphasized that security comes from knowing that a personal GP assumes responsibility, keeps care coordinated and refers to other professionals when needed.

> 'Well, there are good doctors beside mine, but I am totally convinced that my doctor will do what he can.' (Patient)

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Some patients had experienced that the course of investigation, medication and care was changed repeatedly during an ongoing disease due to deviant views by short-term locums and without obvious reason. This created anxiety and insecurity.

> 'And then the risk with medication … to get prescriptions changed by different doctors several times. The new medications might not go with what you've got before. It makes you feel insecure and anxious.' (Patient)

Doctors and other staff had the impression that patients with chronic diseases want a doctor they can trust and who takes on responsibility.

> 'Because they want to see the same doctor. If they find a doctor who they feel takes responsibility, then they prefer to see that person.' (Permanent GP)

Staff members pointed out that patients often report about lack of coordination and progress when short-term locum doctors are involved. They described how patients look upon the treatment of their illness as an active process that the patients want someone to take responsibility for.

> 'When the diagnosis is set, the patient wants someone who works on a long term basis.' (Counsellor).

Skilled doctor. Some patients particularly stressed the importance that the doctor is skilled.

> 'I think it's very important that the doctor is skilled and shows it, along with some human interest in you.' (Patient)

Most patients, however, seemed to assume that doctors usually are skilled.

> 'I suppose they do their job, but it felt safer with the one I knew.' (Patient)

If a patient seriously distrusted the doctor's skills it became a major issue and the patient wished to change the doctor if there was a possibility to do so.

> 'If I get a locum doctor whose skills I don't have confidence in, then I definitely don't want to see that doctor again!' (Patient)

The doctors and other staff did not bring up this subject from the patients' perspective.

A trusting relationship

The main category, a trusting relationship, was based on four subcategories. Patients felt it important to be (i) confirmed and respected as a human being; (ii) met with understanding and empathy; (iii) believed and taken seriously and (iv) that care allows for cooperation, patient participation and empowerment.

Confirmation and respect. Many patients expressed the importance of being identified and respected.

> '… that you feel like a human being when you visit the doctor and that you can relate to each other and talk on the same level.' (Patient)

Understanding and empathy. Most patients felt that they were met with more understanding and empathy by a personal doctor they had previously had, than usually by short-term doctors. A few patients without a personal doctor related to meetings with short-term doctors who seemed to understand them well and who had treated them with empathy. The patients then wanted that locum doctor as their personal doctor. One patient was discontented with the personal doctor he earlier had because of lack of empathy and wanted the short-term doctor with whom he had an occasional appointment as his new personal doctor.

> 'He really wanted to understand, he listened. I would like to see him again for my treatment, but no, he won't be here after this week.' (Patient)

To be believed and taken seriously. The patients who had long-term contacts with a personal GP expressed feelings of mutuality and security in the relationship to the doctor. These patients did not give notions of not feeling believed or not being taken seriously.

> 'I can tell my personal doctor that I think it might be this or that. We will check that up, the doctor tells me. Then you get that fine fellowship, so that you dare tell him about things.' (Patient)

Patients who had had appointments to many different short-term doctors experienced it as a problem to tell about one's own personal problems to someone you do not know. One of the patients conveyed a strong feeling of having been violated by not being believed and taken seriously by a short-term locum doctor.

> 'Not to be believed … to have to repeat everything again. It made me so vulnerable. Now I panic before each appointment … will I get a doctor that understands how I feel this time?' (Patient)

Also GPs had the impression that it is easier for patients to tell the 'real truth' to a personal doctor than to short-term doctors.

> 'The patients open up right away to me in another way, mention things they shouldn't have done to a new doctor.' (Permanent GP)

> 'It's hard for me too, but above all the patients find it hard to tell me all.' (Short-term doctor)

None of the doctors conveyed that they would not believe what patients told them. However, one of the locum doctors reported about some new patients with chronic diseases who he felt had noticed his uncertainty

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in decision-making. He felt that patients may sometimes wrongly interpret this uncertainty as mistrust in the patient's story.

> 'I think the patient notices when I'm a little hesitant . . . and I'm supposed to be informed about the patient's diseases. That's the whole idea behind a personal GP. Then maybe they think I don't believe them when in fact my thoughts are occupied with trying to get a full picture and make a right decision.' (Short-term locum doctor)

Cooperation and empowerment. Cooperation and patient participation seemed to be important elements of care given by personal doctors. Patients speaking in terms of 'we' instead of 'the doctor' emphasized partnership and cooperation.

