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CONTINUITY OF CARE
AND GENERAL PRACTICE
UTILISATION IN AUSTRALIA

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A thesis submitted for the degree of
Doctor of Philosophy
of the Australian National University.

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Declaration

Except where otherwise indicated, this thesis is the result of my own work carried out while I was a PhD student at the National Centre for Epidemiology and Population Health (NCEPH) at the Australian National University in Canberra.

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February 1996
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I am delighted to submit this thesis for examination on leap year day, 1996.
Abstract

This thesis explores the notion of continuity of care and its relevance to quality of care in Australian general practice from both the consumer and general practitioner (GP) perspectives. It reports six studies that examine satisfaction with general practice care and the links between quality of care, consumer dissatisfaction and consumers' decisions about choice of general practitioner. From these findings and a prospective study of consumers' use of GP services, a typology of general practice utilisation is developed.

The first study was a descriptive epidemiological survey which asked 555 Canberra residents about their use of health services. Twenty-three percent of respondents saw two or more GPs in the preceding year. Multivariate modelling showed that the likelihood of an individual seeing several GPs increased with the number of visits, poorer levels of satisfaction with the last general practitioner visit, for the age group 20-29 years, for women, and for those respondents with tertiary qualifications, and decreased for respondents who mentioned communication as the basis for their satisfaction with GP visits.

The second study was a national survey (n= 1,201) to estimate the proportion of respondents who identified with and consulted their 'usual' GP. On their last GP visit, 83% of respondents recorded seeing their 'usual doctor', and a further 4% saw a doctor in their 'usual practice'.

In the third study I interviewed GPs (n= 35) and consumers (n= 35) to explore the reasons why some consumers see several GPs annually. Both groups distinguished seeing various doctors from changing doctors. Further they drew a distinction between changing doctors due to circumstances such as moving residence, and changing because of dissatisfaction.

The fourth study asked consumers about their choice of doctor prior to a consultation (n=802). Fifty-five percent of patients were seeing their usual doctor and an additional 29% were attending a doctor in their usual practice. Random effects logistic regression modelling showed that doctor-patient relationship issues and technical skill were associated with respondents consulting their usual GP or practice while access issues were associated with respondents seeing two or more GPs.
In the fifth study I interviewed GPs (n= 24) and consumers (n= 24) in detail about their experience of general practice care. Consumers' most frequent reasons for changing doctors were moving residence, or following difficulties with access to the doctor, cost of the consultation, or availability of the GP. Problems with communication or feeling that the GP lacked relevant expertise were strongly associated with consumer dissatisfaction and subsequent decisions to change GPs.

In the sixth study consumers (n= 68) kept a health diary to record details about their general practice visits and I interviewed them monthly to explore, prospectively, their actual choice of GP. I depicted each participant's consultations along a timeline to produce a 'trajectory' of general practice use. The trajectories were grouped into patterns that formed the basis of a typology of general practice utilisation comprising four approaches to general practice care. These are visits to one GP, visits to one practice, visits to a variety of GPs in different practices, and visit-by-visit use (where decisions about whom to consult are made when the need for a visit becomes apparent). Some consumers changed their type of utilisation with the advent of illness or when their life circumstances altered.

I convened two reference groups; one consumer group (n= 12) and another of GPs (n= 12). Each reference group met with me on five occasions during 1993-1994 to examine the research findings, develop collaborative interpretations, and identify differences in their perspectives on quality of general practice care.

The sequence of six studies showed that 'continuity' is best understood, not as an entity provided by doctors, but rather as an interaction over time, constructed jointly by consumers and their GPs. The majority of consumers preferred, and by and large achieved, constructed continuity with one GP, at least for periods of time. Continuity was also possible when consumers visited one practice and had visits to a variety of GPs. The essential pre-conditions for continuity of care were ready access, GP competence, good communication, and a mechanism for bridging one consultation to the next. The benefits of constructed continuity were coordination, familiarity and openness in the therapeutic relationship, and review of progress; together these form a framework for high quality care in general practice.
Definitions and Abbreviations

ABS Australian Bureau of Statistics.
ACT Australian Capital Territory.
AGB Australia Market research company.
AMA Australian Medical Association
AMTS Australian morbidity and treatment (general practice) survey (Bridges-Webb, Britt et al. 1992).
BP Blood pressure
BPP Better Practice Program.
CD-ROM Compact disc-read only memory: information storage
CHF Consumers' Health Forum of Australia.
COC Index of continuity of care (Bice and Boxerman 1977).
\[ \text{COC} = \sum_{i=1}^{S} \left( \frac{n_i^2 - n}{n(n-1)} \right) \]
where \( n \) = total number of visits; \( n_i \) = number of visits to provider \( i \);
\( S \) = number of unreferred providers; \( \sum \) = the sum of calculated values.
CON The CON index (Shortell 1976) measures concentration for an illness episode.
CVA Cerebrovascular accident.
DRS Doctors' Reform Society
FC Family care measure (Murata 1993).
Based on individual measures for family members.
FOC Fraction of care continuity (Eriksson & Mattsson 1983).
\[ \text{FOC} = \frac{n(\text{provider of interest})}{n}, \text{where } n = \text{number of visits.} \]
FRAC Fraction of visits to provider \( i \) (Smedby, Smedby et al. 1984; Smedby, Eklund et al. 1986).
\[ \text{FRAC} = (1-HH) \text{ where } HH \text{ is the Herfindahl Index.} \]
FRACGP Fellowship of the Royal Australian College of General Practitioners.
Gini The Gini index (Shortell 1976) measures concentration for an illness episode and takes account of the distribution of the remaining sources of care (ie the number of different providers).
GP General practitioner.
HH: Herfindahl Index
(HH= Σᵢ=₁ pᵢ², where pᵢ is the fraction of visits to providerᵢ during the measurement period).

HIC: Health Insurance Commission.

HRT: Hormone replacement therapy.

ICPC: International Classification of Primary Care

k: Known provider continuity (Eriksson & Mattsson 1983). k equals one if the provider of the visit was also seen at some visit in the continuity defining period, and zero otherwise.

LICON: Likelihood of continuity being present (Steinwachs 1979).

MCI: Modified continuity index (Godkin and Rice 1984).
MCI = 1- (S/(n+0.1), where n = total number of visits; S = total number of different providers seen.

ME: Myalgic encephalitis, also known as chronic fatigue syndrome.

MMCI: Modified, modified continuity index (Magill & Senf 1987). MMCI = 1- (n of providers)/(n of visits + 0.1))/1- (1/(n of visits + 0.1)).

MPF: Medical Provider File, formerly called the Central Register of Medical Practitioners (CROMP).

NCEPH: National Centre for Epidemiology and Population Health.

NES background: Non-English speaking background.

NGO: Non-government organisation

NSW: New South Wales.

NT: Northern Territory

OCP: Oral contraceptive pill.

Pap smear: Papanicolaou smear - cervical cytology test to screen for asymptomatic cervical cell abnormality.

PHIAC: Private Health Insurance Administration Council.

PR: Per rectum.

PSQ: Patient Satisfaction Questionnaire (Ware et al. 1983).

Qld: Queensland

RACGP: Royal Australian College of General Practitioners.

RARA: Rural and Remote Areas classification.
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<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>RCGP</td>
<td>Royal College of General Practitioners (United Kingdom).</td>
</tr>
<tr>
<td>s</td>
<td>Sequential continuity (Eriksson and Mattsson 1983). s is equal to one if the provider of the visit was also seen at the preceding visit in the continuity defining period, and zero otherwise.</td>
</tr>
<tr>
<td>SA</td>
<td>South Australia.</td>
</tr>
<tr>
<td>SACHRU</td>
<td>South Australian Community Health Research Unit.</td>
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<tr>
<td>SAHC</td>
<td>South Australian Health Commission.</td>
</tr>
<tr>
<td>SECON</td>
<td>Average sequential visit continuity (Steinwachs 1979). SECON = Σi=1 to n-1 (pi / (n-1), where pi = ith pair of visits.</td>
</tr>
<tr>
<td>SES</td>
<td>Socioeconomic status or advantage.</td>
</tr>
<tr>
<td>SPSS</td>
<td>Statistical Package for Social Sciences</td>
</tr>
<tr>
<td>Tas</td>
<td>Tasmania</td>
</tr>
<tr>
<td>TPI pensioner</td>
<td>Repatriation totally and permanently incapacitated pensioner.</td>
</tr>
<tr>
<td>u</td>
<td>Visit-based usual provider continuity (Eriksson and Mattsson 1983). u is one if the provider of the visit was the usual provider according to an a priori definition, and zero otherwise.</td>
</tr>
<tr>
<td>UK</td>
<td>United Kingdom.</td>
</tr>
<tr>
<td>UPC</td>
<td>Usual Provider Continuity (Breslau and Reeb 1975). UPC = n(usual provider)/n, where n = the number of visits.</td>
</tr>
<tr>
<td>URTI</td>
<td>Upper respiratory tract infection.</td>
</tr>
<tr>
<td>USA</td>
<td>United States of America.</td>
</tr>
<tr>
<td>Vic</td>
<td>Victoria</td>
</tr>
<tr>
<td>VR</td>
<td>Vocational registration. This qualification ensures training for general practice, establishes criteria for registration, and requires ongoing participation in quality assurance programs (Bollen 1990).</td>
</tr>
<tr>
<td>WA</td>
<td>Western Australia</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organisation.</td>
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CHAPTER 1

Introduction

Continuity of care and general practice

'Continuity of care' is upheld as an essential feature of general practice and this is reflected in health policy (Royal Australian College of General Practitioners and Arthur Anderson & Co 1985; National Health Strategy 1992). Also, continuity is regarded as a desirable feature of primary health care (National Centre for Epidemiology and Population Health 1991; National Centre for Epidemiology and Population Health 1992; South Australian Community Health Research Unit (SACHRU) 1995), and is linked with the achievement of beneficial outcomes for users of health care services (Wasson, Sauvigne et al. 1984; Hjortdahl and Borchgrevink 1991).

General practice organisations' views on continuity

The Royal Australian College of General Practitioners (RACGP) defines general practice as:

the provision of primary continuing comprehensive whole-patient care to individuals, families and their communities (Murtagh 1994).

The RACGP definition emphasises care that is ongoing and indicates that, in an ideal world, all patients would be seen by 'their' (usual) general practitioner (GP) and 'continuity' would be the norm.

There is some evidence that community and practitioner opinion accords with this view. In 1985 a Delphi study of health care experts and community representatives examined the RACGP standards on quality of care and how these related to the way GPs practised (Royal Australian College of General Practitioners and Arthur Anderson & Co 1985). The study found that 99% of respondents thought that general practitioners were now providing continuing care (over extended periods of time), and 99% thought that
they should do so for the next decade. Murtagh stated that *the essence of general practice is continuity of care* (Murtagh 1994).

My initial interest in 'continuity of care' was kindled by the disparity between the ideals alluded to above and my clinical experience of people who were attending a number of different doctors.

'Doctor shopping'
In the early 1990s, while working as a GP in Canberra, I saw a number of patients with complex problems. Some of these patients said that they had seen several other GPs. They conveyed a sense of dissatisfaction and frustration with their previous primary medical care and often described feeling rushed during their consultations. About that time, the expression 'doctor shopping' was used colloquially to describe the pattern of people seeing one doctor after another. The following vignettes illustrate what was being called 'doctor shopping'.

Vignette 1: Mr and Mrs A
Mr and Mrs A. came to me feeling frustrated by their situation. They had consulted three GPs during the preceding months. These visits had been precipitated by acute stress or the need to renew prescriptions. It was apparent that there was a complex interplay between the man's problems which included dementia, gastrointestinal upset and urinary incontinence, and the woman's postmenopausal and depressive symptoms which were compounded by chronic carer stress.

My approach was to explore the interactions between the pathological processes, the medications they were taking and their psychosocial situation. The input of the physio- and occupational therapists, nurses and day care centre staff helped everyone gain a more dynamic and detailed view of the couples' functioning. As their problems were explored, I reflected new perceptions back to Mr and Mrs A. The couples' understanding of the links between the various aspects of their problems deepened and they developed confidence in making decisions about their health.

Vignette 2: Mrs B
Mrs B. was a 44 year old woman who was separated from her husband. When she first came to see me she described multiple problems including chronic musculoskeletal and pelvic pain, urinary incontinence, depression and parenting difficulties with her 5-year old daughter and her son who was
7 years old. Over time I learned that she had consulted 31 health professionals in the preceding 15 months.

During the 18 months that she saw me, it emerged that her own health was affected by an interplay between her physical conditions, the effects of domestic violence and her children's recovery after sexual abuse. A management program was devised that included medication, attending self-help groups, and extensive liaison with other members of the multidisciplinary health team and her previous doctors. However, she ended our relationship abruptly when she learned that I had reduced my consulting hours because I had begun doctoral studies. She felt frustrated and angered by my diminished availability and changed doctors again.

**General practice utilisation**

In addition to the dissonance between the organisational commitment to 'continuity of care' and my clinical experience, I found that the statistical picture of contemporary consumer practice did not fit neatly with the ideal either. The utilisation profile for Australian general practice published in the Health Insurance Commission (HIC) annual report in 1992 showed that 82% of the Australian population attended a general practitioner at least once in the preceding year, and that 56% of patients had seen at least two different general practitioners\(^1\) (Health Insurance Commission 1992).

**Policy options for Australian general practice**

Australian general practice has been undergoing rapid structural change since 1989 (Douglas 1990; National Health Strategy 1992; Douglas 1995). As part of a concerted effort to inform the debate about possible future directions for Australian general practice and continuity in particular, I co-authored a discussion paper which explored various financial arrangements that might operate in Australian general practice (Veale and Douglas 1992).

Three policy options were examined for their effect on discontinuity and dissatisfaction. These were enrolment, general practice as a free market, and pluralist funding mechanisms for GP services. They are summarised, below.

---

\(^1\) Medicare, the Australian health care insurance system, provides publicly funded universal health insurance so access to primary care is not restricted and there is freedom of choice of GP for each general practice consultation.
Enrolment
Enrolment is a formal link between a patient and a doctor (who is nominated by that patient). Once enrolled, the patient receives their health and illness care from that GP who would thereafter be responsible for personally delivering or brokering all their medical care.

Enrolment is viewed by its GP proponents as a mechanism to re-establish continuity. It endorses the GP as the professional who is responsible for the consumer's health and, in its proponents' view, facilitates the provision of good medical care by GPs. Enrolment is a feature of general practice care in some European countries, for example The United Kingdom, Denmark and The Netherlands.

Enrolment is favoured by some public health workers, too, but often for reasons other than remedying discontinuity of care. Public health activists see the advantage in a formalised doctor-patient relationship because it defines a link between a population and a GP. This link allows health promotion efforts to be directed to defined populations, facilitates health program evaluation and makes it possible for disease incidence and prevalence to be calculated locally.

Some health economists and bureaucrats also support enrolment because defining a population in relation to providers is essential for capitation payments for health services. Capitation is one strategy for capping total medical expenditure. Another advantage of defining the population denominator is that it allows comparison of the cost-effectiveness of medical care for different groups.

Free market
A different response to the dissatisfaction and discontinuity problem is proposed by those favouring a free market approach to medical care. These people hold to the premise that medical services are like other commodities and that selling and purchasing services in a free market enhances quality and efficiency through competition. Consumers will choose the best service at the best price and are thereby more likely to be satisfied.

This strategy is favoured by many health economists, consumers and policy makers because it opens general practice to both the scrutiny and price competition of the market place. Many believe that such a policy challenges
the privilege that doctors enjoy as a consequence of their present protection from the full rigours of the free market.

**Pluralist health funding**

A third solution favoured by some GPs, economists and policy makers is a move away from a funding reliance on fee for service because it rewards throughput. Large numbers of brief visits in general practice are seen as the cause of consumer and GP dissatisfaction so the provision of pluralist health funding (a combination of grants, capitation payments and fee for service remuneration, for example) is promoted because it is likely to decrease the volume of GP visits. For this option to improve consumers' satisfaction and continuity, individual GPs would have to spend longer on fewer consultations.

One example of throughput-independent funding is the payment of fixed monies for non-clinical work undertaken by GPs within geographically defined divisions of general practice (Saltman 1995). Fixed remuneration for divisional work enables GPs to be paid to collaborate with their local communities in defining local health needs, and to participate in the delivery of educational and health promotion programs. Consumer organisations have welcomed, albeit cautiously, this development too (Consumers' Health Forum of Australia 1992).

**The Better Practice Program**

The Commonwealth government has given a commitment to reforming general practice and in November 1994 introduced the Better Practice Program (BPP) to provide grants to eligible general practices (Department of Human Services and Health 1994). The grants are intended to reward continuity of care (as measured by an HIC algorithm) within one practice and provide an additional income source for GPs that is independent of service volume. The HIC algorithm includes terms for standardised whole patient equivalents, an adjusted patient continuity index for the practice (not individual GPs), and a rural loading (McCallum and Raymond 1996(b)).

However there has been practitioner-led resistance to this innovation. By November 1995 only 32.5% of eligible practices were in receipt of a BPP grant (Dickson 1995).
Dissonance between policy and practice
Clearly there is a dissonance between policy and practice. Many patients are seeing several general practitioners, but the RACGP stance is that continuity of care (assumed to be care from one general practitioner) is an essential feature of good general practice.

I undertook this research with the aim of understanding why some people saw a succession of doctors and were feeling frustrated and unsatisfied with their general practice care. Through an exploration of these and related issues I wanted to contribute to a better understanding of 'continuity of care' in contemporary Australian general practice and of the links between continuity and quality of care.

Public health focus in the thesis
This is a public health thesis about Australian general practice. The research has a population focus as it seeks to explore the perspectives of the two key parties in general practice care - the consumer and the GP. In addition to the interest in curative general practice that is evident in the studies I undertook, there is a focus on health promotion and illness prevention, and a particular concern for the ethic of empowerment.

Throughout this research I have been conscious of the importance of listening to people and locating the views expressed within the participant's context. In this work consumers have been taken to be the critical reference group (Wadsworth 1991) since it is their interests that should be served by GP services. At the same time, GPs have been seen as an additional important reference group since it is through an interaction between consumers and GPs that a service is delivered (or provided and received).

