The Closure of a Medical Practice Forces Older Patients to Make Difficult Decisions: A Qualitative Study of a Natural Experiment

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OBJECTIVE: The closure of a primary care practice and the relocation of the physicians and staff to a new office forced patients to decide whether to follow their primary care physicians (PCP) or to transfer their care elsewhere. This study explores the perspectives of the older patients affected by this change.

DESIGN: Qualitative study.

SETTING AND PARTICIPANTS: Two lists of patients older than 60 years from the original office were generated: (1) those who had followed their PCPs to the further practice and (2) those who chose new PCPs at an affiliated nearby clinic. One hundred forty patients from each of the two lists were randomly selected for study.

MEASUREMENT: Eight months after the clinic's closure, patients responded to an open-ended question asking patients to describe the transition. Using content analysis, two investigators independently coded all of the written responses.

RESULTS: Over 85% of patients in both groups had been with their original PCP for longer than 2 years. Patients that elected to transition their care to a new PCP within their community were older (75 vs 70 years) and more likely to be living alone (38% vs 18%), both $p < 0.01$. There was still considerable frustration associated with the clinic's closure. Patients from both groups had variable levels of satisfaction with their new primary care arrangements. Patients who moved to the near clinic, now seeing a new physician, commented on being satisfied with the proximity of the site. On the other hand, these patients also expressed longing for the previous arrangement (the building, the staff, and especially their prior physician). Patients who transferred their care to the further clinic indicated a profound loyalty to their PCP and an appreciation of the added features at the new site. Yet, many patients still described being upset with the difficulties associated with the further distance.

CONCLUSION: The closing of this practice was difficult for this cohort of older patients. Patients' decisions were considerably influenced by whether they imagined that convenience or their established relationship with their PCP was of a higher priority to them.

KEY WORDS: elderly; continuity; primary care; patient autonomy.

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The Institute of Medicine defines primary care as "... the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community."¹ Within these sustained relationships between primary care physicians (PCPs) and patients, connections can develop that permit the delivery of high quality care including comprehensiveness of care and effective interpersonal communication.^{2,3} In addition, longer relationships enhance patients' trust in the physician and patients' belief that their physician has a unique and accumulated knowledge of them and their medical history.^{4,5}

The termination of an established doctor-patient relationship is difficult.^{6–8} Select reasons include physician retirement, relocation of the physician or patient, and closure of medical offices. Data quantifying the frequency of such events is scarce. Over the past decade, however, there has been a steady decline in the number of small practices in favor of larger group practices. Larger practices are theoretically able to concentrate capital, dilute costs, and address regulatory and quality compliance issues. Findings from the most recent round of site visits from the 'Community Tracking Study' in 12 metropolitan areas reveal sizeable disparities associated with the geographic distribution of resources for service delivery that may be linked to consolidation of smaller practices.^{9,10}

The closure of a long-standing primary care practice with its incorporation into a large multi-specialty practice is exactly the 'natural experiment' that was used for this study. The smaller clinic's physicians and staff were moved to a nearby town, requiring patients to make a difficult decision. Descriptions of such a threat to 'longitudinality,'^{4,6} particularly using qualitative methodology to provide insight into patient perspectives, have not been described in the literature.

'Natural experiments' are events that occur naturally from which scientific evidence can be drawn to understand the impact of the experience.^{11–12} In this study, we used the closure of a primary care clinic to explore the perspectives of older individuals who were affected by the change. We hypothesized a priori that older patients were particularly

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vulnerable (because of transportation issues, resources and support, and reliance on PCPs to coordinate their care) and thus decided to focus on this subgroup of patients.

METHODS

Study Design

Qualitative methods were chosen to understand the perspectives of older patients affected by the closure of their primary care site.

Setting and Sampling

Economic considerations prompted the closure of a primary care clinic staffed by five internal medicine primary care providers located in a mid-sized unincorporated community in Maryland. Five months before the closure of the clinic, all patients were invited to follow their primary care physicians (PCPs) to a larger multi-specialty practice 11 miles away in a smaller suburban town. The patients were also informed that their care and records could be transferred to an affiliated primary care clinic located 2 miles away from the initial clinic in the same community. Both practices are affiliated with the same hospital system, accept the same insurance plans, and have similar access via public transportation.

Six months after the clinic's closure, electronic databases were queried to generate two lists of patients older than 60 years from the original office: (1) those who had followed their PCP to the new further practice ("continuity patients") and (2) those who had chosen a new PCP at the affiliated clinic closer to the primary site ("proximity patients"). Because some patients only see their doctor biannually, the 6-month point was felt to be the best time to evaluate patients' choice of clinic. Patients living in nursing homes or assisted living communities were excluded. From each of the two lists, 140 patients were randomly selected using a random integer generator (<http://www.random.org>). This sample size was derived based on power calculations for a quantitative research question.

