

# Patients who attend a private practice vs a university outpatient clinic: how do they differ?

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## Summary

**Background:** Although interpersonal continuity is commonly assumed to be essential for care, some patients prefer to attend a university outpatient clinic where physicians change regularly and interpersonal continuity of care is not ensured.

**Objectives:** The aim of this exploratory study was to evaluate the differences between patients attending a university outpatient clinic and patients frequenting a private practice, explore their patterns of care-seeking and their understanding of continued care.

**Methods:** We conducted a cross-sectional study of patients attending the university medical outpatient clinic (OC) in Lausanne, Switzerland and ten randomly selected private general practices (PP). Eligible patients were >30 years, Swiss nationals or long term residents, with one or more chronic conditions and attending the same practice for >3 years. They were asked to complete a questionnaire on sociodemographic data, use of medical resources and reasons for choosing and remaining at the same practice. Semi-structured interviews were conducted with a randomly selected subset of 26 patients to further explore their preferences.

**Results:** 329 patient questionnaires were completed, 219 by PP and 110 by OC patients. OC patients tended to be of lower socioeconomic status than PP patients. The main reason for choosing a PP were personal recommendation, while a higher percentage of patients chose the OC because they could obtain a first appointment quickly. A higher percentage of PP patients accorded importance to physician communication skills and trust, whereas a higher percentage of OC patients favoured investigation facilities. Qualitative data suggested that although OC and PP patients reported different reasons for consulting, their expectations on the medical and relationship level were similar.

**Conclusion:** Our study suggests that the two groups of patients belong to different social backgrounds, have different patterns of care-seeking and attach importance to different aspects of care continuity. However, patients' expectations and perceptions of the physician-patient relationship are similar.

**Key words:** continuity of care; primary care; choice; trust

## Introduction

Continuity of care is the cornerstone of primary care [1]. It is now well known that continuity of care leads to a better knowledge of the patient and enhances the patient's compliance, satisfaction and care, especially among chronic patients [2-4]. Many models of continuity have been proposed. Hennen described four dimensions of care continuity: 1) chronological 2) geographical 3) interdisciplinary 4) interpersonal [5]. Rogers and Curtis added a fifth dimension, informational continuity [6]. Freeman developed a framework of continuity encompassing both outside and organisational factors and patient-centred factors [7].

Although interpersonal continuity is commonly assumed to be essential to patient satisfaction, we observe that some people do not have the

benefit of interpersonal continuity in care. However, they manage to establish a long term relationship with medical institutions and find it a positive experience. In Switzerland, such institutions can be either university outpatient clinics or private drop-in centres.

However, the Swiss primary healthcare system relies mainly on private practitioners. Most practices are headed by one physician, aided by an assistant. Although the Swiss healthcare system is liberal and relies on private supply and financing of health care, all Swiss residents are covered by mandatory health insurance and have a free choice of physicians. Services provided by physicians are generally reimbursed on a fee-for-service basis [8].

Working in a University medical outpatient clinic where residents change regularly, we were interested to find out why our chronic disease patients preferred to attend our clinic rather than a private practice. On the basis of annual statistics we estimated that 10% of all OC patients were long-term. Like many others who work or conduct research in primary care, we considered interper-

sonal continuity to be a “core value” and more important than other aspects of continuity we could offer [9, 10]. The aim of this exploratory study was to evaluate the differences between patients attending a university outpatient clinic and patients frequenting a private practice, explore their patterns of care-seeking and their understanding of continued care.

## Methods

We conducted a cross-sectional study in the university medical outpatient clinic (OC) of Lausanne, Switzerland and ten private general practices (PP). These were located in the same area as the OC and randomly selected to ensure diversity of style in practices. The Lausanne University outpatient clinic offers acute and chronic outpatient care on a 7 day/24 h basis in a city with a population of 130,000. It provides one year training in general internal medicine for 14 residents each year. Their work is supervised by 6 senior physicians with board certification who stay in the clinic for 2–4 years. The centre also includes nursing staff, routine laboratories, x-rays, and special consultations. Private practices are usually run by one physician.

