doi:10.1093/fampra/cml010 Family Practice Advance Access published on 4 April 2006

'Two sides of the coin'—the value of personal continuity to GPs: a qualitative interview study

Matthew Ridd, Alison Shaw and Chris Salisbury

Ridd M, Shaw A and Salisbury C. 'Two sides of the coin'—the value of personal continuity to GPs: a qualitative interview study. *Family Practice* 2006; **23**: 461–468.

Background. Continuity is thought to be important to GPs but the values behind this are unknown.

Objectives. To explore the values that doctors working in general practice attach to continuity of patient care and to outline how these values are applied in practice.

Methods. In-depth qualitative interview with 24 GPs in England. Participants were purposefully sampled according to personal and practice characteristics. Analysis was thematic, drawing on the constant comparative method.

Results. The majority of doctors valued doctor–patient, or personal, continuity in their everyday work. It was most valued in patients with serious, complex or psychological problems. GPs believed that through their personal knowledge of the patient and the doctor–patient relationship, personal continuity enabled them to provide higher quality care. However, the benefits of personal continuity were balanced against problems, and GPs identified personal, professional and external constraints that limited its provision. GPs seemed to have resolved the tension between the benefits, limits and constraints they described by accepting an increased reliance on continuity being provided within teams.

Conclusion. Personal continuity may offer important benefits to doctors and patients, but we do not know how unique its values are. In particular, it is not clear whether the same benefits can be achieved within teams, the level at which continuity is increasingly being provided. The relative advantages and limits of the different means of delivering continuity need to be better understood, before further policy changes that affect personal continuity are introduced.

Keywords. Continuity of patient care, attitude of health professional, family practice.

Introduction

Continuity of patient care has traditionally been a cornerstone of general practice in UK.[1] Until relatively recently patients would have received all their primary care from a nominated GP. This so-called longitudinal continuity is thought to promote the doctor–patient relationship. Through this GPs have aspired to provide personal care, which the literature refers to as 'interpersonal continuity'.[2]

This model of primary care faces new challenges. Practices are getting larger and patients may be less likely to see the same doctor at each consultation. There is an increased emphasis on continuity being provided through teams who share clinical records.[3] Patient choice and access are the watch words that now guide health care policy.[4,5] GPs have expressed concern about the impact of organizational changes on interpersonal continuity,[6] but at the same time have embraced changes that reduce their availability to provide it. This includes the adoption of a more front-line role for nurses, and different attitudes to and patterns of working.[7]

These developments raise questions about the evidence base for continuity. Continuity continues to be identified as being important to patients,[8] especially when they have serious or psychological problems.[9,10] Continuity is associated with higher patient satisfaction[11] and 'knowing the doctor well' correlates with enhanced patient enablement.[12] However, research showing that this translates into improved patient outcomes is weak and inconclusive.[13] GPs also seem to favour continuity,[10] but the views of the profession are relatively unexplored.

Received 7 October 2005; Accepted 8 March 2006.
Academic Unit of Primary Health Care, University of Bristol, Cotham House, Cotham Hill, Bristol BS6 6JL, UK. Correspondence to Matthew Ridd; Email: m.ridd@bristol.ac.uk

So does personal continuity matter to GPs and if so why? The viewpoint of doctors is important because they may offer unique professional perspectives. We decided to undertake a qualitative study to explore the value that doctors working in general practice currently attach to continuity of care.

Method

In order to understand doctors' views and experiences of continuity, interpretive qualitative methods were employed.[14] Qualitative methods are suited to investigating complex social phenomena such as continuity, and can help develop an understanding of attitudes and behaviour.

The sample

Participants were GPs working in Bristol and the surrounding area. We wanted to recruit doctors who might give a range of views on continuity. Because we did not know their opinions on continuity prior to the interview, we purposefully sampled on characteristics that we hypothesized might reflect a diversity of perspectives.[15]

We initially sampled to obtain a mix of different ages, sex and status (practice-based GPs, registrar and locum GPs). For practice-based GPs (principal, retainer or salaried) we tried to recruit doctors who worked a variety of sessions in different types of practice (size, location and whether they operated a personal or shared list system). Data on practice and doctor characteristics were assembled from the Avon Health directory of general practices, practice leaflets and websites. Deprivation levels in the immediate practice areas were obtained from the National 2001 UK census, at the lower layer super output area level (LSOA), using the main practice postcode.[16] We invited GPs attached to practices by letter, with a follow-up telephone call. We approached GP registrars and locums through the Bristol vocational training scheme and non-principal group, respectively.