Data Collection

The study sample was mailed a survey 8 months after the closure of the primary site. This time frame was selected such that participants would have interacted with and received care at their new site. A consent form, to be signed and returned to the investigators, was included with each survey mailing. At the end of a brief survey that asked some specific questions about the closure of the former clinic, the following open-ended question was asked: "Please tell us, in your own words, what the move to (name of new primary care site) has been like for you?"

Pilot testing of the question revealed that this question was clear and that patients were stimulated to describe both the positives and negatives of their experiences. Non-responders received two additional mailings to encourage participation.

Data Analysis

For the quantitative data, we compared the "continuity" patients (who followed PCPs to the distant clinic) and "proximity" patients (who transferred to the closer clinic) using chi-

squared tests for dichotomous variables and t-tests for continuous variables.

Hand-written qualitative responses to the open-ended question were transcribed verbatim. One researcher reviewed all responses and removed personal identifiers. Using content analysis, two investigators independently coded all of the written responses using an "editing analysis style."¹³ Categories and subcategories of themes were generated and conceptually organized by two investigators. A third investigator independently compared the themes to the subjects' comments checking for completeness and congruence. There was agreement among all investigators about the final domains. The number of responses that related to each domain was tabulated. The representative quotes selected for inclusion in the manuscript were agreed upon by consensus.

The study was approved by an institutional review board at Johns Hopkins University School of Medicine (JHUSOM).

RESULTS

Response Rate and Subject Characteristics

The overall response rate to the mailed questionnaire was 64%: 104 of 140 (74%) "continuity" patients and 76 of 140 (54%) "proximity" patients. Non-responders were similar to responders in terms of age, gender, and race (all $p > 0.05$).

Females accounted for 63% of the responding sample. Proximity patients were older (mean age: 75 vs 70 years, $p < 0.01$) and were more likely to be living alone (38% vs 18%, $p = 0.03$), see Table 1.

Ninety-four percent (169/180) of respondents answered the open-ended question that asked about the transition resulting in 20 pages of typed comments. The responses varied in length from a few words to several paragraphs.

Qualitative Assessment of the Patients' Perspectives on the Change

Patients' written responses were categorized into five themes. The frequency with which each theme was mentioned by subjects is shown in Table 2. Thirty-three percent of patients (56/169) described both positive and negative or mixed experiences with their new primary care setting; these mixed responses came from equal proportions of 'proximity' and 'continuity' patients.

Negative Emotional Responses Related to the Transition

Some of the most emotional comments from patients, regardless of their choice for a new clinic, reflected anger about the closure of the original site and a sense of abandonment, particularly of the elderly, by the local health care system.

"The people of community X hardly have any facilities close to us. They are always put further up the beltway."

"I feel that they should never have left. X is an older community and we have a lot of older people that can't drive to town Y."

Table 1. Characteristics of Older Patients who Transferred Care to Primary Care Providers at a Closer Clinic ("proximity") Versus Patients who Followed their Primary Care Providers to a Distant Clinic ("continuity")

	Continuity patients* (N=104)	Proximity patients* (N=76)	P-value
Age in years, mean (SD)	70 (7.4)	74.8 (7.7)	<0.001
Female, n (%)	65 (62.5)	55 (72.4)	0.165
Caucasian race, n (%)	99 (96.12)	69 (93.24)	0.391
Married, n (%)	62 (60.19)	42 (57.53)	0.601
Living alone, n (%)	19 (18.45)	29 (38.16)	0.003
Physical Component Score (PCS) of SF-12 [†] , mean, (SD)	40.25 (11.95)	36.78 (11.19)	0.051
Mental Component Score (MCS) of SF-12 [†] , mean, (SD)	53.32 (8.24)	52.26 (8.27)	0.405
Number of years seeing PCP, n (%)			0.727
Less than or equal to 2 years	11 (11.0)	10 (13.7)	
Between 2–5 years	53 (53.0)	33 (45.21)	
More than 5 years	36 (36.0)	30 (41.10)	
Number of specialists seen in the past year, n (%)			0.118
≤1	52 (54.17)	27 (42.86)	
2	22 (22.92)	15 (23.81)	
≥3	22 (22.92)	21 (33.31)	
See (any) specialist more than PCP, n (%)	22 (21.36)	15 (21.43)	0.991
PCP is more important than specialist, n (%)	89 (88.12)	55 (83.33)	
PCPs are important for coordinating overall health care (SA/A versus N/D/SD) [‡] , n (%)	100 (98.4)	65 (87.84)	0.006
PCPs are important for health maintenance (SA/A versus N/D/SD) [‡] , n (%)	101 (97.12)	69 (93.24)	0.219
PCPs are important for treating acute health issues (SA/A versus N/D/SD) [‡] , n (%)	93 (89.42)	65 (89.04)	0.936
Still driving, n (%)	80 (77.67)	47 (66.20)	0.094