Eligible subjects were patients aged 30 or over, Swiss or long-term residents, with one or more chronic conditions and attending the same practice for at least 3 years. We drew up a prior listing of all the patients meeting these requirements by reviewing all patient records in the university outpatient clinic. In private practices, the main investigator (NJP) and the practitioners drew a quota sample of patients fulfilling these conditions on the basis of the practitioner's diary for the next days or weeks.

We did not calculate a sample size because this study was meant to be exploratory for the research outcomes. However, in the light of a previous study, we estimated that a sample of 30 patients per practice would be representative of the diversity of PP patients [11].

Receptionists were instructed to hand a questionnaire to these patients in the waiting room when they arrived. In the questionnaire, apart from gathering routine sociodemographics, we asked closed-ended questions on how the respondent used medical resources, how he or she chose the practice and why he or she decided to remain with it. Survey questions were derived from previous studies [12, 13]. We proposed five reasons for choosing a practice: proximity, recommendation, relatives/acquaintance already registered, only practice known and first appointment quickly obtained. Among sixteen reasons for remaining with the same practice, patients had a choice of 5 at the maximum: proximity, appointment easily obtained, time spent in waiting room, office hours, quality of reception, investigation facilities (blood tests, x-rays, specialist consultations), the office aspect, the length of consultation, house calls, physician's personal characteristics, communication skills, technical skills, availability, trust, habit. Patients were asked to return the questionnaire by post. Non-respondents were sent a reminder after three weeks. A pre-study pilot test among 10 patients in the university outpatient clinic and 10 in a private practice showed that the questions were clear and comprehensible.

We completed the study with semi-structured interviews of patients who took part in the first study, to gain a better understanding of patients' views and enrich the quantitative findings. Thirteen patients from PP and 13 patients from OC were randomly selected (every patient whose study number ended with 9), and agreed to take part in a semi-structured interview of 45–60 minutes with the main investigator. Questions were formulated in the following way: 1) Tell me about the first encounter with your physician (prompts: reasons, circumstances, expectations, impressions) 2) How would you describe the type of relationship you have with your physician? 3) What do you expect from a physician? 4) What are your reasons for remaining with the same physician (or with the same practice)? The interview took place either at the patient's home or in the university outpatient clinic. All interviews were audiotaped and transcribed verbatim (1–13 for PP, 14–26 for OC patients). The ethical committee of Lausanne University hospital approved the study protocol.

## Analysis

Differences in sociodemographic data, use of medical resources, reasons for choosing and staying with the same practice between the two groups of patients were tested by the chi-square test, *p* values <5% considered to be statistically significant. Such univariate analyses were adjusted for cluster, each private practice and the outpatient clinic forming a cluster. This means that univariate analyses were fitted with each private practice and the outpatient clinic represented by a random effect for possible correlation between observations from the same practice or clinic. We calculated the odds ratio (OR) with the corresponding 95% CI as measures of effect. We used SPSS software 10.0 and Stata 8.0 for analysis.

NJ and MV first read and examined the 26 transcripts independently and then selected patients' utterances on topics relating to 1) reasons for choosing a practice 2) reasons for remaining with the same practice 3) expectations and perception of the physician-patient relationship. They analyzed the qualitative data using the “editing style” described by Crabtree and Miller [14]. They marked key words, sentences or expressions and jointly discussed their findings. Transcripts were continually recoded to reflect emerging concepts and categories. Data displays were then created to facilitate examination of similarities and differences across respondents and to identify overall themes. Then the two examiners independently coded the 26 transcripts. Inter-rater agreement was measured using the kappa coefficient, which measures the degree of agreement between two variables which occurs beyond that expected by chance. Kappa coefficient was 0.867. Themes relevant to quantitative results were then chosen and quotes selected.