In order to ensure robustness of data generated, we continued sampling to include participants who might confirm and disconfirm each other's views and accounts.[17] We stopped recruitment when no new themes were emerging from the data.

The interviews

In-depth interviews were conducted by MR between February and June 2003, at a location of the participant's choice, most commonly in the surgery. They were tape recorded and transcribed verbatim. Although a topic guide was used (see Box 1), flexibility was maintained to allow participants to introduce issues of importance to them, employing an iterative approach of using answers from earlier interviews to inform later questioning.[18] GPs were encouraged to discuss both positive and negative experiences relating to continuity, supported by specific examples where possible. Written consent was obtained and approval granted by the United Bristol Health care Trust research ethics committee and local primary care trusts (PCTs).

Box 1 *Topic guide*

- Participant's background
- Definition of continuity in general practice
- Experience of continuity in patient care
- Views of role in continuity in general practice
- Views and experience of continuity in relation to work satisfaction
- Beliefs about how their values surrounding continuity have developed
- Views and experience of successful continuity and when has it failed
- Views and experience of continuity in relation to people who frequently attend and patients with complex needs
- Experience of continuity influencing career choice
- Views and experience of continuity and competing professional demands
- Views and experience of continuity in relation to personal priorities
- Any other issues

Analysis

Analysis, aided by the qualitative software package Atlas.ti, was led by MR. Data were coded for key categories and concepts, applying the constant comparative method derived from grounded theory approaches.[19] This develops the core themes through continual comparison of data elements with each other in an iterative manner. Early interviews were reviewed in their entirety by all of the authors. The developing coding framework and themes, both anticipated and emergent, were discussed and agreed. Modifications in the light of later transcripts were approved by all of the researchers and participants were invited to comment on a summary of the findings, in order to enhance trustworthiness and credibility.[20]

The themes outlined below emerged across the range of participants and where differences emerged, they are detailed. The quotes used represent the full scope of responses given.

Reflexivity

MR started the study when he was a GP registrar with limited professional experience of continuity. His position was that he was open-minded on its current day relevance but conscious of the need to get beneath surface level accounts, in case they simply reflected professional rhetoric.

Results

In total 24 doctors were interviewed. Of 23 principal, retainer or salaried GPs approached, 17 were interviewed: 4 declined to participate, 1 failed to reply and 1 was unavailable through maternity leave. Two of the 4 locums and 5 of the 18 registrars who volunteered were included.

The 22 practice-based doctors worked in 17 practices within 4 PCTs. Nine practices were in a variety of Bristol suburbs and the remaining surgeries were within a 25 mile radius of the city. The multiple deprivation index for residents in the immediate practice areas varied from 532 to 28 399, where 1 is the most deprived and 32 482 the least deprived area in England. Table 1 shows the characteristics of the participants. Five trained outside the UK (B Germany, K Australia, Q Pakistan, R Ireland and V India) and 1 had worked for 14 years as a GP principal in South Africa (M). One doctor (W) worked in a university student practice.

GPs talked about continuity in terms of doctor–patient contact: a patient seeing a familiar doctor over time, who knew the patient and their family. The seminal features of doctor–patient, or personal, continuity were personal knowledge of, and relationship with, the patient.

Most GPs believed personal continuity enabled them to provide a higher quality of care. However, there were 'two sides of the coin' (K, female registrar): advantages of personal continuity were balanced against disadvantages. Participants further distinguished how the two sides of personal continuity affected care: some features were thought to affect both doctors and patients, whilst other aspects were felt to uniquely affect the GP.

It seemed that as a consequence of these factors, GPs had reached a compromise solution of providing continuity through teams. In doing so they tried to retain some of the benefits of personal continuity whilst addressing the associated problems and constraints.