*Continuity patients followed their relocated PCP to a distant clinic, and proximity patients transferred their care to a nearby clinic with a new PCP

[†]SF-12: A 12-item short form health survey

[‡]SA: strongly agree, A: agree, N: neutral, D: disagree, SD: strongly disagree

"The doctor I had went to [the further clinic]. I think you should be able to keep your regular doctor...It is not the patient's fault...Stop closing medical facilities!"

Distance

When distance to the health-care facility is increased, even minimally, this was perceived as a barrier and cause for dissatisfaction.

Several patients who followed their PCP to the further clinic expressed dissatisfaction:

"A pain in the butt. Finding transportation at the required office visit times is difficult for me. Car rides

take up most of my time and energy...I feel I would almost be more inclined to get a doctor at a clinic which is closer."

"Inconvenient, that's what's important! Hazardous in inclement weather and unsafe."

"Having a location close to home was important. When we're sick the last thing we want to do is have to drive on Interstate-95 to get to the doctor."

In addition, several patients who chose the further clinic expressed fear and doubts about their future health and their ability to continue accessing this practice site.

"I do not drive and my husband now has Parkinson's... don't know how much longer he will drive. Makes it hard for people my age to get around."

"At first, it was hard finding a route with less traffic—so much congestion. It's hard driving that far because of my knee problems."

For patients who chose the closer clinic, 2 miles from the original clinic, even this small further distance could be arduous and lessen the satisfaction with the new clinic.

"I liked [the original clinic] because I could walk to it."

"It [the original clinic] was pleasant, clean, friendly, and easier to get to."

The Facility and its Services

A new, modern facility with increased services facilitated the transition for some to the new, further clinic. Even the proximity of the new clinic to other non-medical facilities, like the shopping mall, was mentioned as being advantageous.

"After an initial reluctance, I now find that because of the more readily available services, it is actually more convenient."

"My daughter brings me and then we go shopping at town Y Mall."

By comparison, the patients' impressions that the closer facility compared unfavorably with the previous clinic, posed barriers to

Table 2. Frequency of Themes Described by the 169 Patients

Theme	Number of individuals who commented on this n (%)
Negative emotional responses to the transition	33 (20%)
Distance	67 (40%)
The building and on-site services	48 (28%)
Relationship with physician	37 (22%)
Adjusting over time	23 (14%)

acceptance of change. Some patients specifically mentioned inferior parking options and suboptimal handicapped/elder access.

"I do not like the clinic. Parking is bad."

"Do not like it, parking, second floor hard to get to."

"The steps going into the building are terrible. I cannot walk steps too good and taking the ramp is terrible."

The PCP Relationship

A first-rate relationship with a PCP facilitated satisfaction, regardless of which new clinic the patient chose. For the patients who chose the further clinic, many specifically mentioned the value of continuing their longstanding patient-physician relationship.

"It is a social call. I look at Dr.— as if she is a personal friend. I look forward to seeing her."

"I transferred my care because that's where my primary care doctor was being transferred. Had she went to [the closer clinic], I would have chosen that site in a heartbeat."

For patients who chose to change PCPs and go to the closer clinic, contentment with their new PCP and confidence in the medical care they were receiving helped with the transition.

"I am very pleased with them. They are interested and are very helpful when I ask or need any information about my condition and are up to date on tests when they are needed. I think Dr.— is exceptional."

"Very good. They are very prompt with the appointments. Dr.— is friendly and efficient."

In contrast, those patients who expressed dissatisfaction with the closer clinic specifically lamented the disruption of their former PCP-patient relationship. Comfort with a physician and trust were the attributes of the relationship that were most poignantly mentioned by patients.

"We did not like the move since our doctor went to town Y and that clinic is farther from our home...Getting used to a new doctor takes time...I believe being comfortable with your doctor makes it easier to talk to and tell how you feel which helps the doctor know how to treat you."

"I was not very happy about the move since my doctor was transferred...She is a very good doctor and she knew all about the medical problems I am dealing with—which are quite a few. It is difficult to get that kind of relationship with a new doctor, it takes time...I miss Dr.—."

"I liked and had faith in my previous doctor."

Select patients had unsatisfying experiences with their new provider and mentioned plans to again transfer care.

"Very disappointing. Don't care for the internist. Not pleased at all. Looking for another doctor."