The research program includes work that was collaborative and multidisciplinary and comprises six studies that use a range of methods and techniques. The project is informed by a constructivist perspective (which is explored in chapters three and nine) and this in turn informs the theoretical perspective which underpins the research. Also the link between the inquiry and action for change is examined in the final chapter.
CHAPTER 2

Literature review

This chapter describes general practice in the context of the Australian health system, and then reviews the theoretical and empirical literature on continuity of care.

General practice in Australia

What is the role of general practice?
The role of general practice in Australia is under review at present, as indeed it is in Europe (National Health Strategy 1992; RACGP Presidential Task Force 1995; WHO working Group 1995). However there is agreement that aspects of this role include the provision of first contact, generalist medical care, so services should strive to be accessible and convenient (Andersen, Bridges-Webb et al. 1986; National Health Strategy 1992; RACGP Presidential Task Force 1995). Although GP services are broad in scope, it is acknowledged that brokering of more specialised services will be appropriate in some circumstances. Also GPs are challenging their exclusion from inpatient medical care in public hospitals, citing the benefits of a liaison role and their involvement in inpatient management (Schattner and Dunt 1989). Quality general practice includes a patient-centred approach which recognises that the person has their own unique context comprising family, friends and community (RACGP Presidential Task Force 1995; Stewart, Brown et al. 1995).
Medicare

Medicare\(^1\), the Australian taxation-based health insurance system, has been operating since 1984. All Australian residents are eligible for health services covered by the scheme. Among these services, Medicare provides access to general practitioner (GP) services which are free at the time of the consultation if the visit is 'bulk billed'. Bulk billing refers to the billing option where the GP accepts 85% of the schedule fee for the relevant service and is paid directly by the Health Insurance Commission (HIC) (Deeble 1991). In 1993-94, 68% of all services eligible for Medicare rebates and over 75% of GP services were bulk billed (Health Insurance Commission 1994).

Utilisation of general practice

Between 1984 and 1990 increasing proportions of Australians had at least one GP visit per year. By 1990, 82% of Australian residents had one or more GP visits (Deeble 1991). Over a five year period nearly all Australians make at least one GP visit. McCallum \textit{et al.} have reported that 99% of their study population in Canberra had one or more GP visits between 1988 and 1992 (McCallum, Lonergan \textit{et al.} 1993).

Four large studies of general practice utilisation have been reported in Australia during the last decade. They are summarised in table 2.1 below. The study by Dunt \textit{et al.} was performed immediately prior to the introduction of Medicare (Dunt, Oberklaid \textit{et al.} 1988). It showed that affordability, proximity to the service, and recommendation affected patients' choice of services.

The national morbidity and treatment survey (AMTS) by Bridges-Webb \textit{et al.} (see table 2.1) has provided a wealth of information about people who visited GPs, the health problems\(^2\) they presented, and the management provided by the GPs (Bridges-Webb, Britt \textit{et al.} 1992). In the absence of specific information for calculating population denominators, this study provides the most accurate comparative data at this time.

\begin{footnotesize}
1 Medicare is funded in part by a levy on all persons in paid employment; the remainder is financed from general revenue.

2 The ten most frequently managed problems were: hypertension, upper respiratory tract infections (URTI), asthma, osteoarthritis, acute bronchitis, immunisation, anxiety, joint sprain, arthritis (other than osteoarthritis), and depression.
\end{footnotesize}
The AGB Australia study\(^3\) compared people from Eastern Australia who visited one versus two or more general practices and found that 'multi users' were 13\% of their sample, that they were younger, were more frequent users of health services, that their second GP was more frequently in medical centres, and that they were more dissatisfied with their GP care than single users (AGB Australia 1992(a)).

Ward et al. found that younger people in Western Australia were more likely than other age groups to attend two or more general practices (Ward, Underwood et al. 1995). They found a higher proportion (31\%) of their sample with this pattern of GP service use than did the AGB Australia study. In related studies, Underwood et al. showed that half of frequent attenders (defined as 4 or more visits) had similar utilisation 12 months later (Underwood, Ward et al. 1992). Ward et al. showed that a third of high attenders (defined as having 7 or more visits in a six month period) continued to visit GPs frequently and that they had more circulatory, musculoskeletal and mental disorders than others (Ward, Underwood et al. 1994).

These studies show that practically all Australians visit GPs. Younger people are more likely to see several GPs and yet are less satisfied with the services they receive than people who attend one general practice.

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\(^3\) AGB Australia is a market research company. They undertook commissioned research for the Commonwealth Department of Health, Housing and Community Services.
Table 2.1  Studies of Utilisation in Australian General Practice

<table>
<thead>
<tr>
<th>Author and Sample size</th>
<th>Subjects</th>
<th>Aim and Methods</th>
<th>Results</th>
</tr>
</thead>
</table>
| (Dunt, Oberklaid et al. 1988) 592 patients | Patients visiting one of 8 general practices, a casualty or a community health centre in one city, Australia | Interview study about patients' views of primary medical care services in an industrialised area of low social amenity in Melbourne during 1983 | • Patients attending general practice were less likely to be in manual occupations or unemployed than those attending the casualty or community health centre.  
• Proximity to home or work, then recommendation were the most frequently cited reasons for choosing a service. |
| (Bridges-Webb, Britt et al. 1992) 98,794 encounters (weighted by state) | Encounters between 495 GPs and consecutive patients | National morbidity data for up to 200 consecutive GP visits over 2 one-week periods were recorded to describe the reasons for encounter, morbidity and their management, in 1990-91 | • The most frequently managed problems were: hypertension, URTI, asthma, osteoarthritis, acute bronchitis, immunisation, anxiety, sprain, arthritis, & depression.  
• There were more female (58%) than male (42%) encounters overall.  
• 16% of encounters were with children; 11% with 15-24 age group; 48% with adults aged 25-64 years; & 25% with those over 65 years. |
| (AGB Australia 1992(c)) 750 GP users | Representative sample of adult GP users from 7 Australian capital cities & 4 rural towns | To describe & investigate factors affecting consumers' GP usage patterns, 1992 | • 80% of adults were single GP users and 13% were multi users.  
• Higher proportions of multi users were aged 18-39 years.  
• Multi users were more frequent users of GP & other health services than single users, & were less satisfied with services. |
| (Ward, Underwood et al. 1994) 2139 patients 3254 visits | Patients from 3 group practices, WA | Comparison of morbidity data and grouped service utilisation for patients seeing 14 GPs at 3 practices for two 6-month periods during 1986-88 | • 30.8% patients had visits in both observation periods.  
• 51% were low attenders (1-3 visits) in both periods; 5% had 4-6 visits in both periods; 4% had 7+ visits in both periods.  
• High attenders had more circulatory, musculoskeletal and mental disorders. |
| (Ward, Underwood et al. 1995) 6,943 patients 16,303 visits | Patients from 3 group practices, WA | Comparison of HIC and practice data for services provided by 14 GPs at 3 practices for two 6-month periods during 1986-88 | • 69% of patients did not attend any other practice during 6 months.  
• More of the very young (0-3 years) and young adults (18-24 years) attended elsewhere than other groups.  
• 85% of patients did not visit a specialist during the study period. |
Who are they?

At present there is no definitive list of actively practising Australian GPs (Saltman and Mant 1992). The Medical Provider File (MPF; formerly called the Central Register of Medical Practitioners - CROMP) does however list all doctors who are registered to receive payments from the Health Insurance Commission which administers Medicare. This source has been utilised by several researchers as it is the most comprehensive list available. However the MPF does not distinguish GPs from non-specialists. Thus this file would be likely to over-enumerate practising GPs since they are in a default category which includes non-accredited specialists and hospital-based doctors in training. Also, the file records the number of services that attracted a rebate, not information about the activity level of the practitioners. With these caveats, there were 12,165 full-time GPs and 10,634 who worked part-time in 1989-90.

Since 1989 GPs have been able to apply for vocational registration (VR) which allows access to a higher fee schedule than is available to non-VR GPs. This VR subset comprises GPs with vocational experience of five or more years and/or the fellowship of the RACGP (FRACGP). The VR subset is likely to be more accurate than the MPF as it excludes non-GPs but it has not been used for research purposes to date.

National information about GPs was collected for the Australian Morbidity and Treatment Survey (Bridges-Webb, Britt et al. 1992; Bridges-Webb, Britt et al. 1993). The sample was derived from the MPF. Those GPs who had provided 1,500 or more general practice services during 1989 were eligible for inclusion in the survey and 3.5% of active GPs in each state were sampled. The Australian Capital Territory (ACT), Northern Territory and Tasmania were 'over sampled' to permit between state comparisons. The

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4 In 1991 Deeble adopted a pragmatic solution to the problems of definition by dichotomising doctors into specialists and general practitioners (Deeble 1991). General practitioners were defined as those without specialist qualifications since those with specialist qualifications were identified for entitlement to higher rebates. Activity in general practice was divided into full-time and part-time as defined by annual gross fee receipts from Medicare above and below $A61,000 respectively.
GP respondents to the survey were predominantly male (80.5%), aged 35-54 years (67.9%), Australian graduates (80.0%) and had been in practice for 10 or more years (68.3%). Comparison of respondents and non-respondents showed the latter to be more likely to be male, older and to conduct a proportion of consultations in a language other than English.

More detailed and accurate information about GPs is available in some regional areas. The Hunter region is notable in this regard (Dickinson and Sanson-Fisher 1992). The Hunter Postgraduate Medicine Institute has developed a database which lists all medical practitioners (subdivided into specialists, doctors in training and GPs). Eventually the divisions of general practice should be able to compile a more accurate list of GPs within their geographical area.

**What types of practices do they work in?**

The practices and affiliations of individual doctors may influence their style of practice and the clientele who consult them. However, until 1995 the MPF did not include verified information on general practices since the file was established for accounting purposes. One of the aims of the Better Practice Program that was launched by the Commonwealth Department of Human Services and Health in November 1994 was to gather information about practice affiliations from GPs who applied for practice enhancement grants. Such information is not available nationally at the present time.

Kinder (Kinder 1986) has documented the organisational shift in Australian general practice from solo to group practice. Prior to World War II, solo practice was the norm. By 1966, 40% of GPs in New South Wales (NSW) were in solo practice and this declined to 38% by 1975. (Chancellor and Andersen 1977) Regional differences in general practice organisation were first described in NSW during the seventies. At that time inner-city GPs were more likely to be in solo practice than those in outer suburban and rural practice. In 1988 a survey of South Australian (SA) GPs found that 29% were in solo practice, 13% were in two person practices and 59% were in groups of three or more GPs (South Australian Health Commission and Joint working party of AMA RACGP and SA Health Commission 1989).

The most recent national data on general practice organisation is derived from the 495 GPs to the AMTS (Bridges-Webb, Britt et al. 1992; Bridges-Webb, Britt et al. 1993). When this survey was conducted in 1990-91, 25.9% of the responding GPs were in solo practice, 40.3% were in groups of 2-3 GPs.
and 33.8% were in practices comprising four or more GPs. Table 2.2 below shows the percentage of GPs arranged by type of practice in NSW, SA, and nationally; these studies show a trend away from solo to group general practice.

Table 2.2  The percentage of GPs arranged by type of practice in NSW, SA, and nationally

<table>
<thead>
<tr>
<th>Type of general practice</th>
<th>Chancellor (1975)</th>
<th>SAHC* (1988)</th>
<th>AMTS† (1990-91)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NSW</td>
<td>SA</td>
<td>National</td>
</tr>
<tr>
<td>solo GP</td>
<td>38</td>
<td>29</td>
<td>25.9</td>
</tr>
<tr>
<td>2-3 GPs</td>
<td>-</td>
<td>13</td>
<td>40.3</td>
</tr>
<tr>
<td>4+ GPs</td>
<td>-</td>
<td>59</td>
<td>33.8</td>
</tr>
<tr>
<td>total</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>

* SAHC is the South Australian Health Commission
† AMTS is the Australian morbidity and treatment survey

Britt et al. compared the practice characteristics of urban and rural GPs. Overall, rural GPs were more likely to work in group practices than their urban colleagues, but those in small towns were more likely to be in solo practice (Britt, Miles et al. 1993). Table 2.3 is an excerpt from table 4.1, page S23 (Britt, Miles et al. 1993) showing the number of GPs (expressed as a percentage) in each type of practice, by location.
Table 2.3  The number of GPs (expressed as a percentage) in each type of practice, by location*

<table>
<thead>
<tr>
<th>No. of GPs in the practice (%)</th>
<th>Small towns† (n=59)</th>
<th>Medium towns‡ (n=59)</th>
<th>Large towns§ (n=58)</th>
<th>All country (n=176)</th>
<th>Metropolitan (n=50)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Solo GP</td>
<td>40.2</td>
<td>15.3</td>
<td>17.9</td>
<td>22.6</td>
<td>29.3</td>
</tr>
<tr>
<td>2-3 GPs</td>
<td>47.6</td>
<td>38.9</td>
<td>21.4</td>
<td>33.7</td>
<td>41.0</td>
</tr>
<tr>
<td>4+ GPs</td>
<td>12.2</td>
<td>45.9</td>
<td>60.7</td>
<td>43.7</td>
<td>29.7</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>

* excerpt from table 4.1, page 523 (Britt, Miles et al. 1993)
† Small country towns - postcodes with populations of less than 5,000 (ABS, 1986 census)
‡ Medium country towns - postcodes with populations of more than 5,000 but less than 15,000 (ABS, 1986 census)
§ Large country towns - postcodes with populations in excess of 15,000, but not metropolitan. (ABS, 1986 census)
Continuity of Care

In this section I describe the origins of the concept of continuity of care, its development in the literature, and measures that have been proposed to evaluate it. Finally, I review the Australian and international studies which are related to continuity of care in general practice.

The concept of continuity of care

Continuity of care is widely regarded now as an essential component of quality general practice care (Royal Australian College of General Practitioners and Arthur Anderson & Co 1985; National Centre for Epidemiology and Population Health 1991; National Centre for Epidemiology and Population Health 1992; National Health Strategy 1992; South Australian Community Health Research Unit (SACHRU) 1995). Its importance has been emphasised in statements about, and definitions of, general practice, for example the statement by the Royal College of General Practitioners (RCGP) in the United Kingdom (UK), 1972, that: 'the doctor should provide his patients with personal, primary and continuous care'.

The RCGP, the first general practice college, was established in the UK in 1952. In the nineteenth and early twentieth centuries most medical practitioners were male and in solo practice. However at the time the college was founded (four years after the introduction of the National Health Service) this was changing and only 44% of GPs were solo practitioners (Gray 1979). The shift from solo to group general practice occurred more slowly in Australia. In 1975, 38% of GPs in NSW were in solo practice (Chancellor and Andersen 1977). Definitions of general practice that emphasised the personal delivery of medical care by one doctor and responsibility over extended periods, seem to reflect the usual situation when they were promulgated.

The development of the concept of continuity of care in the literature

In 1975 a series of four papers explored the concept of continuity and developed the first general (and family) practice theory of continuity care (Geyman 1975; Hansen 1975; Hennen 1975; McWhinney 1975). The papers drew on the authors' extensive clinical and teaching experience in general practice, early health services theory, and studies of continuity of care in paediatric settings in the United States of America (USA).
Hennen stated that the concept of continuity included first contact care, longitudinal responsibility, integration and the family as the unit of care (Hennen 1975). He described four dimensions of continuity of care:

1) chronological (care to persons of all ages, and care throughout the natural history of illness);
2) geographical (provision of primary care regardless of site);
3) interdisciplinary (management of diseases of several body systems and illness in other family members to facilitate the optimal function of the whole family); and
4) interpersonal (relationships with the patient, other family members, and other medical and health professionals). This last aspect was noted to require the skill of continuity of information, which relied 'to a great extent on the written record'.

McWhinney highlighted the importance of relationships in continuity of care, describing the concept as 'an implicit contract (that) exists between the family physician and the patient' (McWhinney 1975). He went on to say that 'continuity is not delineated by disease and the responsibility continues until death or decision to end the relationship'. However the depth of knowledge gained from continuity of care was thought to be more important than the duration of the relationship. McWhinney listed applications of continuity in clinical practice:

1) 'observation over time can be used as a very effective tool for the validation of diagnostic hypotheses';
2) opportunity to use psychotherapy as needed during 'the continuing personal relationship';
3) doctors see the 'illness in the context of the whole person and his environment'.

Hansen synthesised the dimensions and applications of continuity in proposing the first theoretical framework for continuity of care (Hansen 1975). He emphasised the flow between the 'continuity elements': patient-initiated contact with the doctor, the patient-professional relationship, continuity of necessary data (the medical records), delivery of needed services or care, and desired outcome. Hansen reviewed the paediatric evidence regarding continuity of care to determine whether it made any difference in measurable outcomes. Positive effects cited by Hansen
included a reduction in rheumatic fever\textsuperscript{5}, more cost-effective care for ambiguous illness in children presenting for emergency treatment\textsuperscript{6} and enhanced patient and provider satisfaction with care\textsuperscript{7}. However the effect of continuity on compliance with medications was unclear\textsuperscript{8}.

Geyman discussed ways that training in family medicine might be altered 'to include more continuity on a program or group level not (only) ... on the individual resident level' (Geyman 1975). He examined the educational, organisational, and operational issues in designing a family practice residency program that included continuity of care.

The early formulation of continuity of care, outlined above, has been very influential. In 1980, Rogers and Curtis sought to elaborate the theoretical model and emphasise the importance of continuity of information. They defined continuity in medical care as 'a measurable succession of encounters (and) an attitude as well' (Rogers and Curtis 1980(a)). In their revised model, the medical interaction occurred in 'an encounter' that involved 'the provider and consumer elements', in a 'continuity environment' characterised in terms of seven dimensions (chronological, geographic, interdisciplinary, informational, relationship, stability, and accessibility), and which drew on a knowledge base with 'age-dependent, biomedical and psychosocial aspects'.

Wall reviewed the evidence on outcomes attributable to the elements of continuity described in Rogers and Curtis' model (Wall 1981). He suggested that the informational dimension of continuity was the most critical in

\textsuperscript{5} Gordis claimed that comprehensive care programs (which included continuity) had been the critical factor in reducing the incidence of rheumatic fever in the inner city Baltimore (Gordis 1973).