TABLE 1 *Characteristics of participating doctors (n = 24)*

	Status					Total
	Principal	Salaried	Retainer	Registrar	Locum	
Sex						
Male	8	1	0	2	2	13
Female	4	3	1	3	0	11
Age/Years						
20–34	1	1	1	3	0	6
35–49	5	2	0	2	2	11
50+	6	1	0	0	0	7
No sessions per week						
1–6	4	3	1	1	–	9
7+	8	1	0	4	–	13
List system						
Personal	4	2	1	2	–	9
Other	8	2	0	3	–	13
Practice size/No of doctors						
1–3	4	1	0	2	–	7
4–6	3	0	1	2	–	6
7+	5	3	0	1	–	9

Reasons for valuing personal continuity

The majority of the doctors interviewed (23 out of 24) said that personal continuity was valuable in their daily work. It was particularly valued for patients with serious, chronic, complex or psychological problems.

Many GPs said personal continuity helped orientate them in encounters: with known patients they said they were better at discerning patient agendas and identifying problems. They were able to recognize change and spot patterns, sometimes intuitively. Doctors also felt that personal continuity bred trust. Because of this trust, they thought that patients were more likely to disclose problems and GPs felt more able to openly challenge patients.

> ''Sometimes you can just, if there's someone that you know you can just tell when they walk through the door that there's something that is not right. You know can tell from sort of the way they're holding themselves or their expression... You know, sometimes patients will come in and I'll say 'How are you?' and they'll say 'Well I'm fine', and then because you know that they're the sort of patient who actually doesn't really come out with what, how they're feeling, you know I'll come back and say, 'Is that a real fine or, you know, is that the sort of fine when there's lots going on?'" (I, female salaried)

Conversely, discontinuity meant that occasionally opportunities to anticipate problems or provide proactive care were lost.

> ''...quite often there may be something you're involved in, or you're waiting for a result back, or, some sort of thing, and that comes in on a day you're not working, and is to the other person that you're working with, or a locum, they may see it as a fairly trivial result and file it away, and then you suddenly realise because you've not had a prompt that, you're either waiting on a piece of information or, or there may have been something you know, something could have happened as a result of that thing, which in it's own right wasn't important but affected your plan of management with that patient'' (A, female principal)

Most doctors said personal continuity allowed them to break complex problems down into consultation-sized chunks. They thought that patients appreciated not having to repeat their story, were reassured by

consistent advice and were more likely to concord with decisions. It was said to be easier to filter symptoms and interpret results with known patients. GPs said they adjusted their threshold for intervention and tailored their management decisions accordingly.

> ''I think if you're seeing a patient that you've never seen before I think you probably over-investigate and probably have a tendency to over treat, whereas if you've seen the patient with the same symptoms two years ago and you know what happened two years ago, um, you will probably tend to rely more on experience than, you know following A B and C in a set guideline.'' (I, female salaried)

Personal continuity was seen to modify patient and professional expectations about consultations and outcomes. This may help to protect the doctor, colleagues and patients.

> ''And my biggest heartsink who was an absolute nightmare . . . came to see me in a 10 minute appointment as a sort of initial thing and it was just awful. I felt terrible but actually now I quite enjoy seeing her because I know what all her problems are and I know which ones, I know where we are with all of them. And if she ever goes and see anyone else they she overwhelms them every time and they come and tell me and they say 'Oh I saw your nightmare patient' and I say you know 'Actually she's not that bad once you get to know the background to all of it and if you really know her well'.'' (C, female principal)

Personal continuity may increase GPs' accountability and sense of responsibility. Some GPs described an additional commitment to known patients:

> ''X: I mean, if one of my patients was mentally ill, and required detaining under the Act, I would rather do it and follow it up afterwards, than have a stranger come in and do it.
> MR: Right. Why would that matter?
> X: . . . I think it's, you know, it's going through thick and thin with them really, isn't it?'' (X, female salaried)

Many GPs thought that some patients derived therapeutic benefit from personal continuity. This was especially so for psychological problems or conditions with limited treatment options.

> ''Alcoholics, alcoholism. If you've got a working relationship with someone that can be very supportive. There's no question of writing out a prescription for something that solves their addiction. It's a question of your recognising where, what they are doing, you're giving them support by witnessing what they're going through and, if they know you, that can be a very supportive relationship because you're on their side.'' (U, male principal)

Problems with personal continuity

However, continuity was not universally valued. Limits to its benefits were also identified.

