Commitment to a Regular Physician: How Long Will Patients Wait to See Their Own Physician for Acute Illness?

Margaret M. Love, PhD, and Arch G. Mainous III, PhD
Lexington, Kentucky, and Charleston, South Carolina

BACKGROUND. Continuity of care with a physician is associated with better health outcomes and greater patient satisfaction. Having a "regular doctor" could lead to greater continuity of care, but only if the patient consistently seeks care from this physician. How long will a patient wait for care if their usual physician is not available? Our study explored factors related to a patient's decision to seek care from another professional.

METHODS. We analyzed the results of a statewide random digit dialing telephone survey of 658 Kentucky adults. Our study focused on the 466 adults who indicated they usually seek care from the same physician. Respondents were asked about seeing an alternate provider if they had an acute, non–life-threatening condition and their usual physician was not available.

RESULTS. Of the respondents, 48.6% indicated they would seek care from another professional the same day, 41.6% would wait 1 day or more, and 9.8% would not see another professional. Patients with asthma were significantly more likely to wait for care from their regular physician ($P < .05$), as were patients who usually visited a physician's office instead of a clinic ($P < .05$). In a multivariate model, seeking alternate care the same day was significantly more likely among patients who were older, nonwhite, and who would seek alternate care at their usual site of care ($P < .05$).

CONCLUSIONS. Maintaining continuity of care with their usual physician is important to patients. Patient and practice characteristics may influence the decision to wait for care in an effort to maintain continuity.

KEY WORDS. Continuity of patient care; physician-patient relations, primary health care. *(J Fam Pract 1999; 48:202-207)*

A continuous long-term relationship between a patient and a physician is a hallmark of primary care.[1] The hypothesized advantages to continuity of care rest on beliefs that a knowledge base is accrued in a long-term physician-patient relationship.[1-3] Several outcomes have been linked to continuity of care. These include medication compliance[4-6] and patient satisfaction,[7-9] and one study in a Veterans Affairs population suggested fewer emergent hospitalizations for conditions such as sepsis or pulmonary emboli and shorter lengths of stay in the hospital.[10] Some recent evidence suggests that continuity has the important benefit of decreasing a patient's likelihood of future hospitalization.[11,12]

Although data suggest that continuity of care is one of the most highly valued characteristics of health care,[13] other data seem to show that maintaining high continuity is a difficult task.[14] Particularly in the case of group practices, continuity with an individual provider is low.[15] According to data from the 1987 National Medical Expenditure Survey, approximately 50% of patients have high continuity with a physician.[14] When insurance companies force a change of physicians, such as when managed care contractors change, patients rate the quality of care they receive from their physicians as lower.[16]

Although it is acknowledged that maintaining continuity with a provider is important to patients but is a difficult task, little is known about the effort that patients will make to maintain continuity. Having a regular physician can lead to greater continuity of care, but only if the patient consistently seeks care from that physician. However, the patient's regular physician may not be available every time care is necessary. The patient must then choose to either postpone care until that physician is available or seek care from another health professional and allow discontinuity. The tradeoffs that patients are willing to make between commitment to a regular physician and seeking care elsewhere may be different for acute symptoms, chronic conditions, and well care; our study focused only on acute symptomatic problems. The purpose of our study was to examine factors related to patients' decisions to seek care for an acute illness from someone other than their regular physician.

Submitted, revised, December 12, 1999.
From the Department of Family Practice, University of Kentucky (M.M.L.), and the Department of Family Medicine and the Center for Health Care Research, Medical University of South Carolina (A.G.M.). Requests for reprints should be addressed to Margaret M. Love, PhD, Department of Family Practice, University of Kentucky, K302 Kentucky Clinic 0284, Lexington, KY 40536-0284.
E-mail: mlove@pop.uky.edu.

METHODS

The data we used for this study were from the 1998 Kentucky Survey conducted by the Survey Research Center at the University of Kentucky in Lexington. The Kentucky Survey is an annual statewide omnibus survey of noninstitutionalized Kentucky residents aged 18 years and older. We targeted adults, because they are independent decision makers in the use of health care. The Kentucky Survey examines trends and provides investigators with the opportunity to do cross-sectional studies. The survey contains items that are asked annually, as well as questions submitted by a variety of investigators that may only be included in 1 year's data collection. The questions regarding continuity of care were included by the authors in the 1998 survey. These 13 items appeared approximately two thirds of the way through the 141-item survey.