\textsuperscript{6} Alpert et al (1970) showed that the continuous care group in the emergency room had fewer studies and treatments received (and thus lower costs) in situations where the diagnosis was ambiguous. (Alpert, Kossa et al. 1970; Heagarty, Robertson et al. 1970)

\textsuperscript{7} Becker (1974) showed greater satisfaction for patient, physician, and clinic staff in the continuing care group (Becker 1974 (b)).

\textsuperscript{8} Charney (1967) found that compliance was improved when the patient's 'regular' doctor prescribed the treatment, but Gordis (1969) showed no improvement in compliance with penicillin prophylaxis for post-rheumatic fever management in the continuing care team in hospital clinic vs others. (Charney, Bynum et al. 1967; Gordis 1973)
determining important outcomes such as the minimisation of unnecessary or duplicated diagnostic tests, and response to abnormal findings, risk factors or laboratory test results.

More recently, Hjortdahl has proposed a further refinement of the model of continuity (Hjortdahl 1992(d)). He links 'input' or independent variables (longitudinal care, organisational and personal factors, and shared major events) to outcomes of care. The outcomes are primary (medical and personal knowledge of the patient), intermediate (resource use, responsibility, understanding and satisfaction) and final (quality of care, morbidity, mortality, and economic assessment). This model retains the flow and interaction between the elements and emphasises the contribution of longitudinal care to quality and cost-effective outcomes expressed in terms of morbidity and mortality.

The foregoing synthesis of the development of a theory of continuity of care shows that it has been informed in the experience of clinicians and teachers and only recently shaped by empirical research.

Indeed the grounding of commentaries on continuity of care in clinician's experience has been reflected in the debate about definitions of continuity. Most authors have tended to modify the definition idiosyncratically, leading Starfield to observe in an editorial that the notion was characterised by suspense, even continuous confusion (Starfield 1980). She called for a distinction between longitudinality and continuity, proposing that longitudinality be defined as 'a phenomenon involving both the availability of a regular source of care (place or professional) and a decision, by the patient, to seek care from that source whenever care is needed'. Continuity she defined as 'an uninterrupted succession of events (episode of illness); the bridging mechanism between visits for a specific condition or episode with the intent of improving follow-up for patients' problems and facilitating efficiency in diagnostic workup and management (Starfield 1979; Starfield 1980).

Others have proposed different theoretical constructions of continuity of care. Banahan and Banahan highlighted the contractual aspect of continuity and suggested that there were three types (Banahan and B.F. Banahan III 1981). Type A continuity involved a patient-physician relationship extending across periods of illness and well-being and encompassing significant life cycle changes for the patient. Type B was shorter in duration
In summary, descriptions of the elements of continuity of care were founded on the experience of clinicians. Two aspects of continuity have been discussed in detail: the relationship between the doctor and patient, and integration. First contact care is viewed as providing a foundation for continuity by initiating the doctor-patient relationship (Hansen 1975; Hennen 1975). This relationship can be strengthened by the sharing of major health-related events (Banahan and B.F. Banahan III 1981; Hjortdahl 1992(d)). The depth of knowledge gained through repeated interaction and an ongoing relationship has been described by clinicians, researchers and consumers (Hennen 1975; McWhinney 1975; Starfield 1980; Banahan and B.F. Banahan III 1981; Chao 1988; South Australian Community Health Research Unit 1995). This ongoing relationship requires the support of continuously updated clinical information (Hennen 1975; Rogers and Curtis 1980(a); Wall 1981; Ruane and Brody 1987). A frequently reported function of continuity relates to integration of health care within the context of the patient's family (Hennen 1975; McWhinney 1975), and coordination of health services in the primary and specialist sectors (Hennen 1975; Starfield 1980; Rogers and Curtis 1980(a); Banahan and B.F. Banahan III 1981; Wall 1981; Ruane and Brody 1987; Chao 1988; Consumers' Health Forum of Australia 1992; South Australian Community Health Research Unit 1995).

The implications of these understandings of continuity for teaching were drawn out first by Geyman (Geyman 1975). Empirical research has focussed on those health outcomes that can be attributed to the elements of continuity and this has led to considerable interest in measures of continuity which are discussed below.

**Measures that have been proposed to evaluate continuity**

Broadly, the measures of continuity fall into two categories: those that focus on continuity of care for an individual, and visit-based measures which are used to assess the performance of health systems. The individual measures were first developed in North America where individual benefits of care are a focus. In contrast, visit-based continuity measures were developed separately by teachers interested in program evaluation and by researchers in Sweden. The Swedish researchers were evaluating the public health effects of institutional changes within their primary care system that were designed to facilitate provider continuity (that is, the provision of primary medical services for an individual by one GP).
Individual measures of continuity

Five individual measures of continuity have been described which relate the number of visits to the number of providers seen. These are Usual Provider Continuity (UPC), the index of Continuity of Care (COC), the likelihood of continuity being present (LICON), the average sequential visit continuity (SECON), and the Modified Continuity Index (MCI). These measures are described, below.

Breslau and Reeb, 1975 developed an index of continuity for paediatric practice (Breslau and Reeb 1975). Continuity was defined as 'the extent to which a single physician manages the health needs of the patient or the family'. Usual Provider Continuity (UPC) was defined as the number of visits with the patient's 'own' physician divided by the total number of visits in the year. UPC = n(usual provider)/n, where n= the number of visits.

Bice & Boxerman described an index of Continuity of Care (COC) (Bice and Boxerman 1977). Continuity was defined as 'the extent to which a given individual's total number of visits for an episode of illness or a specific time period are with a single or group of referred providers'. Bice and Boxerman proposed that all visits to either a usual provider or a referred provider be viewed as having been to a single provider for this index. This assumption is predicated upon perfect communication between the referral parties.

COC = \[ \sum_{i=1}^{S} (n_i^2 - n) / n(n-1) \]

where n = total number of visits;

n_i = number of visits to provider_i;

S = number of unreferred providers;

\( \Sigma \) = the sum of calculated values. The COC index assesses an individual's continuity and is sensitive to the total number of visits and number of different providers. However this index is not sensitive to the sequencing of visits.

Steinwachs proposed two new measures of continuity: the likelihood of continuity being present (LICON) and the average sequential visit continuity (SECON) (Steinwachs 1979).

SECON = \[ \sum_{i=1}^{n-1} (p_i / (n-1)) \]

where p_i = ith pair of visits. ie SECON = 1 if the same provider was seen on successive visits, otherwise = 0. SECON was the first index that was sensitive to the order in which visits occurred and LICON introduced the notion that the probability continuity could be different from random allocation of visits.
Godkin & Rice reported another individual-based continuity index called the Modified Continuity Index, MCI (Godkin and Rice 1984).

\[ MCI = 1 - \frac{S}{n+0.1} \]

where \( n \) = total number of visits; \( S \) = total number of different providers seen. This index incorporates a weighting for the number of visits and was proposed principally for use by clinicians.

Murata has proposed a Family Care measure (FC) which is based on individual measures for members of a family (Murata 1993). FC examines the frequency of visits, number of family members and number of family providers. \[ FC = \sum_{j=1}^{J} n_j^2 - \sum_{i=1}^{I} n_{ij}^2 / n^2 - \sum_{i=1}^{I} n_i^2 \]

where \( n \) = total number of visits by family; \( n_{ij} \) = number of visits by family member \( i \) to provider \( j \); \( n_i \) = total number of visits by family member \( i \); \( n_j \) = total number of visits by family to provider \( j \).

**Visit-based measures of continuity**

Three indices were developed in North America to assess the continuity of care provided to groups and to allow comparisons between subgroups (not between individuals). These aggregate measures are Gini and CON, and the Modified, Modified Continuity Index (MMCI).

Shortell developed two measures, Gini and CON, based on a definition of continuity as 'the extent to which medical care services are received as a coordinated and uninterrupted succession of events consistent with the medical care needs of the patient' (Shortell 1976). The Gini and CON indices measure concentration for an illness episode and take account of the distribution of the remaining sources of care (ie the number of different providers).

Magill and Senf described a Modified, Modified Continuity Index (MMCI) for use in training settings (Magill and Senf 1987). \[ MMCI = 1 - \frac{n \text{ of providers}}{(n \text{ of visits} + 0.1))/1 - (1/(n \text{ of visits} + 0.1))} \]

The authors designed the MMCI so it was 'not overly sensitive to the large number of providers found in a residency training site'.

The Swedish visit-based measures were pioneered by Eriksson & Mattsson (Eriksson and Mattsson 1983). Five visit-based measures have been developed and three conceptual distinctions necessary for their application have been drawn. Eriksson and Mattsson defined sequential continuity, \( s \), equal to 'one if the provider of the visit was also seen at the preceding visit in the continuity defining period, and zero otherwise'; known provider
continuity, \( k \), equals one if the provider of the visit was also seen at some visit in the continuity defining period, and zero otherwise; and visit-based usual provider continuity, \( u \), as one if the provider of the visit was the usual provider according to an a priori definition, and zero otherwise (Eriksson and Mattsson 1983). These researchers also defined Fraction of Care continuity, \( \text{FOC} = \frac{n(\text{provider of interest})}{n} \), where \( n \) = number of visits. A discounted version of the FOC index was also developed.

Smedby et al. described the fraction of visits to provider, \( \text{FRAC} \) defined as \((1-\text{HH})\). \( \text{HH} \) is the Herfindahl Index \( \text{HH} = \sum_{i=1}^{\text{Pi}} p_i^2 \), where \( p_i \) is the fraction of visits to provider \( i \) during the measurement period (Smedby, Smedby et al. 1984; Smedby, Eklund et al. 1986). This measurement is similar to Ejlertsson's \( K \) index (Ejlertsson and Berg 1984).

Mattsson and Westman introduced the notions of random and potential continuity to evaluate the effects of the availability and stability of providers on continuity (Mattsson and Westman 1987). Random continuity is 'the expected level of continuity if the visits were assigned to available providers by chance alone' while potential continuity is 'the maximum level of continuity possible to attain with respect to the availability of the providers'. Coverage is then defined as 'the percentage of the gap between potential and random continuity that has been filled by actual continuity'.

**Summary of the literature on continuity measures**

In summary, continuity measures have been developed for different purposes. Longitudinality (that is the relationship between the number of visits and the number of providers seen) can be measured with individual-based measures of continuity, while the performance of health care facilities, organisational settings or health care systems is measured more appropriately using an average of visit-based continuity measures (Eriksson and Mattsson 1983). Mathematical and empirical analyses have shown that \( f \) (a visit-based measure) is independent of the level of service utilisation which may itself confound the measurement of continuity (Eriksson 1990). In addition \( f \) is easily interpreted, and is correlated with other visit-based indices, so it has been commended for use by researchers who are interested in the evaluation of continuity of care using continuity indices.

However these measures do not distinguish between or reflect the contribution of the doctor-patient relationship or integration to continuity. None of the continuity indices measure the process of general practice care
over time. Rather they quantify the number of doctors seen over a series of visits and thus might be regarded as evaluating the number of doctor-patient encounters rather than continuity of care as such.

Studies of continuity of care in family and general practice settings
In this section I have summarised studies of continuity of care in family and general practice settings or in primary medical care settings. Published reports of these studies were accessed using a compact disc-read only memory (CD-ROM) Medline review of all articles from 1968 to September 1995 using the following words: 'continuity'9, 'general practice' and 'family practice'. The search process used was 'continuity' and ('general practice' or 'family practice').

Two hundred and fifteen citations were accessed. Each of the abstracts was read and articles that were not about general of family practice, those not written in English, editorial comments and letters were excluded from further consideration. The remaining 160 citations and the references cited in each of these articles were assessed for this review. The secondary citations were an important source of additional references since many general practice journals have not been included on Medline for the entire review period.

Citations were examined for evidence of a clear definition of 'continuity', 'continuous', 'longitudinal', 'returning' or 'personal care'; inclusion of primary data; and a description of the study setting as 'general practice', 'family practice' or primary (medical) care'. Papers that were ambiguous or did not meet these criteria were excluded. Articles that described teaching approaches to continuity without associated data were excluded: (Hennen 1981; Zwick 1989; Biehn 1990; Lyon 1990). Studies that were focussed on a particular disease such as epilepsy, schizophrenia, asthma, diabetes, HIV/AIDS, cleft lip, and hypertension were excluded. Studies that were limited to one age group with care by other than family physicians or GPs were excluded, in particular studies from paediatric settings (Charney, Bynum et al. 1967; Mindlin and Densen 1969; Alpert, Kossa et al. 1970; Heagarty, Robertson et al. 1970; Gordis and Markowitz 1971; Becker, Drachman et al.

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9 The search term continuity (of patient care) is defined as 'health care provided on a continuing basis from the initial contact with a physician or clinic and following the patient through all episodes of his medical care needs'.
1972; Gordis 1973; Becker, Drachman et al. 1974(b); Becker, Drachman et al. 1974(c); Breslau and Haug 1976; Spivak, Levy et al. 1980; Breslau 1982); and antenatal settings (Poland 1976) were not considered. Studies that were limited to a single teaching site for family practice trainees were excluded also: (Curtis and Rogers 1979; Sloane 1979; Patten and Friberg 1980; Rogers and Curtis 1980(b); Fletcher, O'Malley et al. 1984; Bertakis and Robbins 1989; Blankfield, Kelly et al. 1990).

Since the health system provides the context and hence frames each of these studies, I have arranged the review by country. The studies in each group are introduced by a brief description of the national health system. These descriptions were synthesised from Starfield's work (Starfield 1992; Starfield 1994) and information from the cited papers. However, grouping the empirical studies by country does not imply that they were conducted in identical contexts. It is likely that there are considerable differences between general practice and primary medical care settings from region to region within these countries, and that these have varied from decade to decade too.
Australia
The Australian health system has been described in this chapter (pages 7-14). The Australian studies of continuity are summarised in table 2.4.

The first Australian study of continuity in this series was by Liaw et al. who reported a consensus definition of a 'regular family doctor', noting that the attributes desired by patients appeared to differ with socioeconomic status (SES) (Liaw, Litt et al. 1992). They suggested that the lower SES group preferred a caring doctor who knew their history and listened, while the higher SES group emphasised the doctor's competence, judgment and rapport. This study was limited, as participants were recruited from only two general practices and participation rates were poor.

Studies conducted by AGB Australia in 1992 reported that 'continuity' was valued by older people, those women who regarded a relationship with a GP as important for their health, and the chronically ill (AGB Australia 1992(b); AGB Australia 1992(c)). The GPs' definition was different in that it referred to continuity that was applicable to all individuals and which resulted in 'a comprehensive knowledge of the patient, their social and family environment, and their medical history'. These studies involved larger groups of people and have provided useful insights into the value of continuity for different groups of Australians.

A 1995 study of consumer perceptions of continuity by SACHRU described good and bad experiences of continuity (South Australian Community Health Research Unit 1995). Good experiences were related to service provision factors, consumer's personal resources, and 'straight forward' health conditions. Bad experiences of continuity were related to linkage problems such as a lack of coordinated services, ineffective communication, consumer isolation due to geography, culture or language, and complex health conditions. This study was valuable for the consumer perspective that has been described and for the more detailed understanding of the issues that promote and interrupt continuity.

A population based study has shown that 55% of people had sequential continuity for their last GP visit (McCallum, Raymond et al. 1996(a)). The sequential continuity was higher prior to hospitalisation, when 86% of men and 57% of women had this type of continuity. Sequential continuity was found to be higher with increasing age, while higher proportions of visits
bulkbilled and visits on the weekends were both associated with decreased continuity. A recent study shows that sequential continuity is lower for people who are younger, have good physical functioning and self-rated health, normal body mass index, undertake shift work, and had a longer time interval between visits, than others (appendix 2.1 - paper accepted for publication in February 1996). These studies are companions to those developed for this thesis and they provide the first population-based insights into continuity in Australia.

Another study in progress shows that patients who have continuity at one practice were significantly more likely to be very satisfied with their care and to have received more preventive care than others (Steven, Thomas et al. 1995).