Patients may not share some concerns with a familiar doctor, because they are either not given the opportunity or feel unable. On the basis of prior experience, patient or doctor can make assumptions about each other. High personal continuity can cause the doctor to fail to see 'the wood for the trees' (J, male principal), resulting in delayed or missed diagnoses.

Personal continuity also restricts patient choice. This can cause problems in two ways. The degree of investment in the 'usual' GP means that in the doctor's absence consultations with a deputizing doctor can be more difficult. A doctor monopoly also opens the potential for collusion or, in a worse case scenario, abuse of the relationship by the doctor.

> ''My deceased senior partner said that if you've done a home delivery on somebody, you can do anything for them after that and get away with it, right? Because you've got, done something tremendous for them and after that, you know, you can do no wrong.'' (U, male principal)

Participants thought that patients were more likely to forgive a mistake made by a known doctor.

The one doctor (H) who rejected continuity was a locum GP. His reasons for doing so were peculiar to him: personal continuity to him seemed to be about 'hand holding' and 'emotional attachment', which he disliked. He had not been attracted to general practice as a vocation and thought personal continuity was sometimes an inefficient distraction from the business of medicine.

> ''I'm a medicine doctor, not a people doctor, I don't value the relationship, I like interesting medicine, general practice doesn't give you a lot of that unfortunately . . .'' (H, male locum)

However, he still agreed with the idea that for other doctors, continuity had a role in managing chronic disease.

Personal continuity and profession rôle

GPs who valued personal continuity thought it brought additional job satisfaction. Personal continuity was cited as a characteristic that both attracted and retained doctors in general practice. GPs enjoyed the patient loyalty and appreciation.

> ''I just it's very nice on the whole to see patients and build up a relationship with them and a rapport and I think the longer you've known somebody, and built up that relationship, I think it just give the job an extra dimension . . .'' (D, male locum)

Doctors also valued the feedback that personal continuity afforded them, about the outcome of patients

and the consequences of their clinical decisions. Some GPs identified this as being an important means of maintaining professional confidence. The locums (D and H) in our study found this feedback difficult to obtain but did not speak about any professional insecurity.

> ''I think continuity probably is important to me, and in terms of reassurance that I'm doing the right thing . . . and, also seeing patients again so knowing that, you know, they're obviously satisfied with what you're doing.'' (O, female salaried principal)

Doctors closely identified personal continuity with general practice. Personal continuity was commonly associated with the role and purpose of being a GP, a characteristic that distinguished them from hospital colleagues.

> ''I mean that's the point about being a GP is to have that rather than being in A&E and seeing someone different every day.'' (P, female registrar)

On the counter side, doctors reported that in some cases seeing the same patient over time fosters patient dependency and dysfunctional relationships, reducing job satisfaction. This was frequently discussed as the 'heart-sink' patient:

> ''There's also the element of there's some patients you just hate seeing, these heart-sink patients, I've already got one or two of them and you're just, they walk in the door and they say, ''Well doctor,'' and you know for starters that they're never going to be well, you know, I'd say they've never said they've been well in whole life.'' (R, male registrar)

One doctor said personal continuity had sometimes limited his enjoyment of work because it restricted the variety of patients that he saw.

> ''I actually like seeing other people's patients. I mean there's always going to be that slight dichotomy really in terms of how you feel about seeing patients because, and I actually quite like the new challenge from time to time, because if I'm just seeing the same people week after week after week I can get totally bored with that really . . . so actually it's a breath of fresh air sometimes when I get someone coming in who I've never met before really.'' (E, male principal)

Constraints on personal continuity

While valuing personal continuity, the GPs recognized that it demands availability, a commitment which they were reluctant to make. Doctors said they put their family, outside interests and lifestyle before their work. For example, although personal continuity might sometimes be beneficial outside normal surgery hours (out-of-hours), no one in our sample of doctors felt that providing 24 hour care was feasible or acceptable.

Some doctors said issues such as workload and the working environment were more important then continuity. For example, locum D shared the values of the regular GPs but accepted the lower level of personal continuity associated with locum work in preference to the problems he had experienced as a GP principal.

> ''. . . I think far more crucial issues for me are you know, the number of meetings, the amount of paper work, out of hours . . . I think workload, pay and the way you get on with your partners are more crucial issues in deciding on what's your ideal working environment.'' (D, male locum)

GPs suggested that current circumstances meant it was harder to provide personal continuity. They cited an increase in the volume and complexity of their work and rising patient expectations. Some doctors reported a more consumerist attitude amongst patients, for example with wider changes in society affecting out-of-hours care.