> 'We changed medication.' (Patient)

Some patients emphasized that they had been well informed and invited to participate in decisions. They, as well as two of the doctors, felt that this had consequences for the patients' ability to activate themselves, as they felt empowered and able to take responsibility for their own health.

> 'Thus, he could describe to me how. . ., what he thought might be the injury. This made it possible for me to return home and start treating myself.' (Patient)

> 'I can be of some help, but it is the patient who's doing the big job and takes care of his own disease.' (Permanent GP)

Accessibility

The main category accessibility was based on what the patients conveyed about the values of (i) knowledge about the doctor and his/her way of working and (ii) that the doctor can be reached.

Knowledge about the doctor. Both patients and staff emphasized the security that comes from knowledge about the doctor and his or her way of working and 'way of being'. For patients to know what can be expected, reinforced an overall feeling of security.

> 'I want to learn how my new personal doctor is, so I know how to communicate and what I can expect her to help me with.' (Patient).

> 'Patients handle me differently when we have met a few times.' (Permanent GP).

Reaching the doctor. It was important to the patients to be able to reach the doctor. Personal GPs had noticed that their patients felt secure if they knew how to get in touch with their doctor.

> 'Patients know that they can call me. They do not always need to pay another visit in case I change medication, so I tell them that if it doesn't turn out well, call me.' (Permanent GP)

Staff members reported a greater number of telephone calls and extra return visits from worried patients after visits to short-term locums compared with visits to personal doctors. Visits to personal doctors also seemed to leave the patient with fewer questions directed to other staff members.

Discussion

In this study, we investigated the core values of having a personal primary care doctor from chronically ill patients' perspective. A sense of security emerged as the core category, the universal concept that many patients used to describe the impact a personal doctor had. It was based on four main categories which constituted the foundations of the security feeling: feelings of coherence, confidence in care, a trusting relationship and accessibility (Fig. 1).

Conversely, care given by changing short-term locum doctors tended to leave many patients discontented and insecure in what they experienced as discontinuous care without explicit goals, such as when the doctor did not know their history or when medication and care were changed repeatedly by different short-term locums who could not assume full responsibility. This correlates with earlier findings about patients' perception of being 'left in limbo', not making progress, if continuity, co-ordination, communication and access are failing between primary and secondary care.[23] This indicates that similar problems from discontinuity may arise in other parts of the health care system.

When listing the results from a number of studies on patients' experiences and views on having a personal doctor in primary care, it became apparent that our categories of coherence, confidence in care, a trusting relationship and accessibility parallel other findings, indicating that these factors may represent fundamental aspects of continuity in primary care (Table 3).[24–28] Other studies exclusively emphasize the importance of patients being met with dignity and as unique individuals, and patients' trust in their regular doctor, corresponding to our category of a trusting relationship.[29,30]

Feeling believed and taken seriously was generally the case for patients having a personal doctor. The strong negative emotions, bordering on feelings of being exposed to violation when in doubt about being taken seriously by a short-term locum doctor, was an interesting finding. Short-term locums on the other hand revealed they were sometimes concerned about making incorrect assessments in long-term illnesses. It cannot be ruled out that some patients' feelings of not being believed emanated from a misinterpretation of

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TABLE 3 *A number of studies on patients' experiences and views on having a personal doctor in primary care in terms of the categories that emerged in the present study*