These Australian studies suggest that continuity is valued differently by different groups of people. Some have associated continuity with social class (Liaw, Litt et al. 1992), gender (AGB Australia 1992(b); McCallum, Raymond et al. 1996(a)), age (AGB Australia 1992(b)), medical conditions (AGB Australia 1992(b); South Australian Community Health Research Unit 1995; McCallum, Raymond et al. 1996(a)), and aspects of the health system (AGB Australia 1992(b); AGB Australia 1992(c); South Australian Community Health Research Unit 1995). In contrast Australian GPs described continuity being applicable to all individuals (rather than some groups only) although bulkbilling was felt to be a major obstacle to its achievement (AGB Australia 1992(c)).
### Table 2.4  Studies of Continuity of Care conducted in Australia

<table>
<thead>
<tr>
<th>Author (Liaw, 1992)</th>
<th>Year</th>
<th>Sample size</th>
<th>Subjects</th>
<th>Definition of continuity of care</th>
<th>Aim and Methods</th>
<th>Results</th>
</tr>
</thead>
</table>
|                     | 1992 | 2 groups of patients | Patients from a group general practice and a medical drop-in centre, South Australia | Participants were asked: 'What do you understand by "regular family doctor"?' | Focus group discussions with two groups of differing SES about their experience of health service use | • The lower SES group preferred a caring doctor who knew their history and listened.  
• The higher SES group emphasised competence, judgment and rapport. |

| AGB Australia, 1992(b) | 1992 | 10 focus groups | Consumers from different demographic & socioeconomic groups, in urban & rural Australia | Continuity of care was not defined. The report refers to 'a personal relationship (continuity of care)' | Focus group discussions to explore consumers' choice of & satisfaction with GPs and practices, 1992 | • Good GP service included individualised care according to patients' needs, spending adequate time, showing thoroughness, genuine care & consideration, & availability.  
• 'Continuity' was valued by older people, those women who see a relationship with a GP as important for their health, & the chronically ill.  
• Medical centres were valued by those needing infrequent visits, who were working & adopted a pragmatic viewpoint. |

| AGB Australia, 1992(c) | 1992 | 5 focus groups & 16 individual GPs | General practitioners in urban & rural NSW & Qld | Participating GPs were asked: 'What do you understand by the term "continuity of care"?' | Focus group discussions & individual interviews to explore GP attitudes to their patients, the GP system & Medicare, & to continuity of care and linkage between GPs and patients | • 'Emergent' definition of continuity: a comprehensive knowledge of the patient, their social & family environment & their medical history.  
• Bulk billing was seen as the key obstacle to continuity. |
Table 2.4, continued

<table>
<thead>
<tr>
<th>Study</th>
<th>Year</th>
<th>Sample Size</th>
<th>Sample Description</th>
<th>Methodology</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>(SACHRU, 1995)</td>
<td>1995</td>
<td>8 groups of consumers</td>
<td>People who had used more than one health service for a particular condition in the last 12 months, SA</td>
<td>Focus group discussions with diverse groups about experiences of health care services, coordination and improvements to services</td>
<td>- The 'grounded' definition of continuity was: medical &amp; health care over time; an holistic approach; provider continuity; effective links between medical, health &amp; community services</td>
</tr>
</tbody>
</table>
| (McCallum, 1996(a))                  | 1995 | 505 respondents | Population sample, ACT | Interview administered questionnaire about GP service utilisation, satisfaction and demographic information was linked to HIC and hospital utilisation data | - 55% had sequential continuity for the last GP visit.  
- Prior to hospitalisation, 86% of men and 57% of women had sequential continuity.  
- Age is the main predictor of higher continuity.  
- Proportion of visits bulkbilled and proportion of visits on the weekends both predict decreased continuity.  
- High risk drinking predicted less continuity and higher BMI predicted greater continuity. |
Canada
The five Canadian studies of continuity are summarised in table 2.5. Canada's family practitioners work in a partially regulated private health system (Starfield 1992). There are financial incentives for family doctors who practise in under-serviced areas but primary care is not organised by defined geographic areas. There is a national health insurance system that is operated through the provinces and reimbursement is on a fee for service basis at negotiated rates. Generally primary care services are not associated with co-payments or other out of pocket expenses for patients (Deeble 1991). Patients access specialist services by self referral or on referral from a family physician. In the latter case a higher rebate for the specialist service applies. The system is highly regarded for its family-centred orientation and comprehensive provision of primary health care services.

One Canadian study found that 94% of the population had a family physician and 90% had seen that physician in the past 2 years (McWhinney, Bass et al. 1988). In Canada, continuity has been shown to be high when utilisation was regular and of low volume (Béland 1989) and when services were provided by family practitioners in solo practice, and rural practice (Roos, Roos et al. 1980). A study by Roos et al., conducted over 20 years ago, found that lower provider continuity was associated with more respiratory episodes but higher continuity was associated with tonsillectomy and or adenoidectomy being performed when criteria for these operations had not been fulfilled. This study has been valuable in demonstrating that acute illness episodes diminish continuity. However the link between continuity and quality outcome that the authors' sought to evaluate was not examined satisfactorily and criteria for the outcome measures have changed significantly.

A study of mobility and its effect on continuity showed that the five-year move rate was 13.2% for men and 16.6% for women, and that younger persons had higher move rates than others (McWhinney, Bass et al. 1988). The authors felt that mobility was not a significant threat to continuity nor to ongoing care of the chronically ill since hypertensive individuals in all age groups except those in their twenties moved less than normotensives. This is the only study to quantify the effect of mobility on continuity.

A recent qualitative study of seven new female patients aged 25-80 years visiting family doctors for a year examined the evolving doctor-patient
relationship (Stewart 1995). Three distinct relationship types were identified: 1) brisk, focused, trusting, straightforward and unchanging; 2) tolerant, warm, trusting, complex, and evolving but stable; and 3) unfocussed, inconsistent, and unstable. The context of the visit and continuity were identified themes which impacted on these evolving relationships.

One of the few studies of referral continuity was conducted in Canada (Pineault and Lescop 1989). The authors found that when physicians perceived that health services were competitive rather than complementary with their own, they referred patients less often to them. Consequently, physicians referred most often to paramedical professionals, then problem-oriented clinics and least to community centres. This study, which explores the interpersonal dimension of continuity, makes a significant contribution as it suggests that competitive rather than cooperative relationships can effect continuity adversely. Other health systems have been fostering competition in an attempt to make health care cost-effective, so there is a potential for this to have an impact on continuity.
Table 2.5  Studies of Continuity of Care conducted in Canada

<table>
<thead>
<tr>
<th>Author</th>
<th>Year</th>
<th>Sample size</th>
<th>Subjects</th>
<th>Definition of continuity of care</th>
<th>Aim and Methods</th>
<th>Results</th>
</tr>
</thead>
</table>
| (Roos, 1980)            | 1980 | 2,974 patients | Patients who had tonsillectomy and adenoidectomy, in one province, Canada | The extent to which an individual's visits were with a single provider or group of referred providers. Measured by COC and FRAC. | To examine the effect of provider continuity using data from Manitoba health services commission on episodes of illness prior to and after tonsillectomy and adenoidectomy in 1973. | • Patients seeing GPs in solo practice had higher provider continuity than those visiting GPs in a group practice  
  • GPs aged 40+ years working outside the cities showed more provider continuity than others  
  • Higher continuity was associated with not meeting standards for recommending the operation(s)  
  • Less continuity was associated with more respiratory episodes prior to surgery |
| (McWhinney, 1988)       | 1988 | 15,524 patients | Adult patients of 17 family practitioners in one region, Canada           | Continuity of care provided by practices: medical chart evidence of a service to the patient or a family member within previous 2 years & evidence of future commitment | Description of patient attrition rates from practices due to death or moving house by demographic and hypertension status, 1978-1982 | • 94% of population stated that they had a family physician and 90% had seen that physician in the past 2 years  
  • Over five years, the move rate was 13.2% for men and 16.6% for women  
  • Younger persons had higher move rates than others  
  • Young hypertensives (20-29 years) moved more than normotensive persons, but in all other age groups hypertensive individuals moved less than normotensives |
Table 2.5, continued

<table>
<thead>
<tr>
<th>Study (Year)</th>
<th>Year</th>
<th>Sample Size</th>
<th>Study Description</th>
<th>Methodology</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Pineault, 1989)</td>
<td>1989</td>
<td>246 physicians</td>
<td>GP and paediatricians in one city, Canada</td>
<td>Referral continuity: the degree to which physicians refer to public health resources</td>
<td>Telephone survey of randomly selected GPs and paediatricians about referrals to other medical, paramedical &amp; community health care resources, 1984</td>
</tr>
<tr>
<td>(Béland, 1989)</td>
<td>1989</td>
<td>16,681 individuals</td>
<td>Persons aged 50 years and over in one city, Canada</td>
<td>Continuity was assessed with regard to past volume and past regularity of utilisation. Continuity index for CDP of 9 months was calculated</td>
<td>Data were extracted from a file of physicians’ payments claims for medical care, 1981-1982 to examine effects of patients’ sex, age, diagnosis, &amp; specialist visits on continuity</td>
</tr>
<tr>
<td>(Stewart, 1995)</td>
<td>1995</td>
<td>7 patients</td>
<td>New female patients aged 25-80 years visiting family doctors for a year, in one city, Canada</td>
<td>All visits by the patient to family doctors for a year</td>
<td>All visits to family doctors for a year were audiotaped and analysed to describe and identify themes related to the evolving relationship between the doctor and the patient</td>
</tr>
</tbody>
</table>

- Physicians referred most often to paramedical professionals, problem-oriented clinics and then community centres.
- 40% of physicians do not use existing psychosocial resources.
- Physicians perceived that community centres offered competitive rather than complementary services to theirs.
- Continuity was high when utilisation was regular & of low volume.
- Continuity was higher when there was no chronic illness, and for patients who saw only GPs rather than both GPs and specialists.
- Coordination of care was not measured.
- Three relationship types were identified: 1) brisk, focused, trusting, straightforward & unchanging; 2) tolerant, warm, trusting, complex, & evolving but stable; 3) unfocused, inconsistent, & unstable.
- Themes were context of the visit & continuity.
Norway

Norwegian GPs run their own practices and are paid either on a fee for service basis or are salaried and paid by the local municipality (Hjortdahl 1989). Regardless of the doctor's reimbursement system, all patients pay a set fee directly to the doctor's office (Hjortdahl and Laerum 1992(b)), and all emergency after hours visits by GPs are paid on a fee for service basis (Hjortdahl 1989). In Norway, patients can choose which GP they visit on every occasion they require a primary medical care visit (Hjortdahl 1989; Hjortdahl 1992(d)). Eighty-eight percent of people regarded the present doctor as their 'usual doctor' for all or some of their primary health care needs so in spite of theoretical freedom most people do not exercise it (Hjortdahl and Laerum 1992(b)). There is a referral system so that in principle individuals cannot go directly to a hospital or a specialist. Norwegian GPs are recognised as a geographically stable group; the 'average' GP has worked in their present practice for eight years. Norwegian GPs are recognised for their provision of comprehensive health care services and are highly regarded by their patients for their personal care (Hjortdahl and Laerum 1992(b)).

The Norwegian studies of continuity (Hjortdahl 1989; Hjortdahl 1990; Hjortdahl and Borchgrevink 1991; Hjortdahl 1992(a); Hjortdahl and Laerum 1992(b); Hjortdahl 1992(c)) are summarised in table 2.6.

Chronological care (the provision of care over time) was seen by Norwegian GPs as the most important component of continuity and comprehensive care as the least important. Hjortdahl estimated that accumulated knowledge usually took 5 years or longer, or 4-5 consultations within 12 months to build. Such knowledge allowed GPs a substantial saving in time, especially in consultations with children, the elderly, and those with chronic diseases or psychosocial problems. Accumulated knowledge was also associated with financial savings since laboratory tests were 10 times more likely to be ordered when previous knowledge was scant; and expectant management, more restrictive prescribing of drugs, more ready provision of sickness certificates and more ready referral were more likely if knowledge was good.

Hjortdahl's studies have provided the first empirical, representative evidence from general practice of cost-effective care flowing from continuity of care.
<table>
<thead>
<tr>
<th>Author</th>
<th>Year</th>
<th>Sample size</th>
<th>Subjects</th>
<th>Definition of continuity of care</th>
<th>Aim and Methods</th>
<th>Results</th>
</tr>
</thead>
</table>
| (Hjortdahl, 1989) | 1989 | 207 GPs     | Randomly selected GPs, Norway                                                                 | The extent to which one physician has responsibility for an individual's health care | Questionnaire survey conducted in 1987 about GPs and their practices to give a descriptive account of GPs' age, length of experience in practice, type of practice, accessibility, availability and range of services provided | • GPs had been working in their present practices for an average of 8 years, were available for consultation 28 hours per week, & offered limited access to patients outside face-to-face consultations.  
• 1/3 GPs referred some areas of care rather than providing comprehensive care  
• The majority of GPs provided personal care for individuals & families  
• Salaried GPs had lower continuity of care than self-employed doctors working on a fee-for-service basis |
| (Hjortdahl, 1990) | 1990 | 207 GPs     | Randomly selected GPs, Norway                                                                 | The extent to which one physician has responsibility for an individual's health care | Questionnaire survey conducted in 1987 about GPs and their perceptions of continuity of care | • The majority indicated that while continuity was important in the ideology of family medicine, in reality it had less effect on their own practice  
• Chronological care (the provision of care over time) was seen as the most important component of continuity and comprehensive care as the least important |
Table 2.6, continued

<table>
<thead>
<tr>
<th>Year</th>
<th>Study Source</th>
<th>Methodology</th>
<th>Measure</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>1991</td>
<td>Hjortdahl, 1991</td>
<td>Randomly selected GPs, Norway</td>
<td>GPs’ accumulated knowledge of the patient was self-assessed on a five point range from none to excellent</td>
<td>• Accumulated knowledge took an average of 1-5 years or 4-5 consultations within 12 months to develop&lt;br&gt;• Accumulated knowledge allowed a substantial saving in time, especially in consultations with children, the elderly, &amp; those with chronic diseases or psychosocial problems&lt;br&gt;• Laboratory tests were 10 times more likely to be ordered when previous knowledge was scant&lt;br&gt;• Accumulated knowledge allowed more use of expectant management, more restrictive prescribing of drugs, more ready provision of sickness certificates &amp; more ready referral</td>
</tr>
<tr>
<td>1992(a)</td>
<td>Hjortdahl, 1992(a)</td>
<td>Longitudinal care: the duration of the doctor-patient relationship Density of care: the number of consultations within the last 12 months</td>
<td>Cross-sectional evaluation by questionnaire of consultations conducted in 1987 concerning GPs’ perceptions of continuity of care, knowledge about the patient, and use of resources in the consultation</td>
<td>• Duration and density of care accounted for 52% of the doctor’s accumulated knowledge of the patient&lt;br&gt;• It took at least one year and usually 5 years or longer to build a good or excellent knowledge base&lt;br&gt;• GPs expressed an extended medical responsibility in 75% of encounters</td>
</tr>
</tbody>
</table>
Table 2.6, continued

<table>
<thead>
<tr>
<th>(Hjortdahl, 1992(b))</th>
<th>1992</th>
<th>3,044 patients</th>
<th>Patients of randomly selected GPs, Norway</th>
<th>Longitudinal care: the duration of the doctor-patient relationship Density of care: the number of consultations within the last 12 months Personal doctor: today's doctor was my personal doctor for none, some, most, or all my primary health care needs</th>
<th>Cross-sectional evaluation by questionnaire of 3,918 consultations conducted in 1987 concerning GPs' perceptions about aspects of care Questionnaire assessment of matched patients' identification with the doctor and their satisfaction with the visit</th>
<th>• The present doctor was their usual doctor for all and most primary health care needs for 54% and 34% of patients respectively • An overall personal doctor-patient relationship increased the odds of satisfaction 7 times; duration of relationship was associated with satisfaction after 5 years • In addition to continuity leading to increased satisfaction, satisfaction ratings predict what patients will do the next time they need health services • Dissatisfaction was associated with psychosocial reasons for encounter and visits to salaried rather than fee-for-service GPs</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Hjortdahl, 1992(c))</td>
<td>1992</td>
<td>3,918 consultations by 131 GPs</td>
<td>Randomly selected GPs, Norway</td>
<td>Longitudinal care: the duration of the doctor-patient relationship Density of care: the number of consultations within the last 12 months</td>
<td>Cross-sectional evaluation by questionnaire of consultations conducted in 1987 concerning GPs' knowledge about the patient, and their perceptions of the effect of this on management</td>
<td>• Accumulated knowledge of a patient was helpful in the majority of consultations; • Where accumulated knowledge was lacking this was a hindrance in 44% of visits • Accumulated knowledge of a patient was helpful for psychosocial problems, or general complaints</td>
</tr>
</tbody>
</table>
Sweden

Sweden's primary care system is staffed by salaried GPs who work either in hospital based polyclinics or in health centres (Starfield 1992). The national health service is tax-financed and primary care is organised geographically. In the 1970s Ejlertsson conducted an attitude survey and found that 96% of those interviewed wished to see only their personal physician. In response to the recognition that people valued continuity and that fragmentation of primary medical care had adverse health effects, system-wide strategies to enhance personal continuity in Swedish community ambulatory care centres have been adopted (Ejlertsson and Berg 1984). Access to specialists is both by referral from GPs and self referral. The Swedish community care centres are well regarded for their community orientation and the provision of excellent preventive care for pregnant women and children (Starfield 1992).

The Swedish studies of continuity are summarised in table 2.7. Many of the Swedish studies of continuity have used visit-based measures to examine the associations of continuity. They have shown continuity to be related to scheduled visits (Ejlertsson and Berg 1984; Smedby, Smedby et al. 1984), older persons (Ejlertsson 1980; Ejlertsson and Berg 1984; Smedby, Smedby et al. 1984; Mattsson and Westman 1987) and chronic conditions including diseases of the circulatory system (Ejlertsson 1980; Smedby, Smedby et al. 1984; Mattsson and Westman 1987), non-psychotic mental disorders (Ejlertsson 1980; Mattsson and Westman 1987), diabetes (Smedby, Smedby et al. 1984; Mattsson and Westman 1987) and arthritis (Ejlertsson 1980).

Ejlertsson's study of provider continuity showed that the theoretical maximum continuity was specific to the prevailing health system and in the study setting was 64% (Ejlertsson 1980). Provider continuity was diminished significantly by the introduction of evening clinics (Ejlertsson and Berg 1984). Continuity indices were higher for doctors who had been at the health centre for over a year compared with doctors who had been there less than 12 months (Smedby, Smedby et al. 1984; Mattsson and Westman 1987).