"At the present time, I am not happy with my doctor at [the closer clinic] and plan to change to a private doctor."

Adjustment Over Time

Patients acknowledged the importance of being flexible and accepting of change. They wrote about how, over time, they have become more comfortable with the new arrangement. Some explained that their longing for the way things used to be is gradually waning.

"Getting used to the new office and routine was strange at first, but you learn to flow with the waves!"

"Guess when you're as old as I am you learn to adjust the best you can."

"Even though it was hard at first, it has gotten better..."

DISCUSSION

Long-standing physician-patient relationships are at the core of primary care.¹⁴ Many physician groups, including the American College of Physicians, the American Academy of Family Physicians, and the American Academy of Pediatrics, are embracing and promoting the notion of the 'Patient-Centered Medical Home.'¹⁵ This model values an ongoing relationship with a personal physician trained to provide continuous and comprehensive care; care coordinated and integrated across the health care system, including the patient's community; patients actively participating in decision-making; patients and families participating in quality improvement activities at the practice level; and improved access.¹⁵ In studying the perspectives of older adults whose clinic was closed, we have gained new insights into how attached patients can become to their 'medical homes' and how disruptive moving to a new medical home can be. This work builds on that of Casalino and colleagues who assessed the attitudes towards changes in practice structure from the perspective of the physician directors and administrators involved in making these decisions.¹⁶

In planning this study, we elected to focus on older patients and their reactions to the practice closure. Older individuals in this community are not affluent and have limited resources—making them a vulnerable cohort. Older patients are thought to be more loyal to their PCP and less likely to switch away from a PCP voluntarily.^{17–19} This study sheds light on the subject of how older patients balance the priorities of convenience and continuity in relation to their medical care.

Our findings suggest that when a change in care is forced upon patients (e.g., having to choose a new practice location or physician), thoughtful interventions to help with the transition are warranted. Although all patients received letters explaining the clinic closures and changes, one could argue that even more could have been done to help the patients to make well-informed decisions. Slide shows or pictures of the new clinic, informal 'meet the physicians' nights, tours or "open-houses" of the facilities, and designated forums for 'questions and answers' may have served to relieve concerns. Additionally, maps, specific information on distance and timing to clinic, and resources for the disabled might have preempted some access and facility issues.

Ubel and colleagues have described that accurate predictions about the emotional impact of potential outcomes are critical steps in making good health-care decisions.²⁰ Miscalculations, due to lack of knowledge or personal awareness, can result in poor choices. Accordingly, processes that help patients facing such decisions to carefully contemplate the options and anticipate their likely experiences may prove meaningful. For instance, future patients facing similar circumstances might benefit from the knowledge that adjustment and acceptance improves steadily over time. Future research might explore how specific interventions, based on the concerns expressed by our patients, can mitigate the emotional impact of transition and improve patient satisfaction.

Although patients value continuity, empiric data have shown that only a few patients will spend additional time or money to maintain continuity.²¹ The patients believed to most value continuity include the elderly, the less educated, those with Medicare and Medicaid insurance, the chronically ill, and those with poor self-reported health status.²² The commentaries from our informants highlight the fact that current health status and concerns about future health problems may impede even those patients who would be willing to spend additional time or money in order to maintain continuity.

Several limitations of this study should be considered. This study relied exclusively on self-report. However, this is considered to be the most direct approach for understanding attitudes and beliefs. Secondly, the written format used for this study may have excluded low literacy, non-English speaking patients, and patients with certain cognitive and physical disabilities. Thirdly, this study involved only older patients from a single clinic in a specific geographic area and may not be generalizable to other patients or settings. Fourth, the timing of the inquiry, 8 months after the change, may have introduced some recall bias for patients elaborating on the rationale for their decision to select one site over the other. Fifth, the frequency with which any of the themes was described by informants was less than 50 percent. Qualitative analysis does not allow us to know whether 'distance' was a more important theme than 'relationship with physician' merely because it was mentioned more frequently. If all subjects were specifically asked about each theme, the number of comments related to each would certainly be higher. However, it is important to note that the responses emerging from the open-ended question about the impact of the closure of the primary clinic were spontaneous and unsolicited. Finally, despite the fact that our sample size was predetermined based on power calculations related to a quantitative arm of inquiry, the authorship team reviewing the narrative writings believes that thematic saturation was reached.

In conclusion, this study describes how older patients dealt with and felt about an unwanted major change in their health care. Individuals in this cohort made decisions based on their beliefs, attitudes, goals, and the resources available to them. Organizations may want to be particularly mindful of and sensitive to patients' needs when planning changes that will be disruptive or impact upon continuity and prepare them for the complexities of what they are likely to experience.

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