Publication	Themes/categories				
	Main theme	Coherence	Confidence in care	Trusting relationship	Accessibility
von Bültzingslöwen, Eliasson, Sarvimäki, Mattsson, Hjortdahl (present study)	Patients' over-all sense of security based on four categories:	The doctor –knows the patients' history –notices changes in health status –has holistic approach	The doctor –takes responsibility –is skilled	The doctor –respects the patients –shows understanding and empathy –believes and takes patients seriously –lets patients participate	The doctor –is known by the patient; the patient knows how the doctor works and what to expect –can be reached
Liaw[26]	Patients' main reasons for seeing regular doctor:	The doctor –knows the patients' past history medicine	The doctor –has good judgement –is competent	Rapport The doctor –is caring –listens	The doctor's –accessibility
Gabel *et al.*[27]	Main factors contributing to patients' maintenance of a continuous care relationship with a family physician:	Physician's accumulated knowledge of the patients	The patients' –confidence in physician –satisfaction with care –belief in professional growth of physician	The patients' –ease of communication with physician –friendship with physician –experience of personal attributes of physician; caring (understanding, concerned, interested) personable (honest, humble, patient, perceptive) dedicated (reliable, dependable)	The patients' –familiarity with physician (freedom from the unknown) –availability of physician
Flocke[24]	Patients' satisfaction associated with:	Physician's accumulated knowledge of the patient	Coordination of care	Doctor–patient interpersonal communication	Patients' preference to see their regular physician
Preston *et al.*[23]	Patients' overall feeling due to efficient progress through the system, reassurance and confidence. The opposite, feelings of being left in limbo,when any of four themes fails:		Continuity of staff, coordination and communication among professionals	Orientation of care to the patients' requirements (fitting in) Provision of information (knowing what is going on)	Access (getting in)
Tarrant *et al.*[25]	Three main features of personal care:	Whole-person holistic care	Individualised or tailored care	Human communication (good interpersonal communication skills, empathy, listening, taking time)	
Sheppard *et al.*[28]	Factors related to patient trust specific to patient–provider relationships, leading to satisfaction and adherence (outcomes):	Continuity	Perceived competence	Caring Effective communication (understanding, listening)	

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what was in fact an uncertainty on the part of the short-term locum doctor not to make correct assessments in long-term illnesses. The doctor's hesitation and need to ask confirming questions may account for patients' feelings of not being believed.[10] This hypothesis needs to be investigated further.

One patient's experience of more confidence and trust in a short-term locum doctor than in his regular GP, due to feelings of not being met by understanding and empathy by the regular GP, emphasizes the benefits of establishing personal care in longitudinal continuity in primary care, the so-called interpersonal continuity.[25] The patient's wish to choose the locum as his new personal doctor, had the doctor stayed, correlates with earlier findings that not only continuity, but also choice of doctor and a good patient–doctor relationship, are important factors.[2,6,13] It also emphasizes that personal care is promoted by, but not always dependent on, a continuing provider–patient relationship.[25]

Health care professionals seemed to experience the value of a personal doctor for the patients in the same way as the patients did. The personal doctors thought that the patients valued the security and continuity they provided. They also expressed that the patients valued that they were able to notice differences in the health status of their patients, and that the patients felt that they could reach them and trust them. The short-term locum doctors, on the other hand, felt that the patients were frustrated when they did not know which doctor they would meet the next time. The locums also felt that they did not have enough background information about the patients, since the time schedule did not allow for the patient to tell them everything about themselves. A personal doctor would have had more information from the beginning.

Most patients seemed to have a basic assumption that doctors are skilled. However, they seemed particularly confident about this when they talked about their present or former personal GP. Although this may be partly due to an urge by the patient to confirm his or her own choice of a doctor, other studies on continuity of primary care have also reported about great importance of the doctor's competence.[26] The fact that most patients in our study seemed to assume that doctors are usually skilled does not make the subcategory 'skilled doctor' less important in our model. The core category of a sense of security in having a personal doctor is based on the four categories in combination. For example, a long term doctor who knows the patient's history but does not respect the patient does not create the feeling of security. It is the four categories, based on the subcategories, in concert, which build up the foundation of security.

A personal doctor does not guarantee that patients feel secure. Properties of doctors such as age, experience, attitude and behaviour differ. However, the interviewer's and co-assessors' interpretation were that the emotions and experiences that emerged were consistent and associated with having or not having a personal doctor.

Qualitative research data are directly affected by the context in which they are collected and by the methods of data collection and analysis. In view of the small sample size, specific context and methodological decisions in this study, caution must be exercised when attempting to generalize our findings.

A new definition for general practice based on biomedical, psychological, social and cultural components has recently been proposed, in which continuity is described as an aid or tool rather than as a basic element of primary care.[19] Interpersonal continuity, whether viewed as a basic element or a tool, needs a clear theoretical model taking into account the different perspectives; from patients, doctors and other medical staff to make it possible to further assess its values.[15,31,32] In this study we provide the foundations that underpin the value of personal care from the patients' perspective. Our findings indicate that patients with a personal doctor are given the prerequisites to experience a sense of security, based on the four core categories or foundations. More research is needed to demonstrate the added values and the relative importance of the four categories and subcategories.

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