The Swedish studies have been helpful as they have developed and evaluated the performance of the health system with regard to continuity and have identified the patient groups who receive higher levels of continuity. However these studies have not examined the health effects of the provision of continuity within the community ambulatory care centres.
<table>
<thead>
<tr>
<th>Author</th>
<th>Year</th>
<th>Sample size</th>
<th>Subjects</th>
<th>Definition of continuity of care</th>
<th>Aim and Methods</th>
<th>Results</th>
</tr>
</thead>
</table>
| (Ejlertsson, 1980) | 1980 | 2,067 patients | Patients attending a community ambulatory care centre in Dalby, Sweden | K index relates the number of visits to one or different physicians for each patient seen in the centre over a time period | Examination of K index of continuity and demographic and reason for encounter data for all scheduled consultations in 1976 | • Continuity index was higher for diseases of the circulatory system, non-psychotic mental disorders, & arthritis than acute respiratory infections.  
• Continuity index rose with age and was highest in age group >65 years.  
• 64% doctor continuity was the theoretical maximal in that health centre system. |
| (Ejlertsson, 1984) | 1984 | 1,782 patients; 4,722 visits | Patients attending a community ambulatory care centre in Dalby, Sweden | Visit pattern: a patient's sequence of visits, ordered in time with doctors/providers identified | Comparison of SECON, UPC, COC, and K index values were found for elderly compared with younger people who had more scheduled (rather than unscheduled) visits.  
• There was a sharp decline in the centre's continuity (K value dropped from 53% to 42%) with expansion of services to include evening clinics. |                                                                                                                                                           |
| (Smedby, 1984) | 1984 | 47,618 visits | Patients attending a community ambulatory care centre in Tierp, Sweden | The continuity value of a visit is made by comparing the identity of the provider at that visit with providers at earlier visits in the continuity-determining period | Comparison of k, s, f with demographic data for all consultations in 1976-79 | • Continuity was higher for scheduled compared with unscheduled visits.  
• Continuity was higher than average for diabetes and hypertension.  
• Established doctors at the centre provided better continuity than newly employed doctors. |
Table 2.7, continued

| Patients                        | Defined by visit-based measures, \( k, s, f \) and variants, \( K \) index, \( \text{COC}, \text{HH}, \text{UPC} \) | Comparison of \( k, s, f \) and variants, \( K \) index, \( \text{COC}, \text{HH}, \text{UPC} \) for persons making two or more visits during 1979 | • COC was the best measure of continuity using the maximin criterion. • The measures were highly correlated for persons with low and high frequency of visits. |
|---------------------------------|-------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|
| (Smedby, 1986)                  | 1986 7,011 individuals attending a community ambulatory care centre in Tierp, Sweden           | Patients Provider continuity: the extent to which each individual sees only one physician                                        |
| (Mattsson, 1987)                | 1987 1,517 visits Patients attending a community ambulatory care centre in Vännäs, Sweden            | Comparison of random, actual and potential continuity over three 6-week periods during 1978-1979 with demographic data |
|                                 |                                                                                                  | • Actual continuity was consistently higher than random continuity. • Actual continuity increased with the age of the patient but random and potential continuity remained constant. • Mental disorders, diabetes and diseases of the heart attained higher actual continuity than average. • Visits to permanent physicians exhibited the highest actual, random, and potential continuity. |
United Kingdom

In the UK patients must enrol with a GP to access the services provided by the National Health Service. GPs' income is derived from a combination of capitation payments, an amount for overhead expenses, salary, and fee for service for designated procedures (Starfield 1992). Some general practices in UK hold budgets and are referred to as 'fund-holding practices'. GPs in these practices manage their own practices, pharmaceuticals and services by allied health professionals and also purchase selected hospital services on behalf of their patients (Veale and Douglas 1992). Primary care is organised geographically and access to National Health Service (NHS) specialists is by GP referral only. The UK health system is well regarded for its universal coverage despite the relatively low percentage of gross domestic product (GDP) expended on health (Starfield 1994).

A study by Salisbury explored newly enrolled patients' reasons for choosing their new practice (Salisbury 1989). He found that most people changed doctors because they moved residence but waited to register until they became ill. In registering with a GP or practice, most patients exercised little active choice; instead the majority enrolled at the nearest practice or one where other family members were registered.

The focus of continuity studies in the UK has been on evaluations of personal and combined practice lists and their effects on continuity (Aylett 1976; Gray 1979; Ettlinger and Freeman 1981; Freeman 1985; Roland, Mayor et al. 1986; Freeman and Richards 1993; Freeman and Richards 1994). The studies of continuity conducted in the UK are summarised in table 2.8.

Personal care was shown to be higher when GPs operated personal lists (Gray 1979; Freeman 1985; Roland, Mayor et al. 1986; Freeman and Richards 1990; Freeman and Richards 1993). Gray estimated the maximum personal continuity was 75% (Gray 1979). Continuity was associated with patient characteristics such as age over 45 years, an external locus of control, a low extroversion score, and with scheduled visits (Freeman and Richards 1993). On the other hand, discontinuous care was found to be more likely for young, socially disadvantaged people (Shaw and Holloway 1991; Sweeney and Gray 1995) and for those who had been diagnosed with schizophrenia (Shaw and Holloway 1991) or depression (Sweeney and Gray 1995).

Hart and coworkers have shown that 25 years of continuous, systematic case finding and audit in his general practice resulted in a reduction in the
prevalence of several individual risk factors (for example, hypertension). He postulated that this reduced risk had contributed to the lower mortality in the practice compared with a control population (Hart, Thomas et al. 1991).

However other UK studies have not shown significant associations between continuity and quality or other outcomes of care. An immediately satisfying relationship and good communication with the GP were associated with medication compliance (Freeman 1987).
Table 2.8, continued

<table>
<thead>
<tr>
<th>Study</th>
<th>Year</th>
<th>Patients</th>
<th>Study Design</th>
<th>Continuity Measure</th>
<th>Findings</th>
</tr>
</thead>
</table>
| (Roland, 1986)   | 1986 | 128      | Patients in 4 training group general practices, UK | Provider continuity: the identification of one doctor as the provider of primary care for an individual patient over a long period of time, UPC | • Patients in personal list practices had higher continuity scores than others.  
  • GPs agreed that patients should be encouraged to stick to the same doctor. |
| (Freeman, 1990)  | 1990 | 776      | Patients from four group general practices, UK | Defined by UPC for the last 12 consultations | UPC was higher in the practice that used a personal list system.  
  • Compared with children, the elderly had higher continuity of care. |
| (Shaw, 1991)     | 1991 | 190      | Adult patients in one UK hospital | Registration with a GP | Patients who did not know the name of their GP were more likely to be young, single, male, unemployed, and have schizophrenia than others.  
  • Patients in the regional secure unit were significantly less likely to have a GP than others. |
| (Freeman, 1993)  | 1993 | 111      | Patients from three group general practices, UK | Defined by UPC for the last 12 consultations | High received continuity of care was more prevalent in the personal list compared with the combined list practices.  
  • High received continuity of care was associated with age >45 years, an external locus of control, a low extroversion score, and scheduled visits. |
<table>
<thead>
<tr>
<th>Study</th>
<th>Year</th>
<th>Sample Size</th>
<th>Description</th>
<th>Methodology</th>
<th>Findings</th>
</tr>
</thead>
</table>
| Freeman (1994) | 1994 | 99 patients | Patients with epilepsy from 4 group general practices, UK | UPC for the last 12 visits, UPC_{12} | Semistructured interview with epileptic patients aged 15-64 years about psychosocial experiences, & relationship with GPs Medical record review to calculate UPC_{12} | - UPC_{12} was 55%.
- Better continuity was not associated with increased discussion about psychosocial experiences. |
| Sweeney (1995) | 1995 | 110 patients | Patients from one group general practice, UK | Discontinuity; four consecutive consultations that did not occur with the same doctor | Age and sex case-controlled study of discontinuous care using medical records in a personal list practice | - Patients having discontinuous care were more likely to be younger; socially disadvantaged; have relationship problems recorded in the notes; have diagnosed depression; have had 'difficult' consultations; and not to attend appointments than controls.
- Women having discontinuous care were more likely to have vaginal discharge and men having discontinuous care were more likely to have non-cardiac chest pain than controls. |
United States of America

In the USA, the health system is unregulated and private, and fee for service reimbursement predominates. Individuals can consult specialists and primary care physicians directly if the visit is covered by their health insurance, they can pay personally or if they are eligible for governmental assistance (Starfield 1992). Primary care services are provided by doctors from a variety of backgrounds including family practitioners, general internists, and paediatricians. Primary care is not organised on a geographical basis, and the extent of community orientation is regarded as poor. Individuals have variable access to comprehensive, coordinated services (Starfield 1992).

The studies of continuity conducted in the USA are summarised in table 2.9. Many USA studies have examined the process of health care as health outcomes are dependent on the degree to which the clinical elements of health care are assimilated into a consistent problem solving pattern (Starfield, Simborg et al. 1976; Shorr and Nutting 1977; Starfield, Simborg et al. 1977). The integrative component of continuity has been emphasised in the USA since fragmentation is a potential consequence of unrestricted access to services at all levels of the health system (Bass and Windle 1972).

In 1982, Dietrich and Marton reviewed studies which examined the effect of longitudinal care on the quality of health care (Dietrich and Marton 1982). Their review stressed that studies of longitudinal care (defined as 'an ongoing relationship between health care provider and patient that exists over time regardless of the patient's health status') had focussed almost exclusively on paediatric populations. Positive effects of longitudinal care were: improved appointment compliance (in one paediatric experiment (Becker, Drachman et al. 1974(b); Becker, Drachman et al. 1974(c))); improved medication compliance (in paediatric acute illness (Charney, Bynum et al. 1967)); increased mothers' willingness to disclose behavioural problems in their children (in one paediatric experiment (Becker, Drachman et al. 1974(b); Becker, Drachman et al. 1974(c))); increased satisfaction for providers and patients (Caplan and Sussman 1966; Becker, Drachman et al. 1974(b); Becker, Drachman et al. 1974(c); Woolley, Kane et al. 1978).

Other USA studies have shown continuity to be more likely for older persons (Shortell 1976; Shortell, Richardson et al. 1977; Boyle and Rockhold 1979; Chao 1988), women (Boyle and Rockhold 1979), those with chronic conditions (Boyle and Rockhold 1979; Godkin and Rice 1981) and scheduled
visits such as for well-child checks (Breslau and Reeb 1975). Continuity was more likely when care was delivered from private clinics rather than residency-based sites (Breslau and Reeb 1975; Hennelly and Boxerman 1979; Shear, Gipe et al. 1983; Godkin and Rice 1984). Satisfaction with care has been shown to be enhanced by continuity (Shortell, Richardson et al. 1977; Shear, Gipe et al. 1983; Ware and Davies 1983; Wasson, Sauvigne et al. 1984). Indeed, Ware et al. have shown that with each 1-point decrease on the Patient Satisfaction Questionnaire (PSQ) General Satisfaction scale there was a 3.4% increase in probability of provider change in the next year (Ware and Davies 1983). Discontinuous care has also been shown to be associated with more visits (Breslau and Reeb 1975; Bice and Boxerman 1977; Hennelly and Boxerman 1979; Goldberg and Dietrich 1985; Ellsbury, Schneeweiss et al. 1987), increased rates of emergency hospitalisation and longer hospital stays (Wasson, Sauvigne et al. 1984).

Provider continuity did not have a beneficial effect on the rate of complications in pregnancy or on women's satisfaction in one study (Flynn 1985), and in another study participation in research had no effect on patients' willingness to continue a professional relationship with the physician researcher (Sansone, Sansone et al. 1994).

The only randomised controlled clinical trial (RCT) to assess continuity was performed in the USA (Wasson, Sauvigne et al. 1984). This study was restricted to male veterans aged over 55 years and it showed benefits for patients' health and cost-efficiencies for the health system that were attributed to continuity of care. Apart from this study (which may have limited applicability to the wider population), the major benefit attributed to continuity is satisfaction with care.
### Table 2.9  Studies of Continuity of Care conducted in USA

<table>
<thead>
<tr>
<th>Author</th>
<th>Year</th>
<th>Sample size</th>
<th>Subjects</th>
<th>Definition of continuity of care</th>
<th>Aim and Methods</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Bass, 1972)</td>
<td>1972</td>
<td>136 clients</td>
<td>Patients in an inpatient mental health centre; USA</td>
<td>The relatedness between past and present care</td>
<td>Assessment of client movement, client-caretaker relationships, interstaff communication, and client follow-up over one month</td>
<td>• 38% of clients did not receive continuity of care &amp; the most common reason for this was rejection by the patient or a family member of recommended treatment.</td>
</tr>
</tbody>
</table>
| (Breslau, 1975) | 1975 | 63 families | Patients in authors' paediatric practice, USA                            | The extent to which a single physician manages the paediatric health needs of a family | Comparison of continuity in two sites in 1970 (joint private practice) and 1972 (university hospital unit) using interviews in 1970 and 1972, & chart review for the number of visits | • Lower overall continuity for families in the unit compared with private practice.  
• Continuity for well-child visits remained high at 90%  
• Reduced continuity for illness visits in the unit, and increased mean number of visits for illness care in unit compared with private setting |
| (Shortell, 1976)| 1976 | 8,744 person-illness episodes; 1,591 respondents | Patients who had five or more visits during the year, national data collection, USA | The extent to which medical care services are received as a coordinated and uninterrupted series of events | Estimation of Gini and CON continuity indices by age, race, income, and health service utilisation | • Patients who were over 55 years, nonwhite, & below the poverty line had greater continuity than others.  
• Continuity was associated with satisfaction with initial and followup care.  |
<table>
<thead>
<tr>
<th>Study</th>
<th>Year</th>
<th>Count Type</th>
<th>Count</th>
<th>Study Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Starfield, 1976)</td>
<td>1976</td>
<td>1,369 visits</td>
<td></td>
<td>Charts of returning patients attending six clinics affiliated with a teaching hospital, USA</td>
</tr>
<tr>
<td>(Bice, 1977)</td>
<td>1977</td>
<td>73 patients</td>
<td></td>
<td>Hypertensive patients from a primary care clinic, USA</td>
</tr>
</tbody>
</table>

- Recognition of clearly identified problems, therapies and tests was better when there was provider continuity from the index to follow-up visit. 
- Recognition of laboratory tests which were scheduled at intervening visits was extremely low in all clinics. 
- Greater number of visits was associated with less continuity. 
- Contact rates were high, & screening rates were variable, but overall case-finding rates were adversely affected by impaired recognition and diagnostic evaluation rates. 
- Overall management rates were adversely affected by impaired system contact and recognition rates. 
- The continuity of health care process is dependent on the degree to which clinical elements of health care are assimilated into a consistent problem solving pattern.
Table 2.9, continued

<table>
<thead>
<tr>
<th>Reference</th>
<th>Year</th>
<th>Patients/Visits</th>
<th>Type of Patients</th>
<th>Number of Different Contact Points</th>
<th>Comparison of Fee-For-Service and Pre-Paid Plan Care</th>
<th>Continuity and Patient Satisfaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Shortell, 1977)</td>
<td>1977</td>
<td>106 patients</td>
<td>Hypertension</td>
<td>1977</td>
<td>Family practitioners provided better continuity</td>
<td>Family practitioners provided better continuity (fewer contact points for care) than specialist internists.</td>
</tr>
<tr>
<td>(Starfield, 1977)</td>
<td>1977</td>
<td>542 visits</td>
<td>Charts of returning patients</td>
<td>1977</td>
<td>Provider continuity: patients were seen by the same practitioner at the index and follow-up visits</td>
<td>Provider continuity was a positive determinant of patients' satisfaction with care.</td>
</tr>
<tr>
<td>(Boyle, 1979)</td>
<td>1979</td>
<td>95,694 visits</td>
<td>Subsample of the Virginia family practice data system</td>
<td>1979</td>
<td>Patient return rate: proportion of current patients who return to the practice in the following year</td>
<td>Returning patients were more likely to have chronic illness eg diabetes and hypertension than non-returning patients.</td>
</tr>
</tbody>
</table>
Table 2.9, continued

<table>
<thead>
<tr>
<th>Study</th>
<th>Year</th>
<th>Sample Size</th>
<th>Description</th>
<th>Measure</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Hennelly, 1979)</td>
<td>1979</td>
<td>1,410 cases</td>
<td>Subsample of a national sample of individuals using health care services, USA (demographic data are not reported)</td>
<td>Provider continuity: the patient could identify a specific physician as his (sic) regular source</td>
<td>Survey of individuals regarding their utilisation and costs of health services in 1970 to determine the extent to which continuity, operationalised in the referral process, specifies the relationship between structure and utilisation. The patient's payment method, severity of his (sic) illness, and the referral process significantly influenced the number of physician visits during an illness episode. Number of visits increased as continuity decreased; clinic users made more visits than patients in a group or non-group setting.</td>
</tr>
<tr>
<td>(Godkin, 1981)</td>
<td>1981</td>
<td>1,464 episodes</td>
<td>Patients seen at 4 family health centers, USA</td>
<td>Continuity index: the average number of visits made by a patient divided by the average number of providers encountered</td>
<td>Review of 14 diagnoses, 6 chronic and 8 acute conditions, for all episodes (2 or more visits with the same diagnosis) at 4 family health centers, 1978-79. No significant difference in the mean number of visits made for a chronic diagnosis or an acute illness. The mean continuity index was higher for chronic diagnoses studied (anxiety, depression, diabetes, hypertension &amp; obesity).</td>
</tr>
<tr>
<td>(Shear, 1983)</td>
<td>1983</td>
<td>117 women</td>
<td>Women delivered of a live infant at one medical centre, USA</td>
<td>SECON was measured as an index of provider continuity</td>
<td>Chart review and questionnaire study to measure the association between provider continuity, satisfaction and quality of ambulatory pregnancy &amp; delivery care in 1981. Women attending the family practice clinic had higher sequential continuity than those seen at the obstetric clinic and there was a trend to higher satisfaction among these women. Babies of women attending the family practice clinic had higher birth weights than others.</td>
</tr>
</tbody>
</table>
Table 2.9, continued

| (Ware, 1983)  | 1983 | 1) 323 persons  
|             |     | 2) 432 persons  
|             |     | 3) 279 persons  
|             |     | 4) 1,314 persons |
|             |     | 1) Mainly black  
|             |     | residents, Illinois  
|             |     | 2) Mainly white  
|             |     | residents, Illinois  
|             |     | 3) Mainly white  
|             |     | residents, Ohio  
|             |     | 4) Residents in California, USA |
|             |     | Continuity of care:  
|             |     | seeing one's regular doctor  
|             |     | Continuity score = 0 if 50% or more visits were with the one provider, 1 otherwise  
|             |     | * Those rating financial arrangements and continuity favourably were significantly more likely to seek care for muscle aches.  
|             |     | * With each 1-point decrease on the PSQ General Satisfaction scale there was a 3.4% increase in probability of provider change in the next year.  

| (Godkin, 1984) | 1984 | 20,000 patients  
|               |     | Four family health centres, USA  
|               |     | The degree to which the medical care of an individual patient is provided by a single physician  
|               |     | Measurement of MCI, COC, and SECON from utilisation data 1978-1979 to compare residency-based centres with others  
|               |     | * MCI, COC, and SECON were all higher in the non-teaching health centre than in the residency-based site.  

| (Wasson, 1984) | 1984 | 776 men patients  
|               |     | Men aged 55 years and over attending a veteran's clinic, USA  
|               |     | Provider continuity: percentage of total medical visits a patient experienced with their primary provider, & COC index  
|               |     | Double-blind randomised trial to compare the effect of provider continuity vs provider discontinuity on the process and outcome of medical care between 1979 & 1980  
|               |     | Records were reviewed and patients completed a questionnaire to assess their functional ability, attitudes to & utilisation of the health service  
|               |     | * Patients receiving discontinuous care had a 2-fold increase in emergency hospital admissions & hospital days.  
|               |     | * Patients in the discontinuous group were less satisfied with continuity and educational aspects of their care, & felt providers were less knowledgable & less thorough than patients in continuous groups.  