## Results

Of the ten practitioners, 8 actively participated in the study, two of whom were women. Patient refusal rate was 10.3% in the outpatient clinic, but was not recorded in private practices. Response rate was 79% for OC patients and 87% for PP patients.

329 patient questionnaires were obtained and analysed, 219 from PP patients and 110 from OC patients. Table 1 shows sociodemographic data and use of medical resources: a higher percentage of elderly, male and non-Swiss patients attended the OC. However, more than 95% of foreign patients had been in Switzerland for more than 10 years in both groups and we assumed that after 10 years of residence their patterns of care-seeking would be similar to those of Swiss patients. A higher percentage of OC patients were from lower educational and income groups. A higher percentage of

them consulted frequently and used the emergency care settings often.

Seven men and 6 women attending private practices and 6 men and 7 women attending the outpatient clinic took part in semi-structured interviews. The mean age was 65.9 and 70.7 years in both groups. The average number of years during which they had attended the same practice was 17.7 for PP patients (range 6–25 years) and 15.1 for OC patients (range 3–30 years). 23 out of 26 patients were Swiss and 3 were long-term residents in Switzerland.

### Reasons for choosing a practice

Recommendation and proximity were two of three main reasons for choosing a practice in both groups (table 2). The univariate analysis adjusted for cluster showed that the main reasons for choos-

**Table 1**

Sociodemographic data and use of medical sources among university medical outpatient clinic (OC) patients and private practice (PP) patients.

	OC patients		PP patients		p
	n	%	n	%	
<b>Age (years)</b>					<0.01
30–40	7	6.4	20	9.7	
41–65	40	36.4	97	44.3	
66–80	48	43.6	85	38.8	
81–100	15	13.6	17	7.8	
<b>Sex</b>					<0.01
Male	64	58.7	74	33.8	
Female	45	41.3	145	66.2	
<b>Origin</b>					<0.01
Swiss	74	67.3	168	78.1	
Non-Swiss (>15 years residency)	36	32.7	47	21.9	
<b>Education</b>					<0.01
Compulsory school	45	44.1	66	30.8	
Vocational school	33	32.4	76	35.5	
Secondary school	6	5.9	36	16.8	
University etc	18	17.6	36	16.7	
<b>Income (\$)</b>					<0.01
<1500	26	27.1	24	11.9	
1500–2749	36	37.5	45	22.3	
2750–4000	20	20.8	40	19.8	
>4000	14	14.6	93	46.2	
<b>Follow-up duration (years)</b>					0.09
0–5	14	13.0	27	12.4	
6–10	33	30.6	35	16.1	
>10	61	56.5	155	71.4	
<b>Medical visit frequency</b>					<0.01
≤1×/year	1	0.9	22	10.1	
>1×/year and <1×/month	48	44.9	103	47.5	
≤1×/month	58	54.2	92	42.4	
<b>Use of emergency care settings</b>					<0.01
Never	41	38.3	110	52.1	
1–2×/year	44	41.1	84	39.8	
>2×/year	22	20.6	17	8.1	

**Table 2**

Reasons for choosing a practice among university medical outpatient clinic (OC) patients and private practice (PP) patients.

	OC patients		PP patients		p	Odds ratio adjusted for cluster	95% CI
	n	%	n	%			
Proximity							
No	83	75.5	156	72.6		1.00	
Yes	27	24.5	59	27.4	0.39	1.16	0.83-1.63
Recommendation							
No	78	70.9	104	48.4		1.00	
Yes	32	29.1	111	51.6	<0.01	2.60	1.96-3.46
Relative/acquaintance already registered							
No	92	83.6	134	62.3		1.00	
Yes	18	16.4	81	37.7	<0.01	3.09	2.10-4.54
Only known practice							
No	95	86.4	211	98.1		1.00	
Yes	15	13.6	4	1.9	<0.01	0.12	0.04-0.33
First consultation rapidly obtained							
No	72	65.5	196	91.2		1.00	
Yes	38	34.5	19	8.8	<0.01	0.18	0.10-0.35
Other reasons							
No	90	81.8	187	87.0		1.00	
Yes	20	18.2	28	13.0	0.10	0.63	0.42-1.08

ing a private practice versus an outpatient clinic were recommendation and the fact that relatives or acquaintances were already registered in it. A lower percentage of PP patients chose their practice because it was the only practice known to them or because they could obtain a first appointment quickly. It suggests that PP patients relied essentially on their private social network while OC patients favoured convenience and rapid access to care for a first consultation.