The survey used random digit dialing with Waksberg clustering.[17] That design offered every residential telephone line in Kentucky an equal probability of being selected. Waksberg clustering also supplies an almost completely unbiased sample of households with telephones.[18] Individuals were not interviewed if they were deaf, too ill to come to the telephone, or could not complete the interview in English.

The 1998 survey had a response rate of 39.0%, supplying a sample of 658 respondents. Calls were made between May 11, 1998, and June 10, 1998. The margin of error was ±3.82 percentage points at the 95% confidence interval. The survey took an average of 15 minutes to complete.

MEASURES

Relationship with a regular physician was defined according to previously used items that evaluated health care access.[3] Respondents were asked if there was one particular clinic, health center, physician's office, or other place that they usually visit if they are sick or in need of health advice. If they answered yes to this item (n = 531, 81%), they were asked if they usually see the same doctor or health care professional at this place. If they responded that there was a specific physician (n = 466, 88% of respondents with a usual site of care), they were asked to estimate how long that person had provided their health care. Only 11 respondents with a usual site of care usually saw a different health professional (2%).

An assessment was made of how long respondents would wait to see their usual physician when they had an acute, non–life-threatening illness (eg, bad cough, diarrhea). Specifically, respondents were asked how long they would wait to see their physicians before going to see someone else about the problem. An additional set of questions was used to identify where they would go for care (eg, emergency department, other provider in a group practice, urgent treatment center).

Standard demographics were collected. Two additional questions were asked that may affect continuity with a physician. The first concerned restricted choice of providers. In an assessment of their insurance status, respondents were asked about their freedom of choice in selecting providers and seeking care, as well as overall type of health care coverage (private insurance or Medicare, low-income insurance, such as Medicaid, or none). The second question asked whether the respondent had a chronic disease, since there is the possibility that patients with chronic diseases may visit their physicians more often and have a greater desire for continuity.

ANALYSIS

Analyses are limited to respondents who reported having a regular physician. All analyses were conducted with SAS statistical programming, release 6.09, using complete data for each item (SAS Institute, Inc, Cary, NC). Because of some small cell sizes, Fisher exact tests were used for comparisons between discrete variables. We used analysis of variance for comparison among means for continuous variables, with Tukey's studentized range tests for pairwise comparisons where appropriate. We employed a stepwise logistic regression to find the best model to predict the decision to wait for care (0 = wait less than 1 day before using another physician; 1 = wait at least 1 day). All demographic variables (age, sex, race, metropolitan statistical area, education, income), characteristics of health care and coverage (number of years regular physician provided care, usual site of care, alternate site of care, alternate care at same location as usual care, type of health care coverage), and chronic disease status (diabetes, asthma, hypertension, arthritis, other) were entered. Choice within insurance plan was not entered because only 318 people responded to that item, and the regression only includes subjects with no missing data on the regression variables; the sample size would have been reduced by 32%. However, the 2 items about location of alternate care were answered by more of the respondents (n = 385 and n = 390) and were included. Their inclusion reduced the sample size for the regression by approximately 17%, because respondents who indicated they would not seek care from another professional were not asked those items and were not included in the regression. Finally, the regression analysis included only those variables that maximized the fit of the model ($P < .05$).

RESULTS

Seventy-one percent (466) of all survey respondents reported that they had a regular doctor. This was 88% of the respondents who reported a usual site of care. The demographic characteristics of the sample are presented in Table 1. If their usual physician would not be available to respond to an acute non–life-threatening illness, almost half of the respondents (48.6%) would seek care from another professional within a few hours or the same day, 24.8% in 1 or 2 days, 6.8% in 3 or 4 days, 10.0% in more than 4 days, and 9.8% would not seek care from another professional.

TABLE 1

Demographic Characteristics of Study Respondents (N = 466)

Characteristic	%
Sex	
Male	42.5
Ethnic background	
White	91.6
African American	6.7
Hispanic	0.2
Other	1.5
Highest grade completed	
Less than high school	16.3
High school or GED	38.5
More than high school	45.2
Metropolitan statistical area	40.3
Annual household income	
$25,000 or less	35.2
$25,000 to $50,000	36.1
$50,000 or more	28.7
Age (mean years±SD)	48.5±15.9

GED denotes general equivalency diploma; SD, standard deviation.