<table>
<thead>
<tr>
<th>Study (Year)</th>
<th>Year</th>
<th>Count</th>
<th>Setting</th>
<th>Methods</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Flynn (1985)</td>
<td>1985</td>
<td>61</td>
<td>Pregnant patients of a university-based family medicine residency practice, USA</td>
<td>COC index to assess provider continuity during the antenatal period and delivery</td>
<td>The effect of provider continuity on obstetric outcome assessed by chart audit &amp; questionnaire survey of attitudes to and satisfaction with care</td>
</tr>
<tr>
<td>Goldberg (1985)</td>
<td>1985</td>
<td>1,327</td>
<td>Adult patients of 40 physicians within a 40 km radius of a University Medical Centre, USA</td>
<td>The proportion of visits that a patient received from their primary physician, measured by UPC and number of providers seen in one year</td>
<td>Retrospective chart audit to determine whether medical subspecialists were providing more or less continuity to their adult, primary care patients (study year not reported)</td>
</tr>
<tr>
<td>Ellsbury (1987)</td>
<td>1987</td>
<td>12,928</td>
<td>Services provided by 35 senior FP residents (number of services not reported)</td>
<td>Continuity: the likelihood of a patient seeing one or two senior residents on 4 follow-up visits</td>
<td>Analysis of database for billing of services to determine the degree of continuity of care provided by residents in model teaching units, 1985-1986</td>
</tr>
<tr>
<td>Chao (1988)</td>
<td>1988</td>
<td>147</td>
<td>Adult patients from a private group family practice, USA</td>
<td>Defined by COC, and UPC</td>
<td>Cross-sectional random sample survey using a perception of continuity (PC) scale, utilisation and demographic data</td>
</tr>
</tbody>
</table>

- Provider continuity demonstrated no beneficial effect on the rate of pregnancy complications or on satisfaction.
- All physician types saw their primary care patients between 78 and 83% of the time.
- UPC scores declined with increasing utilisation.
- 44 - 81% of patients with four visits saw one or two senior residents.
- Continuity of care deceased proportionately with increasing numbers of visits.
- High perceived continuity in the sample, increasing with age.
- Two factors were identified in the PC scale: structural factors and interpersonal elements.
- The PC scale was correlated with satisfaction.
### Table 2.9, continued

<table>
<thead>
<tr>
<th>Study Reference</th>
<th>Year</th>
<th>Sample Size</th>
<th>Setting</th>
<th>Patients Aged ( \geq )35 Years</th>
<th>Study Description</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Gabel, 1993)</td>
<td>1993</td>
<td>60 patients</td>
<td>Patients from 4 family practices, USA</td>
<td></td>
<td>Ethnographic study using structured interview</td>
<td>- Main factors contributing to maintenance of continuous relationships were patient familiarity with the physician, physician knowledge of the patient, patient satisfaction with care received, and patient confidence in the physician.</td>
</tr>
<tr>
<td>(Sansone, 1994)</td>
<td>1994</td>
<td>261 women patients</td>
<td>Patients in one health maintenance organisation (HMO), USA</td>
<td>Patient initiated changes in primary care physician</td>
<td>Comparison of recorded patient initiated changes in primary care physician between a group involved in psychological research and a control group matched by height, weight, length of study interval, &amp; type of service at HMO</td>
<td>- Participation in the psychological study had no effect on the willingness of patients to continue a professional relationship with the physician researcher.</td>
</tr>
</tbody>
</table>
Summary and conclusions

Early definitions of general practice emphasised the personal delivery of medical care by one doctor who was regarded as being responsible for that patient's medical care over extended periods of time. This notion came to be called continuity of care and, it has been variously defined and conceptualised. Chronological, geographic, interdisciplinary, informational, relationship, stability, and accessibility factors have been used to describe this complex phenomenon.

Continuity indices have been developed to evaluate continuity so that its extent and effects could be measured. Individual-based measures have been used where benefits of care are a focus, while visit-based measures have utility in assessing the performance of health systems. Although many studies have failed to demonstrate any health consequences of continuity, Hjortdahl's Norwegian studies and a randomised controlled trial in the USA point to efficiency benefits that could be attributed to continuity of care. No studies have shown ill effects of continuity although some authors have expressed caution regarding generalisations about continuity of care based on anecdotal experience.

This review has highlighted the groups who have been shown to be more likely than others to experience single provider continuity. They are people who make scheduled rather than emergency visits, the elderly, and persons with some chronic conditions. In several health systems, higher levels of continuity have been experienced by patients with cardiovascular disease, diabetes and mental illness.

Freeman and Gray in the UK and Stewart in Canada have identified that doctor-patient relationships characterised by trust and clear communication were more likely to lead to continuity of care. Also continuity has been associated with provider and patient satisfaction that in turn makes future continuity more likely. Although the importance of the doctor-patient relationship in continuity is acknowledged in the literature, this dimension cannot be quantified. Highlighting this dilemma, Steinwachs has said that 'provider continuity is not a simple and unidimensional process and no single measure can be expected to address adequately all questions' (Steinwachs 1979).

A Canadian study of referral continuity showed that continuity was impaired when a doctor perceived that the other services were competitive
rather than complementary to their own. In an era where competition is fostered as a mechanism to enhance cost-effectiveness, this is a significant issue for health care systems (including the Australian one) that have explicit policies designed to facilitate continuity.

I have shown that clinicians, researchers, teachers, health service evaluators, and consumers perceive and value continuity differently. Consumers have stated that the doctor-patient relationship and coordination aspects of continuity of care are important to them, but to date, little research has focussed on their views about continuity. Such conceptual work is a prerequisite for understanding the effect of external factors, such as mobility of both doctors and patients, on continuity of care. Also a conceptual framework that incorporates the consumer perspective will facilitate meaningful evaluation of continuity in terms of quality of care and health outcomes.

As continuity and longitudinal care are integrally related to the health care system in which the visits are enacted, studies are needed in each of these contexts. Since comparatively little research has been conducted in Australia, there is a need for a research-based understanding of continuity of care and doctor-patients relationships in Australian general practice. These will be useful for the evaluation of Australian general practice and consequent health service policy reform.
CHAPTER 3

Methodology

'What we take to be objective knowledge and truth is the result of perspective' (Schwandt 1994).

This research was conducted to find out more about continuity of care in Australian general practice. I realised that the views of both consumers and general practitioners (GPs) would need to be sought to help gain a fuller understanding of the factors that people weighed when they decided to see a particular doctor. Also the interaction itself between the consumer and GP had to be examined to see how the dynamics between the participants effected their experience of GP care. Because a wide range of issues had to be explored, I developed a multi dimensional study design.

Methodology

Multiple methods

Table 3.1 (over) provides an overview of the studies comprising the research program. Both quantitative and qualitative methods were used to build a multi-faceted view of peoples' experience of GP care.
### Table 3.1, continued

<table>
<thead>
<tr>
<th>STUDY</th>
<th>AIM</th>
<th>POPULATION</th>
<th>TECHNIQUE(S) USED</th>
</tr>
</thead>
</table>
| 4. *Seeing doctors*  
(Intake survey of patients) | a) To explore whether consumers chose a doctor prior to the consultation.  
b) To examine the rationale for consumer choices.  
c) To describe the demographic and illness profile of patients attending selected general practices for comparison with studies 6 and 7. | Patients attending nine purposively sampled general practices in urban and rural NSW.  
n=802 | Self-completed brief questionnaire. |
| 5a. *GP interviews*  
(Detailed interviews with GPs) | To discuss patients who were frequent attenders, to explore continuity and discontinuity of care, management of uncertainty, and concepts of ideal general practice care with GPs. | Purposive sample of experienced GPs, stratified by gender, practice location and qualifications.  
n=24 | Semi-structured detailed interviews. |
| 5b. *Consumer interviews*  
(Detailed interviews with consumers) | To explore continuity and discontinuity of care, management of uncertainty, and concepts of ideal general practice care with consumers (who were frequent attenders). | Purposive sample of consumers who were frequent attenders at general practice(s) in the previous year, stratified by gender, age and practice location.  
n=24 | Semi-structured detailed interviews. |
| 6. *Health diary study*  
(Longitudinal diary study with consumers) | To explore consumers' rationale for their choice of GP over a nine month period.  
To develop a typology of general practice utilisation. | Purposive sample of consumers who were frequent attenders to general practice in the previous year, stratified by gender, age and practice location.  
(Half the participants were interviewed in study 5b).  
n=48 | 1. Diary record of all visits to GPs.  
2. Brief, semi-structured interviews conducted by telephone at monthly intervals. |
The epidemiological studies
I began the inquiry with survey-based descriptive epidemiological studies (Kleinbaum, Kupper et al. 1982; Hennekens and Buring 1987) that were designed to provide an overview of the factors that are associated with satisfaction with GP services, use of multiple GPs, and the extent to which Australians identify with a regular doctor or practice. These studies, which are summarised below, helped define the field of the research inquiry and located my clinical experience within an epidemiological context.

Three surveys were conducted: Consumer use of multiple general practitioners, A doctor of one's own?, and Seeing doctors. The first of these studies described both the prevalence of persons seeing more than one GP in the preceding year and the general characteristics of these people. This study included an examination of basic demographic factors, lifestyle variables and indices of satisfaction.

The second study, A doctor of one's own? added descriptive information about the proportion of people identifying with and consulting their 'usual GP'. Table 3.1 shows the aims, population and methods for these two studies which are presented in chapter 4.

The Seeing doctors survey, described in chapter 6, sought information about consumers' choice of doctor immediately prior to a consultation and described the demographic and illness profiles of patients attending nine selected general practices. This last aim allowed me to compare those people who were interviewed (Consumer and GP Interviews and Health diary study) and the wider patient group who attended the same general practices.

For the Seeing doctors study, I framed questions in the language people used during the preliminary interviews (described below). These draft questions were modified in the light of advice from the reference groups and following piloting. I was available to talk with respondents while they were completing the questionnaire. This allowed respondents to discuss the context from which the questions were derived and provided them with additional information about the study and its aims.

However the interpretation of the factors associated with people seeing multiple GPs was fraught with difficulty and necessarily speculative. Were identifiable groups (such as younger persons or women who had seen more
than one GP in the preceding year) acting similarly for the same reasons or were their actions the result of complex interplays between heterogenous factors? Such questions demanded more qualitative research and longitudinal studies (Mant 1990).

Qualitative research
Qualitative research is 'multimethod in focus, (and) involv(es) an interpretative, naturalistic approach' (Denzin and Lincoln 1994). Various qualitative approaches are associated with differing interpretive paradigms and perspectives (Denzin and Lincoln 1994), and with differing research interests (Tesch 1990).

The qualitative component of this research uses a constructivist framework which 'assumes a relativist ontology (there are multiple realities), a subjectivist epistemology (knower and subject create understandings), and a naturalist (in the natural world) set of methodological procedures' (Denzin and Lincoln 1994).

From a constructivist perspective, Guba and Lincoln emphasise that reality is local, specific, multiple, and relative (Guba and Lincoln 1994). This ontological position (which addresses the form and nature of reality and, therefore, what can be known about reality) informs and constrains the epistemology. Epistemological questions explore the relationship between the knower and what can be known. Within a constructivist framework, knowledge is created by interaction between people; this stands in contrast to the view that facts have an objective and separate existence. Finally, methodological questions address the way in which an inquirer develops a strategy or plan of action to link methods to the desired outcomes of the research. The constructivist methodology employs both hermeneutic techniques and dialectical interchange to interpret the understandings that have been generated by interactions between the investigator and research participants. A concern for unitary truth is replaced by a concern for a sophisticated statement of understanding for which there is a reasonably

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1 A paradigm is 'a basic set of beliefs that guide action' (Guba 1990) which contains the researcher's ontological, epistemological, and methodological premises (Denzin and Lincoln 1994).
high degree of consensus among those perceiving and interpreting a situation or event (Guba and Lincoln 1989; Baum 1995).

One feature of the constructivist position is that unmediated knowledge is not possible since the knower is deeply embedded in that which is known. Acknowledging this, and the central role of values in the inquiry process, constructivist qualitative research demands that the researcher identifies her/himself as a subject in the inquiry, and as a person with a biography that influences and informs her/his gaze and inquiry. The introductory chapter to this thesis outlines some autobiographical details relevant to the research.

A social constructivist inquiry seeks to hear stories from participants to form a coherent account that becomes 'an expression of relationships among persons' (Gergen and Gergen 1991). Although each story is partial and reflects the purpose for which it was told, social constructivists focus on the collective generation of meaning as shaped by conventions of language and other social processes (Schwandt 1994).

Two sets of criteria for judging the quality of a constructivist inquiry have been developed. The first criteria, proposed by Guba, address the issue of trustworthiness of the data (Guba and Lincoln 1989; Guba and Lincoln 1994). These criteria parallel positivist procedures for demonstrating rigour, and comprise credibility, transferability, dependability and confirmability. Credibility has been conceptualised as arising from the researcher's prolonged and in-depth engagement with the research problem, personal reflective practice and reflection with peers and stakeholders to monitor subjectivity and emergent understandings, and a thorough search for disconfirming evidence (Guba and Lincoln 1989). More recently, additional
notions of fairness\(^2\), and ontological\(^3\), educative\(^4\), catalytic\(^5\) and tactical\(^6\) authenticity have been proposed (Guba and Lincoln 1989; Guba and Lincoln 1994). These latter criteria assess the whole inquiry process rather than focusing on data quality.

Patton discusses the issues of credibility in qualitative research from the pragmatic standpoint of an evaluator. He states that there are three areas for scrutiny: the philosophical underpinning of the research; the credentials of the researcher in terms of credibility, competence, and perceived trustworthiness; and the extent to which rigorous techniques have been employed in data gathering and analysis (Patton 1990).

Triangulation is a strategy for strengthening study design. It was first described by Denzin who asserted 'because each method reveals different aspects of empirical reality, multiple methods of investigation must be employed' (Denzin 1978). Denzin described four types of triangulation: data triangulation, that is different data sources are used; investigator triangulation where different researchers are involved in the study; theory triangulation wherein data are interpreted using varying theoretical

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\(^2\) Fairness has been conceptualised as the extent to which different constructions and their underlying value structures are solicited and honoured within the evaluation process. This involves the identification of stakeholders and open negotiation of recommendations and subsequent actions.

\(^3\) Ontological authenticity refers to an improvement in the individual's or group's conscious experiencing of the world. This change can be documented, for example, in testimonies or an audit trail.

\(^4\) Educational authenticity is seen when an improved understanding emerges between different groups. This change can be documented, for example, in testimonies or an audit trail.

\(^5\) Catalytic authenticity refers to the extent to which action is stimulated and facilitated by the evaluation process. These actions can be documented, for example, by individual testimony, or an audit trail which show that joint negotiation and systematic followup were integral to the research process.

\(^6\) Tactical authenticity refers to the extent to which stakeholders and participants were empowered to act during and following the research.
traditions; and methodological triangulation which includes the use of multiple techniques to study the research problem (Patton 1990). Janesick has proposed the use of interdisciplinary triangulation as both a counter-hegemonic strategy and a means of strengthening study design (Janesick 1994).

In a constructivist study, the use of triangulation reflects the value of drawing on multiple perceptions in a dialogic context, rather than as a device to define intersections between differing viewpoints that might bound a unitary reality (Denzin and Lincoln 1994).

The ethical issues that arise in research of all kinds relate to physical and psychological harm, consent, deception, privacy, and confidentiality of data (Punch 1994). These dilemmas arise in interactions where there are power differentials or where the report of an interaction might disempower and disadvantage the informant. The authentic engagement of constructivist research offers some solutions to these ethical dilemmas. Fine puts this elegantly as she describes the constructivist task:

'... that researchers stop trying to know the Other or give voice to the Other (Scott, 1991) and listen, instead, to the plural voices of those Othered, as constructors and agents of knowledge.' (Fine 1994) (emphasis in the original).

The qualitative studies
The qualitative studies involved individual and focus group interviews.

The preliminary studies, called Consulting Colleagues and Consulting Consumers, were structured interviews conducted by telephone that sought to establish whether matters related to dissatisfaction, changing doctors and continuity of care were issues that people were prepared to spend time exploring with me. Was my approach seen as 'worth a go' with all the uncertainty that such exploration entails? The preliminary interviews were encouraging and pointed to the need for further research. They also indicated that I would be able to attract freely consenting participants to the subsequent studies. Table 3.1 shows the aims, population and methods for this study which is presented in chapter 5.

The major qualitative studies consisted of individual interviews with consumers and GPs (called Consumer Interviews and GP Interviews), and a
longitudinal study of consumers' experience of continuity and discontinuity of care, the management of uncertainty and concepts of ideal general practice care (called Choosing Doctors). Again, table 3.1 shows the aims, population and methods for these studies which are presented in chapters 7 and 8 respectively.

The Consumer and GP Interviews were semi-structured so similar scenarios and issues were covered in the 48 interviews but there was also scope for each participant to explore other issues as they wished. Each interview was conducted face-to-face in a conversational style. I commenced with an inquiry about the person's most recent experience so that the discussion was grounded in a particular and contemporary interaction. Participants were invited to reflect on the significance and consequences of those interactions and to ponder alternative processes that might have led to more satisfactory outcomes. The final part of the interview asked the participant to begin to generate visions of future, more ideal, interactions in general practice.

Health diaries have been used as a tool to gather data prospectively about morbidity, disability and health-related actions (Verbrugge 1980). In the longitudinal Health diary study, diaries were used to collect prospective information about consumers' visits to GPs and as a memory aid for the consumer when we discussed these visits during monthly telephone interviews.

The sequential interviews that were part of the longitudinal study opened with a semi-structured format and then provided an opportunity for participants to discuss matters of concern in an unstructured narrative interaction.