> ''Everything's twenty-four hour. Clubs, drinking, cash machines, doctor, you know supermarket, everything's twenty-four hours and I think we just had to for our own survival move into a situation where we hand over lock, stock and barrel.'' (W, male principal)

Attempts at resolution—fudged continuity

Most doctors in our sample seemed to have settled for a continuity 'fudge' (E, male principal). In an attempt to resolve tensions between the benefits, problems and constraints surrounding personal continuity, patient care was increasingly provided through the practice team.

It was argued that some of the values of personal continuity could be provided through teams because they have their own knowledge and relational dimensions. Team knowledge, like personal knowledge, was felt to be broad and secure, with the advantage that members contributed different, complementary information.

> ''. . . we've been lucky in the fact that many of our team members whether it be mid-wives or, um, district nurses have worked here a long time. I think they've been very good at sort of bridging that gap, they often know things about patients that we don't . . .'' (A, female principal)

Shared continuity might avoid some of the downsides of personal continuity. GPs felt that a team approach reduced the impact of a doctor's absence, and it offered patients choice, for example to see a female doctor for a gynaecological symptom. Consulting different team

members might help bring new problems to light or identify questionable practice by a health professional.

> ''. . . there's the disadvantages where, you could miss something genuine because you're quite happily in that little furrow thinking, ''Oh it's only her and it's only this'', I mean you can miss things and sometimes a new light, and new looking at somebody in a different way can pick up a disorder that you've missed because you've been a little complacent because it's Mrs Smith with her same bevy of things, so yes there is that side.'' (M, female principal)

Doctors may benefit from seeing a greater variety of patients and from the professional support of colleagues in difficult cases.

The acceptability of continuity through teams, or team continuity, was said to be dependent on the team's structure and function. Ideally the team had to be small and stable, with members working in well-defined roles to a shared standard. Vitally, team members had to be available to one another and meet in order to share knowledge verbally.

This related to the opinion expressed by most participants that information that was important for personal continuity could not be relayed through the medical records. Specifically, patient notes could not convey the subjective, broad and detailed information that arose from repeated doctor–patient encounters.

> ''N: . . . I think you write in the notes pertinent points, you have to because you can't write everything but there's a lot else that isn't written down as well.
> MR: And what would that be if you don't mind me asking?
> N: Sort of conversations in the corridor sort of stuff really you know.'' (N, male principal)

Finally, GPs gave less positive explanations for the shift toward greater team continuity. According to some, it was a 'survival' response to increased workload and financial pressures.

> ''Okay, it is not possible, I don't believe, to be a good general practitioner and, not to have branched out into having nurse practitioners or practice nurses. I just simply don't believe that with the demands currently in terms of standards, in terms of audit, in terms of follow-up and indeed if we go for it, the new contract, and the demands that are going to be placed on us, it is possible to proceed in any other way.'' (F, male principal)

Discussion

Principal findings

The majority of doctors said they valued personal continuity in their everyday practice. By seeing the same patients over time, doctors said they developed a personal knowledge of, and a relationship with, them. These elements were thought to improve trust, communication and concordance. Doctors may be able to provide better care and some patients may derive benefit from a 'therapeutic relationship'.

However, on the other side of the coin, problems with personal continuity were described. Key concerns were poorer communication and clinical care. Its provision may also be constrained by personal, professional and external factors. As a consequence, doctors said they increasingly provided continuity at the practice team level.

Strengths and limitations of the study

Although there have previously been quantitative investigations of doctors' opinions about continuity, we think this is the first qualitative study in the English literature to specifically examine the value that GPs attach to continuity of patient care. The views presented provide a contemporary insight into the worth of a traditional core value. Participants had a range of characteristics and worked in a variety of settings. It is likely that the findings presented here are transferable to other doctors from similar backgrounds working in similar settings.

Despite achieving a high response rate, we only had one 'deviant case' (a GP who did not personally value continuity) and it is possible that this study underrepresents a minority negative view. Some of the findings may be unique to family doctors working within the NHS in the UK. Doctors working in very rural settings were not included and they may have a different perspective. Nevertheless, all of our GPs qualified the benefits of personal continuity in terms of problems and restrictions, and the one participant who was negative agreed that personal continuity still had its place.