The qualitative results confirmed trends shown by quantitative results. For example, more PP patients appeared to consult with friends/relatives first before seeing a physician.

*"Because when Dr. X [my previous doctor] retired, I found it logical to go to the doctor my mother was happy with". [9]*

*"It was through relatives, an aunt who knew a young friend who had recently married a physician working in Lausanne". [1]*

At least half of OC patients were directed to the outpatient clinic by health professionals (nurse, hospital, occupational medicine). OC patients also often chose the clinic for urgent somatic problems because of convenient hours or investigation facilities.

*"But I chose the outpatient clinic because I needed a doctor on a Thursday afternoon and, at that time, it was impossible to find one immediately available on that day, so I went to the clinic instead." [22]*

*"The nurse told me: Why don't you go to the outpatient clinic. They have everything there". [16]*

#### Reasons for remaining with a practice

Patients mentioned both interpersonal and structural aspects of care as the main reasons for staying. In order of preference, trust, friendly receptionists and easily obtained appointments were

considered to be important for a large percentage of all patients (table 3). However, trust, physician communication and technical skills, availability, house calls and investigation facilities were assessed differently by the two groups. The univariate analysis adjusted for cluster showed that while a larger percentage of PP patients highlighted the importance of house call opportunities, physician communication and technical skills, availability and trust, a larger percentage of OC patients focused on investigation facilities as reasons for continuing to attend the same practice. Most structural aspects of care such as proximity, office hours, fees, office aspects, consultation duration and waiting time played only a moderate to minor role in patients' assessment.

The analysis of transcripts suggested that PP patients did indeed emphasise the importance of personal care and continuity. Feeling known, at ease, and friendship were highly valued.

*"You are wearing a wedding ring? Yes. Well, why don't you change husbands? There is no reason to do so when you have a pleasant human relationship based on trust, a sort of friendship ..." [9].*

*"Well, it is precisely because she takes care of me, when I call, there's no problem, I can come straight away". [11]*

*"Because she knows so much about me. She knows everything ... she listens", [12]*

while OC patients reported paying much attention to technical skills, investigation facilities and convenience.

*"Because, if you need an x-ray and all that, you have them on the spot" [14]*

*"Firstly, they listen to us, they take care of us, lab [exams] are on the spot, results are almost instantaneous". [19]*

**Table 3**

Reasons for remaining at the same practice for university medical outpatient clinic (OC) patients and private practice (PP) patients.