Reference groups
Reference groups of consumers and GPs were convened for the middle two years of the research program. Each group met on five occasions to examine practical and theoretical aspects of the research program. The substantive findings from these meetings are presented in chapter 9. The groups were somewhat structured for the first meeting and became progressively less structured in keeping with the exploratory and constructivist nature of this study.
Consumers were the critical reference group\(^7\) for this inquiry. This contrasts with earlier research on 'continuity of care' where GPs were the reference group (often, by default). The iterative group discussions also provided an opportunity for information exchange between the groups thus allowing significant perceptual differences between the two groups to be identified (Guba and Lincoln 1989; McGuiness and Wadsworth 1991). Additionally the groups acknowledged that innovations that might arise from the research would have to be acceptable to both groups (perhaps after negotiation or a phase of dialogue) for implementation to be practicable. Wadsworth and coworkers and Summers had shown the need for such dialogue in their work (Wadsworth 1984; McGuiness and Wadsworth 1991; Wadsworth 1991; Summers 1993).

One of the aims of the inaugural reference group meetings was to provide advice about the language I should use for the questions in the *Seeing doctors* survey and the more detailed interview study (chapters 6 and 7).

The consumer group thought that great care should be taken with the choice of word for the respondents to the survey and participants in the interview and *Health diary* studies. They discussed their own preferences regarding language and voiced differing views about each of the terms: 'consumer', 'client', and 'patient'. Each of the views, below was expressed by a consumer.

For 'consumer':

*If you are the consumer of services provided by a professional, you choose the professional and you choose the service you want.* (Paul)

\(^7\) Wadsworth describes the several elements that comprise a critical reference group perspective. This involves an identification of the interests of those meant to be served by the service, who may be currently suffering disadvantage, discrimination, deprivation or injustice or otherwise identifiably unmet needs. Also important is identification with those interests; a profound respect for those belonging to the critical reference group; a sharply-felt dissatisfaction with any adverse conditions effecting the group; and a consequent commitment and determination to work towards the best way of overcoming these conditions (Wadsworth 1991).
For 'client':

We tend to use (the term) 'client' because it denotes consumer quality service which has been provided by the professional. (Kirk)

Against 'client':

I've (seen some) services where people talked about clients and treated them like dirt. (Jenny)

For 'patient':

When we're talking about a GP and the person there relating to an individual, I'm on the whole comfortable about the (designation) 'patient' (but) when we're talking about a group of them I'm much less comfortable about it. (Jenny)

Against 'patient':

We are definitely not patients and I would think that we are not patient (in the sense of waiting submissively); 'patient' reminds me of the old form of the doctor in a white coat and the patient being the person who is being treated without consent; 'Patients' well that sounds a bit callous and (deals only) with complications and illness, ... but quite often people do come to the practice for prophylactic treatment. (Kirk)

No-one spoke against the term 'consumer' and those who preferred the term 'client' mentioned the word 'consumer' in their explication of the term. There was agreement in the group that this label was not entirely appropriate because of the connotation of destruction and squandering, but it was thought to be the best description presently available and I have used it throughout the research.

During the consumers' discussion of methodology there was interest in matters to do with consent, confidentiality and interactions with people who declined involvement in the study. The GP group's methodological suggestions related to sampling, obtaining consent from patients and conduct of research in general practice settings.

The institutional ethics committee had proposed that people visiting the practice on the day(s) the study was in progress should be informed of the study and recruited for it by the non-medical practice staff to protect against
infringement of doctor-patient relationships. The consumers and GPs disagreed with that view. Several GPs mentioned that the relationship between patients and receptionists could be strong and they felt that ethical concerns about infringement of doctor-patient relationships applied equally to relationships with other practice staff. They were unanimous that people should be made aware of the study by a prominent poster which the practice staff could draw to their attention. They thought that I should seek each individual's consent to participate in the study because this was more direct and would protect those who declined from coercion. Consumers also thought that names should not be included on the survey forms. Most group members thought that non-respondents would not mind being asked about their age if it were explained:

You could say, 'Well OK if you don't want to do this, do you mind telling me what your age is and just let it go at that. ... Say, 'It's for my statistics - give them a reason for doing it'. (Paul)

The GP group's concern about the impact of the research in a busy general practice suggested that I would have to tailor my approach, be aware of practice variations in workloads and waiting times from day to day, acknowledge the demand on practice staff, observe the intensity of staff-patient relationships, and be available to help consumers with completing questionnaires.

After these meetings I contacted the institutional ethics committee and outlined the reference groups' advice. Their suggestions were ratified and I followed them.

Institutional ethics approval
Institutional ethics approval was gained for all the studies in this research program. A lengthy process was undertaken to gain privacy and ethical approval for The NCEPH record linkage pilot study (McCallum, Lonergan et al. 1993). Consumer use of multiple general practitioners was part of this larger project. Approval was granted by the respondents to the 1989 National Heart Foundation Survey, the Australian National University Ethics in Human Experimentation Committee, the Commonwealth Minister of Health, the Commonwealth Privacy Commissioner, the Health Insurance Commission, and the Health Care Access Division, Department of Health, Housing, Local Government and Community Services.
The preliminary studies, *Consulting Colleagues* and *Consulting Consumers* were approved by the ethics Committee of the National Centre for Epidemiology and Population Health. Approval for the *Seeing doctors* questionnaire, the interviews and the diary recordings (*Health diary study*), and both reference groups was obtained from the Australian National University Ethics in Human Experimentation Committee and the Royal Australian College of GPs' Ethics Committee.

As I have indicated, a particular ethical concern in all these studies was that the research should not impact adversely on the doctor-patient relationship. The staff at each practice let it be known that a research project was being conducted at the rooms. All intending patients arriving at the practice for an appointment and those ringing or presenting in person to make an appointment for a consultation were told that the practice was hosting university research on that day. Also a sign was placed adjacent to the reception desk informing all potential patients about the research. Patients were informed that questions about the research would be welcomed by the practice staff, GP(s) and me. Two opportunities were given for patients to decline involvement without explanation or obligation. It was made clear that the doctor(s) would never know whether an individual had agreed or not to be involved. Specific consent to complete a short questionnaire, was requested by me. This design differed from others described in the Australian general practice literature (Steven and Douglas 1988; Lloyd, Lupton *et al.* 1991) in that informed consent was sought by the researcher not the practice staff so that pre-existing relationships were not intruded upon.

Consent for continuing involvement in the research project (volunteering for an in-depth interview and or diary recording) was sought at the end of the questionnaire. I was available in the waiting room to answer any questions and to explain the demands of further involvement, as required. People were assured that there were no health risks associated with the research and that their privacy and confidentiality would be protected.

In my research discussions (where the goal was to understand the participant's views and experiences, in so far as they wished to explore and discuss them), I asked participants to consent to involvement in an exploratory process. Concurrently I made explicit statements to indicate that they had, and could exercise, the option to withdraw without prejudice and rescind the approval for use of quotations as they wished. In addition, all
participants were aware that I was a GP with knowledge of community and health services. Privacy was discussed and I asked each person to choose a *nom de plume* for the research process. Some people took up this offer but many participants said that they wished to be identified so they could be linked to their comments and views.

Throughout the research endeavour I accorded respect and autonomy to each respondent and participant. Confidentiality was protected by secure housing of data, the decision for tape transcription to be carried out in a different state from the one where the interviews were carried out, and by member checks during reference group discussions. Once data were entered on to a computer these were protected by the use of a password thus preventing unauthorised access.

**Methodological summary**

The purpose of my research was to gain a detailed understanding of the problems experienced by people who changed doctors and were unsatisfied and frustrated with aspects of their general practice care. This research sought the views of many people, both as they recalled the experience and as they lived it. While no one account would be 'right' or 'truer than another', each would contribute to a fuller understanding of 'the phenomenon'. In keeping with a constructivist approach, a composite picture of continuity of care and relationships in general practice was created from the elements provide information about the richness and diversity of these social experiences (Guba and Lincoln 1994; Neuman 1994).

This understanding, and an exploration of the related issues would be the basis for a grounded theory of continuity of care in Australian general practice.
CHAPTER 4

Consumer use of multiple general practitioners, and
A doctor of one's own?

Introduction
The two surveys reported in this chapter, Consumer use of multiple general practitioners and A doctor of one's own?, provide a descriptive account of the reasons consumers gave for seeing more than one general practitioner (GP), and a population estimate of the proportion of respondents who consulted their 'usual doctor' on their last visit. Consumer use of multiple general practitioners was published in Family Practice in September 1995 and is reproduced in appendix 4.1.
Consumer use of multiple general practitioners

Background

The utilisation data from the Health Insurance Commission (HIC) show that the majority of Australians see more than one GP annually (Health Insurance Commission 1992). However the reasons for this utilisation pattern have not been examined in detail.

Nationally, 26% of Australian GPs are in solo practice (Bridges-Webb, Britt et al. 1992), so it is possible that some of the visits to different GPs recorded by the HIC are visits to a dual GP, or group, practice.

Some of these visits to different doctors may reflect dissatisfaction with previous consultations. In a convenience sample of 333 patients from four urban general practices, Lupton et al. found that 24% of respondents had ever changed doctors (Lupton, Donaldson et al. 1991). A minority gave a reason for the change of doctors; 10% of the sample citing factors relating to problems with access to consultations, 10% stating problems with the doctor's competence, and 8% for problems associated with the doctor-patient relationship. Lupton et al. developed a classification based on the features of respondents' explanations for initial choice of doctor, reasons for continuing to attend a doctor, and rationale for changing doctors. These were accessibility, instrumental, and affective features, features of continuity of care, recommendation, and other features.

Similarly in the United States, a relationship between patient satisfaction with medical care and subsequent change of doctor has been demonstrated. Marquis et al. have shown a linear relationship between dissatisfaction and provider change (Marquis, Davies et al. 1983). However in the United Kingdom the situation is different. Salisbury surveyed new registrants with five general practices there and found that the majority changed doctors because they had moved to a new area, while 10% of people who changed GPs did so for convenience or because of dissatisfaction with the last doctor (Salisbury 1989).

Clearly, satisfaction is a major issue when people choose a doctor. Empirical research on satisfaction in general practice shows that patients distinguish many components of satisfaction. Zastowny et al. have demonstrated that satisfaction related to patient-doctor contact can be distinguished from global satisfaction (Zastowny, Roghmann et al. 1989). They showed that it is this
specific satisfaction that is causally related to use of health services and that it is context specific. Salisbury in the UK found that predictors of consumer satisfaction with GPs were 'the giving of information by the general practitioner, the general practitioner's medical skills, the general practitioner's (inter)personal skills, and faith in doctors' (Salisbury 1989). He found that older people were more satisfied with most aspects of their primary health care; a finding that is consistent with Australian research on satisfaction with general practice (Steven and Douglas 1988; Dickens, Browning et al. 1993). Salisbury also found that women tended to be slightly less satisfied overall with their primary care and that social class, educational and health status were not significantly related to satisfaction (Salisbury 1989). Penchansky et al., in the United States, have shown that those with less education were more satisfied with access to services (Penchansky and Thomas 1981) and in Australia Lloyd et al. found that high and low-status respondents did not differ significantly on matters relating to changing GPs (Lloyd, Lupton et al. 1991).

**Aims**

The aims of this study were to explore the reasons why Australians visited more than one GP, and to examine the sociodemographic and interactional factors that were associated with this pattern of GP service use. This study was the general practice component of a larger study based in Canberra, Australia, 'The NCEPH Record Linkage Pilot Study' (McCallum, Lonergan et al. 1993).

**Definition:**

For the present study, multiple GP use was defined as the service utilisation pattern where more than one GP was seen during the preceding 12 months.

**Method**

In 1992 a team of researchers performed a follow-up survey of residents who had participated in the 1989 National Heart Foundation Cardiovascular Risk Factor Screening Survey in Canberra (National Heart Foundation 1990). Subjects for that survey were selected from the electoral roll (n=981 of 1500 identified on the roll). National Heart Foundation staff gained informed consent from the original participants who were willing to be contacted about the follow-up study. Five hundred and eighty people (59 percent) were contacted and agreed to participate, 183 (19 percent) were contacted and refused, and 218 (22 percent) were untraceable. Subsequently, at the time of the interview, twenty-five people either refused to complete the interviews
or could not be contacted. For the present study, a questionnaire was administered by trained research assistants to 555 people during an hour-long interview.

The questionnaire sought information about health service use, health conditions, women's and men's health, satisfaction with services, health behaviours, private health insurance and detailed demographic information.

Utilisation of more than one GP was examined in terms of sociodemographic factors, health status and satisfaction with the last general practice visit.

The respondent's sociodemographic characteristics were examined: age - grouped by decade; gender - male or female; and ethnicity - respondents designated their country of birth. The responses were grouped as those who were Australian born, those born in another English-speaking country (UK, Ireland, North America and New Zealand) and 'Other'. Socioeconomic status was assessed using educational achievement (at primary, secondary and tertiary levels) and occupation.

General self-rated health for each respondent was appraised by self-report (ranging from excellent to poor). In addition, respondents reported the number of GP visits in the preceding year, whether they had experienced depression during that year, and the nature of current health problems.

To investigate satisfaction with the last GP visit, respondents were asked, "With regard to the last time you consulted a general practitioner, how would you describe the service you received?" The reasons for the satisfaction rating were sought in an open-ended question, "Why do you say that?" Responses were grouped according to an expanded range of Lupton's categories (Lupton, Donaldson et al. 1991). Accessibility features included proximity to a GP, patient's convenience, availability of bulkbilling, and locational change by either the patient or GP. Instrumental features included the patient's assessment of the attending GP's competence, preventive activity, practice organisation and availability of special services in the practice. Affective features included communication between the patient and GP, patient expressed gender preference of GP, and GP speaking a language other than English. Similarly, the reasons given for seeing more
than one GP in the previous year were characterised as accessibility, instrumental and affective.

Analysis
Univariate analysis using the Chi-square test and the Mantel-Haenszel test for trend was performed to determine whether there was an association between respondents attending more than one GP and the sociodemographic and health-related variables described above. Significance was assessed at both the 0.05 and 0.01 levels, and both are reported.

Multiple logistic regression was performed using SPSS 4.0 to generate multivariate models to examine the factors that were associated with respondents attending more than one GP. Respondents who had two or more consultations in the preceding year were divided into those who had seen one GP and those who had seen two or more GPs. The models used multiple GP use as the dependent variable (coded 0/1: 0= those who seen one GP, 1= those who had seen two or more GPs). The variables found to be significant at the 0.05 level on Chi-square testing were included in the original model and the least significant variable was removed sequentially. The final model was chosen for its parsimony.

Results
Of the 555 people surveyed, 49.7% were female. Ninety-one percent of the sample had visited a GP during the preceding 12 months. Seventy-three percent (404 individuals) had two or more visits to GPs in that time, and of these, 32% (129/404) had seen more than one GP. There was a high level of satisfaction with the most recent visit to a GP. This visit was rated as excellent by 184 (33%), as very good by 207 (37%), as good by 81(15%), as fair by 22 (4%), as poor by 2 (0.4%) and the question was not answered by 59 (10.6%).

Univariate analysis showed that age and gender were associated with multiple GP use. Age was grouped by decade, and those aged 20-29 were significantly more likely to have consulted multiple GPs (Mantel-Haenszel test, p<0.05). Gender was significant, with women being more likely than men to have seen more than one GP in the preceding year (p<0.01). When age groups were examined for men and women separately, there was a statistically significant tendency for younger men to have seen more than one GP compared with older men (Mantel-Haenszel test, p<0.01).
was no significant relationship for women across age groups. Figure 4.1 shows the distribution of respondents seeing one GP or two or more GPs by age group and gender.

There was no significant effect of ethnicity on the likelihood of people seeing multiple GPs. None of the indicators of socioeconomic status (educational achievement and occupation) had a statistically significant effect on the tendency to visit more than one GP in the univariate analysis.

Univariate analysis of the respondents' health status showed a significant relationship between the number of GP visits an individual had in the previous year and the tendency to see more than one GP ($p<0.01$). Women were more likely than men to have five or more visits during the preceding 12 months ($p<0.01$) and for both groups an increasing number of visits was associated significantly with seeing more than one GP (male: $p<0.01$; female: $p<0.01$).

Figure 4.2 shows the distribution of respondents seeing one GP or two or more GPs by the number of visits and gender.

There was no significant effect on the likelihood of seeing more than one GP of self-assessed health status, self-reported depression during the preceding year, or of self-reported current health problems.

Satisfaction with the last GP visit was found to be related significantly to seeing multiple GPs. Less satisfied persons were more likely to have consulted another GP ($p<0.01$). There was a significant association for those who explained their satisfaction with the last GP visit in instrumental terms, but accessibility or affective explanations were not statistically significant predictors. If competence were mentioned as a reason for a respondent's satisfaction assessment of their last visit to a GP, they were less likely to see multiple GPs ($p<0.05$).

Some respondents gave two or more reasons for seeing more than one GP in the previous year. Accessibility reasons were given by 58%, instrumental factors were cited by 42% and affective features by 25% of the respondents.

In the multivariate model for multiple GP use, the following explanatory variables were significant: number of GP visits ($p=0.0004$), satisfaction with the last GP visit ($p=0.002$), age group ($p=0.05$), gender ($p=0.05$), respondent's qualifications ($p=0.02$), and communication as an explanatory factor for the
satisfaction rating for the last GP visit (p=0.003). See table 4.1. These mean that the likelihood of seeing multiple GPs increased with the number of visits (odds ratio of 1.4 per visit; this is multiplicative with the number of visits); poorer levels of satisfaction with the last GP visit (odds ratio of 2.3); younger age group so the 20-29 year olds were most likely to see multiple GPs and the age group 50-59 were least likely (odds ratio of 0.3); female gender thus women were more likely than men (odds ratio of 1.8); those respondents who had tertiary qualifications - degree or diploma (odds ratio of 1.8); and decreased with mentioning communication issues as the reason for their satisfaction rating for the previous GP visit (odds ratio of 0.4).
Figure 4.1
The age group and gender of respondents seeing one GP or multiple GPs

![Bar chart showing the age group and gender of respondents seeing one GP or multiple GPs.]

- Male 1GP
- Male >1GP
- Female 1GP
- Female > 1GP

Figure 4.2
The gender and number of visits made by respondents to one GP or multiple GPs

![Bar chart showing the number of visits made by respondents to one GP or multiple GPs.]