All of the interviews were conducted by a GP (MR). Inter-professional interviews can present their own methodological challenges, but we believe we benefited from the richer and more personal accounts that can accompany such interactions.[21] We recognize that all interviews are social encounters, and as such the accounts given are particular to the context and purpose of the research. However, we believe that the grounding of participants' views in specific examples from their practice bridges some of the gaps that may exist between what GPs say in an interview and what they do in practice. This at least partially addresses an anticipated concern about GPs' responses being based purely in professional rhetoric.

Comparison with existing literature

Continuity is a complex concept. The doctor's perspective has previously been represented through quantitative surveys and narrative reviews,[10,22] methods that usually impose a prior framework and cannot always answer the 'how' and 'why' questions. We

wanted to examine in-depth the current day value of continuity, choosing a qualitative approach to allow us to see the issue 'through the eyes of' those experiencing it and to examine the rationales they provide for their views.

Whilst the needs of patients should guide how primary care is delivered, and continuity is associated with patient satisfaction, GPs perspectives' are nevertheless important. Continuity may affect job satisfaction, and hence the attractiveness, of general practice. Firstly, it may help doctors cope with situations of complexity or uncertainty, with concomitant benefits to patient care. Secondly, personal continuity may bring doctor-specific benefits, particularly in terms of professional identity.

Continuity is preferred in patients with serious, chronic and psychological problems,[9,10,23] and we report reasons why this might be. Personal continuity provides a context to encounters and contextual information may help doctors to make diagnoses.[24,25] It may help them to 'chunk' problems, recognize patterns and work intuitively, all tools for managing complexity.[26] Although researchers have been unable to agree on how to conceptualise continuity, these findings improve our understanding of important differences between the informational, longitudinal and interpersonal dimensions commonly described.[2]

If personal continuity and the doctor–patient relationship bring benefits to doctors and patients, they also have the potential to do harm.[1,27] A longitudinal relationship is neither a pre-requisite nor a guarantor of good quality care and patients may experience personal care in the context of a single encounter.[23] Just as patients make trade-offs in seeking continuity of doctor,[9] our study reports parallel factors that appear to determine the extent to which GPs are willing to provide personal continuity. Although a team approach to continuity may address some of the GPs' concerns about personal continuity, and bring additional advantages,[28] questions about its consequences for patient care remain unanswered.

Implications

We think our findings have important implications for research and policy making. We need to examine how the ascribed benefits and harms of personal continuity affect patient care and job satisfaction of GPs. If personal continuity is important for the satisfaction and standing of the profession, its erosion or loss at any meaningful level may have implications for future recruitment and retention of GPs.

Personal continuity may be an important means of coping with the increasing levels of complexity in general practice, but policy emphasizes a greater reliance in the future on shared electronic records and multidisciplinary teams.[29] We need to ask how interchangeable are any benefits of personal with team continuity? If practices continue to grow in size, one option may be to have several 'continuity teams' within each surgery, which possess the desirable characteristics identified by doctors in our study.

Whatever the form and future of continuity in general practice, we think our findings underline the importance of on-going mixed-method evaluations of its value. Only with a better understanding of patient and professional perspectives can organizational changes that affect the provision of continuity be sensibly made.

Declaration

Ethical approval: United Bristol Healthcare Trust Research Ethics Committee E5576.
Funding: MR's salary as an academic GP registrar for the duration of the study was funded by the South West Deanery.
Conflicts of interest: none.
Authorship: all the authors wrote the study proposal and contributed to the analysis and interpretation of the interview data. MR was responsible for the data collection and wrote the first draft of the paper. MR will act as guarantor.

Acknowledgements

We are grateful to the doctors who took part and to Margaret Johnson, Jo Overton and Tina Ellis for transcribing the interview tapes.