Characteristics of respondents' care and health care coverage are shown in Table 2 and chronic disease status is shown in Table 3. For most of the respondents (73.3%), the regular physician had been providing care for at least 3 years. A physician's office was the usual site of care for the majority of these respondents. If care was sought from another physician, most respondents (67.2%) would seek care from another professional at the same location. For alternate care, most respondents (76.6%) would seek care at a physician's office instead of a clinic. Most respondents (94.7%) had some type of health care coverage, mostly private insurance or Medicare. Of respondents who had an insurance source (n = 318), 37.7% would pay the same amount for any doctor; 32.7% would pay less for doctors on the insurance company list; and 29.6% would pay the whole doctor bill for doctors not on the list. Nearly half of all respondents had a chronic disease.

The 192 respondents who were not included in the analyses because they did not have a regular doctor were demographically similar to the 466 individuals who usually see the same physician at a usual site of care: 39.6% were men; 93.1% were white; 37.5% had a chronic illness; 94.8% had health care coverage; and 32.8% of the 116 with insurance were paying the same amount for any physician. However, these patients were somewhat younger (mean age 42.8±16.6 years) and more urban (52.6%) than the respondents who reported visiting a regular physician.

For analyses of the factors associated with waiting for care, responses were collapsed into 3 waiting categories: a few hours or same day (48.6%); 1 or more days (41.6%); and would not see another professional (9.8%). These 3 groups differed demographically only in terms of their ethnic background ($P = .045$) and age ($F = 4.97$; $P = .007$). Although white and nonwhite respondents were most likely to seek care from someone else the same day rather than wait, white respondents were less likely than nonwhite respondents to seek care from someone else the same day (46.9% vs 67.6%), more likely to wait 1 or more days (42.6% vs 29.7%), and more likely to say that they would not see another doctor (10.5% vs 2.7%). The respondents who would seek care from someone else the same day were significantly older than the respondents who would wait a day or more for care (mean = 50.2 and 45.7 years, respectively; $P < .05$), but neither of these groups differed in age from the respondents who said that they would not see another professional (mean = 51.4 years).

Comparisons between waiting and other factors are presented in Table 3 (chronic disease diagnoses) and Table 4 (care and coverage). Patients who usually sought care at a clinic were more likely to seek care from another physician the same day than were patients who usually sought care at a physician's office, while patients who usually sought care at a physician's office were more likely to say that they would not see another physician ($P = .01$). Respondents whose alternate source of care was at their usual site were more likely to seek alternate care the same day than were those whose alternate source of care was at

TABLE 2

Health Care and Coverage of Respondents in Study Sample (N = 466)

Characteristic	%
Amount of time regular physician has provided care	
<1 year	7.7
1 to 3 years	18.9
3 to 5 years	18.7
5 to 10 years	20.0
10 or more years	34.6
Usual site of care	
Physician's office	85.1
Clinic	14.0
Emergency department	0.4
Urgent treatment center	0.4
Type of health care coverage	
Private insurance or Medicare	72.2
Low income insurance	22.5
No coverage	5.3

TABLE 3

The Amount of Time Respondents with a Chronic Disease Will Wait Before Seeing Another Physician (N = 466)

Disease	n (total %)	Less than 1 Day (%)	1 or More Days (%)	Would Not See Other Physician (%)	*P*
Diabetes	33 (7.1)	54.8	32.3	12.9	>.10
Asthma	30 (6.4)	28.6	50.0	21.4	.03
Hypertension	81 (17.4)	53.3	33.8	13.0	>.10
Arthritis	97 (20.8)	53.3	35.6	11.1	>.10
Other chronic disease	66 (14.2)	46.8	33.9	19.4	.03
Any chronic disease	195 (41.8)	46.8	39.9	13.3	.10

GED denotes general equivalency diploma; SD, standard deviation.

a different place ($P = .0007$). Compared with other respondents, patients with asthma were less likely to seek care from someone else the same day (28.6% vs 50.0%), more likely to wait for care (50.0% vs 41.0%), and more likely to say they would not seek care from someone else (21.4% vs 9.0%, $P = .03$). Compared with other respondents, patients who had a chronic disease other than diabetes, asthma, hypertension, or arthritis were similar in seeking care the same day (46.8% vs 49.0%), but less likely to seek care after waiting (33.9% vs 42.9%), and more likely to say they would not seek care from someone else (19.4% vs 8.2%, $P = .03$). The alternate site of care, the number of years the regular physician had provided care, the type of health care coverage, and choice within insurance plans did not vary significantly with waiting to see another professional.