	OC patients		PP patients		p	Odds ratio adjusted for cluster	95% CI
	n	%	n	%			
Proximity							
No	84	77.8	164	77.4		1.00	
Yes	24	22.4	48	2.6	0.88	1.02	0.74–1.41
Appointment easily obtained							
No	64	59.3	112	52.8		1.00	
Yes	44	40.7	100	47.2	0.26	1.30	0.82–2.06
Short waiting time							
No	82	75.9	180	84.9		1.00	
Yes	26	24.1	32	15.1	0.07	0.56	0.30–1.06
Office hours							
No	97	89.8	195	92.0		1.00	
Yes	11	10.2	17	8.0	0.49	0.77	0.36–1.63
Friendly receptionists							
No	62	57.4	114	53.8		1.00	
Yes	46	42.6	98	46.2	0.41	1.16	0.81–1.65
Investigation facilities							
No	61	56.5	182	85.8		1.00	
Yes	47	43.5	30	14.2	<0.01	0.21	0.10–0.47
Fees							
No	94	87.0	191	90.1		1.00	
Yes	14	13.0	21	9.9	0.33	0.74	0.40–1.36
Office aspect							
No	103	95.4	198	93.4		1.00	
Yes	5	4.6	14	6.6	0.35	1.46	0.66–3.22
Long consultations							
No	87	81.3	182	85.8		1.00	
Yes	16	14.8	56	14.2	0.37	2.06	0.35–1.48
House calls							
No	92	85.2	156	26.4		1.00	
Yes	16	14.8	56	23.3	0.04	2.06	1.05–4.08
Physician personal characteristics							
No	98	90.7	197	92.9		1.00	
Yes	10	9.3	15	7.1	0.47	0.75	0.34–1.66
Physician communication skills							
No	74	69.4	79	37.3		1.00	
Yes	33	30.6	133	62.7	<0.01	3.83	2.52–5.82
Physician technical skills							
No	74	68.5	116	54.7		1.00	
Yes	34	31.5	96	45.3	<0.01	1.80	1.54–2.10
Physician availability							
No	76	70.4	113	53.3		1.00	
Yes	32	29.6	99	46.7	<0.01	2.08	1.60–2.71
Trust							
No	52	48.1	54	25.5		1.00	
Yes	56	51.9	158	74.5	<0.01	2.72	1.85–3.99
Habit							
No	85	78.7	181	85.4		1.00	
Yes	23	21.3	31	14.6	0.07	0.63	0.39–1.03
Other reasons							
No	96	88.9	204	96.2		1.00	
Yes	12	11.1	8	3.8	<0.01	0.31	0.16–0.61
University affiliation							
Yes	21	24.7					



### Patients' views of the patient-physician relationship

The qualitative analysis downplays OC patients' tendency to attach importance almost exclusively to structural and logistic aspects of care. When asked about general expectations, all patients, whatever the type of practice attended, expected physicians to be caring, available, good listeners and technically competent. They all emphasised the need for a good and trustful relationship with their physician.

*"Above all I expect him to be a good listener, to hear what I want to tell him. So the main thing is listening ability, someone who will pay attention; then the second important thing is for my doctor to be a good diagnostician ..."* [1]

*"Availability, this is important because, when you don't feel well, the only thing you wish is to be taken care of."* [10]

*"[I expect him] to take care of me, to reassure me, the physician's kindness face to face with me ... therefore, to be taken care of, to feel that the person who is taking care of me is capable, it is like a friendship, I could say ..."* [26]

PP patients talk of their physicians in a very personal manner

*"A very, very good relationship, almost friendly I would say. He knows me well, I know him well. That's it."* [8]

*Yes, she reinvigorates me. When I am with her, when I see her, she says the right words whenever needed* [12]

*"One can say that it is a friendly relationship, of course, we have known each other for a long time and so I trust him entirely,* [6]

while OC patients speak in more general terms and tend to refer to hospital doctors in the plural.

*"There has always been a good understanding, a good relationship ... They are open-minded, they listen, they study our case, they are well-informed."* [24]

Finally, many OC patients considered discontinuity of interpersonal care with favour. They thought that young physicians in training behaved more professionally, showed more interest than PP physicians. They also felt more secure and at ease with OC physicians.

*"Because the person who is in charge, the next one, the one who takes over from the one who first examined me, reexamines my file. He reads it in depth and he draws his own conclusions."* [19]

*"I must say I have been very pleased with the rotation of doctors. What one doctor doesn't see, the next one often does."* [15]

*"I do not feel the doctor looking down on me, anyway, I never had this feeling here. Perhaps, with the one before [in private practice], he was the kind of doctor who does not really get involved".* [21]

## Discussion

Our findings suggest that the two groups of patients differ in terms of social context and follow different social patterns in seeking medical care. However, although they initially express different expectations and needs, they seem to appreciate similar aspects of long term care.