References

[1] Freeman G, Hjortdahl P. What future for continuity of care in general practice? *BMJ* 1997; **314:** 1870–1873.
[2] Saultz JW. Defining and measuring interpersonal continuity of care. *Ann Fam Med* 2003; **1:** 134–143.
[3] Adam R, Guthrie B. The death of the personal doctor. *J Health Serv Res Policy* 2001; **6:** 129–130.
[4] Department of Health. *The NHS Plan: A Plan for Investment, a Plan for Reform*. London: HMSO; 2000.
[5] Department of Health. *Building on the Best: Choice, Responsiveness and Equity in the NHS*. London: HMSO; 2003.
[6] Maeseneer JD, Hjortdahl P, Starfield B. Fix what's wrong, not what's right, with general practice in Britain. *BMJ* 2000; **320:** 1616–1617.
[7] Evans J, Lambert T, Goldacre M GP recruitment and retention: a qualitative analysis of doctors' comments about training for and working in general practice. Royal College of General Practitioners Occasional Paper 83. London: Royal College of General Practitioners; 2002.
[8] Wensing M, Jung HP, Mainz J, Olesen F, Grol R. A systematic review of the literature on patient priorities for general practice care. Part 1: Description of the research domain. *Soc Sci Med* 1998; **47:** 1573–1588.
[9] Schers H, Webster S, van den Hoogen H, Avery A, Grol R, van den Bosch W. Continuity of care in general practice: a survey of patients' views. *Br J Gen Pract* 2002; **52:** 459–462.
[10] Kearley KE, Freeman GK, Heath A. An exploration of the value of the personal doctor–patient relationship in general practice. *Br J Gen Pract* 2001; **51:** 712–718.

[11] Saultz JW, Albedaiwi W. Interpersonal continuity of care and patient satisfaction: a critical review. *Ann Fam Med* 2004; **2:** 445–451.
[12] Howie J, Heaney D, Maxwell M, Walker J, Freeman G, Rai H. Quality at general practice consultations: cross sectional survey. *BMJ* 1999; **319:** 738–743.
[13] Freeman G, Shepperd S, Robinson I, Ehrich K, Richards S. Continuity of care: report of a scoping exercise for the SDO programme of NHS R&D. London: NCCSDO; 2001.
[14] Pope C, Mays N. Qualitative research: reaching the parts other methods cannot reach: an introduction to qualitative methods in health and health services research. *BMJ* 1995; **311:** 42–45.
[15] Patton MQ. *Qualitative Research and Evaluation Methods*, 3rd edn. London: Sage; 2002.
[16] National Statistics. http://www.neighbourhood.statistics.gov.uk (accessed 26 January, 2006).
[17] Gilchrist VJ. Key informant interviews. In Crabtree BF, Miller WL, (eds). *Doing qualitative research*. London: Sage; 1992, 70–89.
[18] Pope C, Ziebland S, Mays N. Qualitative research in health care: analysing qualitative data. *BMJ* 2000; **320:** 114–116.
[19] Strauss AL, Corbin J. *Basic of Qualitative Research: Grounded Theory Procedures and Techniques*, 2nd edn. London: Sage; 1998.
[20] Mays N, Pope C. Rigour and qualitative research. *BMJ* 1995; **311:** 109–112.
[21] Chew-Graham CA, May CR, Perry MS. Qualitative research and the problem of judgement: lessons from interviewing fellow professionals. *Fam Pract* 2002; **19:** 285–289.
[22] Gray DP, Evans P, Sweeney K *et al*. Towards a theory of continuity of care. *J R Soc Med* 2003; **96:** 160–166.
[23] Tarrant C, Windridge K, Boulton M, Baker R, Freeman G. Qualitative study of the meaning of personal care in general practice. *BMJ* 2003; **326:** 1310.
[24] Granier S, Owen P, Pill R, Jacobson L. Recognising meningococcal disease in primary care: qualitative study of how general practitioners process clinical and contextual information. *BMJ* 1998; **316:** 276–279.
[25] Summerton N. Making a diagnosis in primary care: symptoms and context. *Br J Gen Pract* 2004; **54:** 570–571.
[26] Wilson T, Holt T, Greenhalgh T. Complexity science: Complexity and clinical care. *Br Med J* 2001; **323:** 685–688.
[27] Chew-Graham CA, May CR, Roland MO. The harmful consequences of elevating the doctor-patient relationship to be a primary goal of the general practice consultation [Editorial]. *Fam Pract* 2004; **21:** 229–231.
[28] van Weel C. Teamwork. *Lancet* 1994; **344:** 1276–1279.
[29] Department of Health. Improving Chronic Disease Management. London: HMSO; 2004.