A stepwise logistic regression was used to find the best model to predict the decision to wait 1 day or more for care. Three variables significantly contributed to the model at the $P < .05$ level with standardized estimates in the analysis of maximum likelihood estimates: age (0.1719, $P = .02$), race (white vs nonwhite, 0.1732, $P = .03$), and whether care would be sought at the same or a different location (-0.2377, $P = .001$). Respondents were more likely to seek care the same day if they were older, nonwhite, and would seek alternate care at their usual site.

DISCUSSION

Many people (51.4%) seem to value continuity with their regular physician to the extent that they would wait a day or more to receive care from their own physician even while suffering from an acute illness. Many who would not wait for care would seek alternate care at their usual site (67.2%), suggesting that continuity may be maintained within a practice if not with a particular physician. Large group practices are often organized to favor quicker access over continuity with an individual physician for acute problems. Unfortunately, maintaining continuity with a site of care may not produce the same benefits as continuity with a specific physician. Continuity with an individual physician, more than continuity with a site of care, is associated with reduced risk for hospitalization.[12] More research is needed on outcomes associated with continuity of provider, continuity of site, and discontinuity with both provider and site.

Patients with chronic disease seem to have a greater desire to receive care from their regular physician. It is possible that the relationship between a patient and a physician that is created in ongoing treatment of a chronic disease may sensitize patients to prefer a physician who is familiar with their medical history. Of the respondents with chronic diseases, those with asthma were particularly oriented toward loyalty to their physician. It may be that the immediate effects of asthma exacerbation and the corresponding relief through appropriate treatment makes patients especially likely to seek care from a physician who has helped them in the past.

The construct of continuity with a physician involves the accrual of knowledge by both patient and physician in the relationship. Our results, however, do not indicate a positive relationship between length of time with a regular physician and length of time that patients would wait to see that physician. Why would length of time in the physician-patient relationship not have a significant linear correlation with likelihood of waiting? Perhaps some patients and some physicians are more attuned to the physician-patient relationship than others.

The factors that emerged as significant in the regression analysis may represent the complex influence of this relationship, as well as more pragmatic issues, such as convenience. The decision to choose an alternate physician from the the usual site of care or another site may be a relatively pragmatic issue, related to convenience or familiarity with the settings or the professionals at that settings. Patterns of age and race emerged, with younger patients and white patients more likely to wait a day or more for care. Age and race are not simply confounded with measures of cost and convenience of medical care and may represent differences in patients' relationships

with their physicians and their approach to seeking medical attention.

LIMITATIONS

There are several limitations to the generalizability of these results. First, the survey had a relatively low response rate (39%). The random digit dialing method would not suggest a systematic selection bias, but the large number of nonresponses may not be randomly distributed. Second, the study reported behavior in a hypothetical situation. Responses may meaningfully indicate intentions but not necessarily actual behavior if the situation were to arise. Discerning whether patients behave as their responses suggest is a topic for future research. Third, although we found that a substantial proportion of people reported a desire to wait for their regular physician in response to a general scenario of acute illness, they may not wait for care for certain acute, non–life-threatening illnesses. Also, the factors influencing the decision to wait for the regular physician may be different for acute problems, chronic problems, and well care. Further research could differentiate commitment to a regular doctor for different types of care.

CONCLUSIONS

Self-reports suggest that many patients with an acute illness are willing to wait at least a day to receive care from their regular physician. A substantial number of respondents said that they would not see another physician.