When asked about their reasons for choosing a practice, most patients of both groups mention recommendation. These findings support previous research which found that patients mainly rely on their social network before consulting a doctor [12, 15]. However, convenience and access appear to be important elements influencing OC patients who initially tend to look for urgent and immediate care and rely on an institutional rather than a private network when they need help.

Patients stayed with their healthcare providers for more or less the same reasons. However, PP patients highly valued the quality of the physician-patient relationship and interpersonal continuity: trust, communication skills and physician availability were considered to be essential. For OC patients, structural features of care were deemed more important than its interpersonal aspects. Furthermore, OC patients are of lower socioeconomic status. Previous studies have shown that patients with a lower socioeconomic status or lacking social support emphasise access factors [17, 18] and do not necessarily contact their regular source of care before seeking care in emergency settings

[19]. There is also a link between attendance at open access clinics, low socioeconomic status and discontinuity in interpersonal care [20].

Although on the surface these factors look different (personal continuity versus technical care), the qualitative data tend to show that there are similarities in patients' appreciation of good care. In general, both groups of patients expect their physicians to be committed, available, technically competent and good listeners. Most patients underline the importance of trusting their physician, feeling understood, being someone for him/her, sometimes even a friend. Such findings are quite similar to those reported by Gabel, who identified confidence in the physician and physicians' and patients' mutual knowledge and familiarity as factors contributing most to a long term relationship [16]. Likewise, long term patients of a family practice teaching unit in Canada highlighted the relationship context and mentioned physicians' characteristics such as listening, rapport-building and technical competence as major factors motivating their attendance at the centre [21].

However, it is interesting to note that many OC patients value discontinuity of interpersonal care. One plausible explanation is that after having an initial consultation or follow-up that was positive, OC patients stay and eventually learn to value the quality aspects of the setup and may end by downplaying or even appreciating the changeover

of doctors. We may also speculate that institutional care, through its durability, may offer more protection and security over time for some people. University affiliation, changing physicians and teamwork may give the impression of greater experience and knowledge and therefore better care [21]. It is also possible that institutional care is more suitable for patients who experience difficulty establishing long term relationships with individuals [22].

Our study has several limitations. We only looked at patients who had developed a long term relationship with the practice and we do not know why other patients did not come back. In the first (quantitative) part of the study it is possible that only "good patients" have been selected and that

30 patients per practice may not be representative of the PP patient population. However, 30 patients per cluster is sufficient to estimate any cluster effect. Non-respondent sociodemographic data have not been collected in either group and it is also possible that only the more satisfied patients took part in the study. Although the questionnaire submitted to patients was tested for clarity in a pre-study pilot test, it was not previously tested for reliability and validity. Diagnoses and health outcomes were not known and therefore we were unable to assess whether quality of care was similar between the two groups. However, we believe that our findings indicate new fields of exploration that could lead to a better understanding of patients' views and motivations.

## Conclusion and implications for the future

Our study suggests that trust and communication skills were significant reasons for staying with a physician, but so were non-personal factors such as availability, house-calls and access to investigations.

As previously shown, continuity of care can be achieved in teaching outpatient clinics or drop-in centres [17, 21, 23]. This is of importance, since many countries are experiencing changes in the organisation of primary care which tend to reduce interpersonal continuity, e.g. larger practices, increasing number of walk-in centres, delegation of some tasks to other professionals [9, 24]. As family medicine focuses more and more on primary care with team approaches, our results suggest that trust, loyalty and satisfaction do not exclusively depend on patient-physician interactions and that continuity of care can be achieved in teamwork, at least for a fraction of the population. Reasons why people with a lower socioeconomic status initially favour access factors remain partly unexplained and require more research.

Finally, the moderate trust shown by patients in institutional care is striking and should be further explored, since trust is closely related to patient satisfaction and adherence to treatment [25, 26]. One way of promoting interpersonal continuity of care inside a team would be to involve

permanent staff such as nurses, social workers or receptionists more actively in care. However, it would be important to determine beforehand whether differences in trust are more closely linked to the lack of interpersonal continuity than to patients' psychosocial characteristics.

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