TABLE 4

Care and Coverage Factors Associated with the Amount of Time Respondents Will Wait for Care from Their Regular Physician

Factor	Wait Less than 1 Day (%)	Wait 1 or More Days (%)	Would Not See Other Physician (%)	*P*
Usual site of care				.01
Physician's office	45.5	43.4	11.1	
Clinic	63.1	33.9	3.1	
Location for alternate physician				.0007
Same place	60.5	39.5	—	
Different place	41.9	58.1	—	
Alternate site of care				>.10
Physician's office	55.0	45.1	—	
Clinic	52.2	47.8	—	
ED or UTC	52.0	48.0	—	
Amount of time regular physician has provided care				>.10
Less than 1 year	55.6	41.7	2.8	
1 to 3 years	47.0	42.2	10.8	
3 to 5 years	47.1	44.7	8.2	
5 to 10 years	43.0	45.4	11.6	
10 or more years	52.0	37.3	10.7	
Type of health care coverage				>.10
Private insurance or Medicare	49.3	40.9	9.8	
Low income insurance	54.4	38.0	7.6	
No coverage	28.6	52.4	19.1	
Reimbursement within insurance plan				>.10
Same amount for any physician	50.9	36.2	12.9	
Less for physicians not on list	43.3	50.5	6.2	
None for physicians not on list	52.2	40.0	7.8	

ED denotes emergency department; UTC, urgent treatment center.

However, many respondents would not wait; they would seek alternate care the first day. In our sample, these respondents included older patients, nonwhite patients, and patients who would go to a different site if they sought alternate care. In contrast, patients with asthma were more likely to wait and maintain continuity with their usual physician. Our data suggest that patient characteristics and practical considerations such as location are important factors in patient attempts to maintain continuity. Further research is needed to understand the complex interplay among characteristics of the physician-patient relationship across different care situations that encourages patients to remain loyal to their regular physician.

REFERENCES

1. Starfield B. Primary care: concept, evaluation, and policy. New York, NY: Oxford University Press, Inc, 1992.
2. Emanuel EJ, Dubler NN. Preserving the physician-patient relationship in the era of managed care. JAMA 1995; 273:323-9.
3. Weiss LJ, Bluestein J. Faithful patients: the effect of long-term physician-patient relationships on the costs and use of health care by older Americans. Am J Public Health 1996; 86:1742-7.
4. Becker MH, Drachman RH, Kirscht JP. Predicting mothers' compliance with pediatric medical regimens. J Pediatr 1972; 81:843-54.
5. Becker MH, Drachman RH, Kirscht JP. A new approach to explaining sick-role behavior in low-income populations. Am J Public Health 1974; 64:205-16.
6. Charney E, Bynum R, Eldredge D, et al. How well do patients take oral penicillin? A collaborative study in private practice. Pediatrics 1967; 40:188-95.
7. Hjortdahl P, Laerum E. Continuity of care in general practice: effect on patient satisfaction. BMJ 1992; 304:1287-90.
8. Blankfield RP, Kelly RB, Alemagno SA, King CM. Continuity of care in a family practice residency program: impact on patient satisfaction. J Fam Pract 1990; 31:69-73.
9. Weyrauch KF. Does continuity of care increase HMO patients' satisfaction with physician performance? J Am Board Fam Pract 1996; 9:31-6.
10. Wasson JH, Sauvigne AE, Mogielnicki P, et al. Continuity of outpatient medical care in elderly men: a randomized trial. JAMA 1984; 252:2413-17.
11. Gill JM, Mainous AG III. The role of provider continuity in preventing hospitalizations. Arch Fam Med 1998; 7:352-7.
12. Mainous AG III, Gill JM. The importance of continuity of care in the likelihood of future hospitalization: is site of care equal to a predominant clinician? Am J Public Health 1998; 88:1539-41.
13. Fletcher RH, O'Malley MS, Earp JA, et al. Patients' priorities for medical care. Med Care 1983; 21:234-42.
14. Cornelius LJ. The degree of usual provider continuity for African and Latino Americans. J Health Care Poor Underserved 1997; 8:170-85.
15. Freeman GK, Richards SC. How much personal care in four group practices? BMJ 1990; 301:1028-30.
16. Flocke SA, Stange KC, Zyzanski S. The impact of insurance type and forced discontinuity on the delivery of primary care. J Fam Pract 1997; 45:129-35.