- Male 1 GP
- Male > 1 GP
- Female 1 GP
- Female > 1 GP
Table 4.1  The independent variables and corresponding adjusted odds ratios and 95% confidence intervals for the factors associated with multiple GP use in the multivariate model (n=404)

<table>
<thead>
<tr>
<th>Independent variables</th>
<th>Adjusted odds ratio</th>
<th>95% confidence interval</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of GP visits</td>
<td>1.4</td>
<td>1.2 - 1.8</td>
<td>0.0004</td>
</tr>
<tr>
<td>Dissatisfaction vs satisfaction with last GP visit</td>
<td>2.3</td>
<td>1.3 - 3.9</td>
<td>0.002</td>
</tr>
<tr>
<td>Age group (years)</td>
<td></td>
<td></td>
<td>0.05</td>
</tr>
<tr>
<td>30-39 vs 20-29 (n=88)</td>
<td>0.6</td>
<td>0.2 - 1.3</td>
<td></td>
</tr>
<tr>
<td>40-49 vs 20-29 (n=118)</td>
<td>0.6</td>
<td>0.3 - 1.3</td>
<td></td>
</tr>
<tr>
<td>50-59 vs 20-29 (n=96)</td>
<td>0.3</td>
<td>0.1 - 0.7</td>
<td></td>
</tr>
<tr>
<td>&gt;60 vs 20-29 (n=66)</td>
<td>0.5</td>
<td>0.2 - 1.2</td>
<td></td>
</tr>
<tr>
<td>Gender: female vs male</td>
<td>1.8</td>
<td>1.1 - 2.8</td>
<td>0.05</td>
</tr>
<tr>
<td>Respondent's qualifications: tertiary vs other</td>
<td>1.8</td>
<td>1.1 - 2.8</td>
<td>0.02</td>
</tr>
<tr>
<td>Communication as a criterion for respondent's satisfaction rating for the previous GP visit</td>
<td>0.4</td>
<td>0.2 - 0.7</td>
<td>0.003</td>
</tr>
</tbody>
</table>
Discussion
The study was conducted in Canberra, the national capital, where residents were more affluent and more likely to have completed tertiary education compared with the wider Australian population (Santow 1995). Also, the study population was a less mobile subgroup as respondents were followed up from a 1989 National Heart Foundation Risk Factor Assessment Study. Nevertheless, differential attrition was not a significant problem from 1989 to 1992 (McCallum, Lonergan et al. 1993). Both age and gender were controlled in the multivariate model to account for the demographic structure of the sample.

The association between increasing numbers of GP visits and seeing more than one GP was expected, since the availability of both the GP and the patient will be tested with increasing utilisation. This association has been noted in other health systems (Breslau and Reeb 1975; Bice and Boxerman 1977; Hennelly and Boxerman 1979; Ejlertsson and Berg 1984; Smedby, Smedby et al. 1984; Ellsbury, Schneeweiss et al. 1987; Béland 1989; Freeman and Richards 1993).

Respondents were more likely to see multiple GPs if they were dissatisfied with their last GP consultation. This is an interesting finding as it suggests that respondents were indicating both a broad sense of dissatisfaction and dissatisfaction that was specific to the last visit. In the USA Ware et al. have shown that each 1-point decrease on the Patient Satisfaction Questionnaire (PSQ) General Satisfaction scale was related to a 3.4% increase in the probability of provider change in the next year (Ware and Davies 1983). The association between dissatisfaction and visits to more than one doctor has been reported by researchers in the UK, Norway and USA (Shortell 1976; Marquis, Davies et al. 1983; Wasson, Sauvigne et al. 1984; Young, Wasserman et al. 1985; Chao 1988; Salisbury 1989; Hjortdahl and Laerum 1992(b)).

Younger patients (aged 20-29 years) were more likely to have seen multiple GPs than other age groups. This finding has been observed in regional studies in Australia (AGB Australia 1992(a); Ward, Underwood et al. 1995), and internationally (Shortell 1976; Shortell, Richardson et al. 1977; Boyle and Rockhold 1979; Ejlertsson 1980; Sloane and Egelhoff 1983; Ejlertsson and Berg 1984; Chao 1988; Freeman and Richards 1993; Sweeney and Gray 1995). Also, McWhinney et al. have shown that younger people in a Canadian city
moved more frequently and this too would increase the likelihood of individuals in this age group seeing multiple GPs (McWhinney, Bass et al. 1988).

This study found that women and more highly educated respondents were more likely to have seen more than one GP. Similar associations have been reported in Denmark (Bjerrum and Sorensen 1992). There may be several reasons for these associations including a preference by some women for visiting different doctors for general and women's health needs (Bensing, Brink-Muinen et al. 1993; Britt, Bhasale et al. 1994), a tendency for pluralist health service use by persons from more affluent suburbs (Lloyd, Lupton et al. 1991) and a possibility that women may be more likely to voice dissatisfaction with their primary medical care than men (Salisbury 1989).

Tertiary educated respondents were more likely to have seen more than one GP. Previous research in Australia has shown that people of low and high socioeconomic status hold different views about health-related matters. This finding builds on the earlier work of Lloyd et al who found that people from more affluent suburbs were more likely to have a pluralist use of health services (Lloyd, Lupton et al. 1991). Further research is needed to explore this aspect of multiple GP use.

The importance of good communication and satisfaction with general practice visits have been reported internationally (Shortell 1976; Marquis, Davies et al. 1983; Wasson, Sauvigne et al. 1984; Young, Wasserman et al. 1985; Chao 1988; Salisbury 1989; Bjerrum and Sorensen 1992; Hjortdahl and Laerum 1992(b); Bensing, Brink-Muinen et al. 1993). This has been reinforced in this retrospective Australian study of the reasons for multiple GP use.

This study raises the possibility that some aspects of multiple utilisation of GPs result in health benefits for consumers while other aspects may be detrimental. The qualitative studies that follow explore this in detail.
A doctor of one's own?

Background
There has been no national research on the extent to which Australians identify with and visit a particular doctor. A recent study in six general practices in Sydney indicated that 96% of respondents said they had a regular doctor (Lupton, Donaldson et al. 1991) while a national poll conducted in 1995 for the Australian Medical Association (AMA) found that 82% of people had a regular GP or family doctor (Australian Medical Association 1995). These two studies indicate that Australians tend to report identifying with a particular GP, but the proportion who consult them is not known.

This finding is not dissimilar from others reported from other countries where there are no barriers to consumers choosing their GP on each occasion they visit. The proportion of the population identifying with a particular doctor varies from 88% in Norway (Hjortdahl and Laerum 1992(b)) to 94% in Canada (McWhinney, Bass et al. 1988) and 96% in Sweden (Ejlertsson and Berg 1984).

Aims
The survey was performed to estimate the proportion of respondents who identified with and consulted their 'usual doctor' on their last GP visit. This question was also used in the Seeing doctors questionnaire (see chapter 5). Also the study explored the price-sensitivity of Australian consumers for GP services.

Method
This study revolved around two questions that were included at my request in the 1993 Medicare Satisfaction Study. The survey was conducted by Minter Research1.

A questionnaire was administered to 1,201 persons by trained staff during a telephone interview. The sample was stratified by state and urban/rural location. Using a CD-ROM database of the number of telephones in geographical areas, quotas were set which reflected the number of

---

1 Minter Research is the firm that was commissioned by the Health Insurance Commission (HIC) to conduct the 1993 Medicare Satisfaction Study.
households with a telephone. A random dialling technique was used. Each interviewer had a proforma which directed them to choose a page at random from the white pages of the telephone book, select a predetermined column (1-5 nominated for each page), and then to start dialling numbers from the top or bottom of that column. Contacts were attempted between 3 pm and 8.30 pm weekdays and on Saturdays and Sundays. If the telephone were not answered, two callbacks were attempted before another household was sought as a replacement. Once the telephone was answered, the interviewer sought informed consent from an adult for a brief interview about matters related to Medicare. The interview schedule for the study, *A doctor of one's own?* is shown in Figure 4.3

**Analysis**

These data were released to me in cross-tabulated format so only univariate and bivariate analyses were possible. Bivariate analysis using the chi-square test of significance examined the associations between demographic variables and the two questions of interest. As unit record data were not available, multivariate analysis was not possible.

---

**Figure 4.3** The interview schedule for the study, *A doctor of one's own?*

1. Please think about your last visit to a GP (general practitioner).....
   - Did you see your usual doctor? (Please tick one box)
     - Yes, I saw my GP/ usual doctor
     - No, but I went to the practice that I usually go to
     - No

2. Would you change doctors if your usual doctor stopped bulkbilling?
   - Yes, I would change doctors if my usual doctor stopped bulkbilling
   - No, I would not change doctors if my usual doctor stopped bulkbilling
   - My usual doctor does not bulkbill
   - Don't know
   - Doctors who bulkbill are of a low quality

---

2 This last response option was added by Minter Research.
Results
The sample comprised 1,201 people of whom 794 (66.1%) were female and 407 (33.9%) were male. Interviewers reported that there was a tendency for an adult woman to be nominated as the respondent for this study since women were commonly responsible for all household administration for Medicare claims. This tendency was reflected in the female preponderance of the sample. Eight hundred and seventy-two respondents (83.2%) lived in metropolitan areas and 176/1048 (16.8%) lived in rural settings, so the sample included more urban dwellers than does the Australian population. The demographic characteristics of the sample are presented in table 4.2.

One thousand and forty-eight people answered the question about their 'usual doctor' and 1,198 answered the second question. The number of non-respondents for the second question was small (3/1201). On their last GP visit, 872 (83.2%) people saw their 'usual doctor', and a further 45 (4.3%) saw a doctor in their 'usual practice'.

The differences between observed and expected values for several demographic factors and seeing a usual doctor on the last visit are summarised in table 4.3. There was no significant gender difference between non-respondents and respondents for this question. However observed use of usual doctor was significantly greater than expected for respondents who were aged 45-54 years, those who had ever had children, and those who held private health insurance.

When asked whether they would change doctor if he/she stopped bulkbilling, 27.5% said they would change, 40.0% said they would not change and 30.1% said they already attended a doctor who did not bulkbill all services. Only twenty-nine people (2.4%) agreed with the statement that 'doctors who bulkbill are of a low quality'.

The differences between observed and expected values for several demographic factors and changing doctors if he/she stopped bulkbilling are presented in table 4.4. The percentages refer only to those people who responded this question. Observed intention to change doctors if the GP stopped bulkbilling was significantly less likely for respondents who were aged 45-54 years, those resident in the non-Eastern mainland states, persons living in a household that included a male who was employed in a 'white collar' job, those who held private health insurance, and people who had children that had left home.
Table 4.2 The demographic characteristics of the sample for the study: A doctor of one's own? and national estimates

<table>
<thead>
<tr>
<th>Category</th>
<th>n</th>
<th>%</th>
<th>ABS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>407</td>
<td>33.9</td>
<td>49.9</td>
</tr>
<tr>
<td>Female</td>
<td>794</td>
<td>66.1</td>
<td>50.1</td>
</tr>
<tr>
<td><strong>Age group (years)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18-34</td>
<td>346</td>
<td>28.8</td>
<td>37.5</td>
</tr>
<tr>
<td>35-44</td>
<td>309</td>
<td>25.8</td>
<td>20.7</td>
</tr>
<tr>
<td>45-54</td>
<td>212</td>
<td>17.7</td>
<td>14.8</td>
</tr>
<tr>
<td>over 55</td>
<td>333</td>
<td>27.7</td>
<td>27.0</td>
</tr>
<tr>
<td><strong>Geographical location</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urban</td>
<td>872</td>
<td>83.2</td>
<td>72.4</td>
</tr>
<tr>
<td>Rural</td>
<td>176</td>
<td>16.8</td>
<td>27.6</td>
</tr>
<tr>
<td><strong>Australian State</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>New South Wales</td>
<td>477</td>
<td>39.7</td>
<td>34.2</td>
</tr>
<tr>
<td>Victoria</td>
<td>314</td>
<td>26.2</td>
<td>25.3</td>
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<tr>
<td>Queensland</td>
<td>142</td>
<td>11.8</td>
<td>17.5</td>
</tr>
<tr>
<td>SA</td>
<td>114</td>
<td>9.5</td>
<td>8.5</td>
</tr>
<tr>
<td>WA/ Tas/ ACT/ NT</td>
<td>154</td>
<td>12.8</td>
<td>14.5</td>
</tr>
<tr>
<td><strong>Type of health insurance</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private</td>
<td>597</td>
<td>57.0</td>
<td>39.4</td>
</tr>
<tr>
<td>Medicare</td>
<td>451</td>
<td>43.0</td>
<td>60.6</td>
</tr>
<tr>
<td><strong>Head of household (male)</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Prof/Self-employed/White collar</td>
<td>423</td>
<td>41.2</td>
<td></td>
</tr>
<tr>
<td>Trades/Unskilled</td>
<td>354</td>
<td>34.4</td>
<td></td>
</tr>
<tr>
<td>Retired/Home/Student/Social Security</td>
<td>251</td>
<td>24.4</td>
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<tr>
<td><strong>Head of household (female)</strong></td>
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<td></td>
<td></td>
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<tr>
<td>Prof/Self-employed/White collar</td>
<td>323</td>
<td>29.8</td>
<td></td>
</tr>
<tr>
<td>Trades/Unskilled</td>
<td>194</td>
<td>17.9</td>
<td></td>
</tr>
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<td>Retired/Home/Student/Social Security</td>
<td>568</td>
<td>52.3</td>
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<tr>
<td>Single/married, with children</td>
<td>612</td>
<td>51.3</td>
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<tr>
<td>Single/married, children left home</td>
<td>312</td>
<td>26.1</td>
<td></td>
</tr>
</tbody>
</table>

3 National estimates were extracted from C-DATA, Australian Bureau of Statistics (ABS), 1991.
4 Comparative data were extracted from Rural/Remote Areas Classification (Department of Human Services and Health 1994) which used the 1991 Intercensal population estimate.
5 Comparative data were extracted from the Annual Report 1992-93 of the Private Health Insurance Administration Council (page 15).
Table 4.3  The differences between observed and expected values for several demographic factors and seeing a usual doctor on the last visit (expressed as a row percentage)

<table>
<thead>
<tr>
<th>Category</th>
<th>n</th>
<th>Usual GP (%)</th>
<th>Usual practice (%)</th>
<th>Other (%)</th>
<th>p value</th>
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<tr>
<td><strong>Gender</strong></td>
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<td></td>
<td></td>
<td></td>
<td>NS</td>
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<tr>
<td>Male</td>
<td>351</td>
<td>80.3</td>
<td>4.9</td>
<td>14.8</td>
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</tr>
<tr>
<td>Female</td>
<td>697</td>
<td>84.6</td>
<td>4.0</td>
<td>11.4</td>
<td></td>
</tr>
<tr>
<td><strong>Age group</strong></td>
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<td></td>
<td></td>
<td>&lt;0.05</td>
</tr>
<tr>
<td>18-34 years</td>
<td>306</td>
<td>80.0</td>
<td>4.2</td>
<td>15.8</td>
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</tr>
<tr>
<td>35-44 years</td>
<td>257</td>
<td>79.8</td>
<td>7.4</td>
<td>12.8</td>
<td></td>
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<tr>
<td>45-54 years</td>
<td>189</td>
<td>88.9</td>
<td>2.7</td>
<td>8.4</td>
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</tr>
<tr>
<td>over 55 years</td>
<td>296</td>
<td>85.8</td>
<td>2.7</td>
<td>11.5</td>
<td></td>
</tr>
<tr>
<td><strong>Geographical location</strong></td>
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<td></td>
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<tr>
<td>Urban</td>
<td>872</td>
<td>83.8</td>
<td>4.0</td>
<td>12.2</td>
<td></td>
</tr>
<tr>
<td>Rural</td>
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<td>80.1</td>
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<td>14.2</td>
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<td></td>
<td>NS</td>
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<tr>
<td>New South Wales</td>
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<td>86.1</td>
<td>3.0</td>
<td>10.9</td>
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<tr>
<td>Victoria</td>
<td>314</td>
<td>80.9</td>
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<td>14.6</td>
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<tr>
<td>Queensland</td>
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<td>6.1</td>
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<td>SA/WA/Tas/ACT/NT</td>
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<td>81.4</td>
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<td></td>
<td></td>
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<td>Private</td>
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<td>85.3</td>
<td>4.5</td>
<td>10.2</td>
<td></td>
</tr>
<tr>
<td>Medicare</td>
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<td>4.0</td>
<td>15.5</td>
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</tr>
<tr>
<td><strong>Household head (male)</strong></td>
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<td></td>
<td></td>
<td>NS</td>
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<tr>
<td>Prof/self/white collar</td>
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<td>3.0</td>
<td>12.0</td>
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</tr>
<tr>
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<td>11.4</td>
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</tr>
<tr>
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<td>86.9</td>
<td>2.8</td>
<td>10.3</td>
<td></td>
</tr>
<tr>
<td><strong>Household head (female)</strong></td>
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<td></td>
<td></td>
<td></td>
<td>NS</td>
</tr>
<tr>
<td>Prof/self/white collar</td>
<td>286</td>
<td>81.5</td>
<td>5.9</td>
<td>12.6</td>
<td></td>
</tr>
<tr>
<td>Trades/unskilled</td>
<td>168</td>
<td>83.3</td>
<td>4.8</td>
<td>11.9</td>
<td></td>
</tr>
<tr>
<td>Retired/home/other</td>
<td>487</td>
<td>86.2</td>
<td>3.3</td>
<td>10.5</td>
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<td><strong>Household composition</strong></td>
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<td></td>
<td></td>
<td></td>
<td>&lt;0.01</td>
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<tr>
<td>Single/married, no children</td>
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<td>19.4</td>
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<tr>
<td>Single/married, with children</td>
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<td>85.4</td>
<td>4.6</td>
<td>10.0</td>
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<tr>
<td>Single/married, children left</td>
<td>282</td>
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<td>3.2</td>
<td>11.3</td>
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</tr>
</tbody>
</table>

NS indicates the difference between observed and expected values was not statistically significant at 0.05 level.
Table 4.4 The differences between observed and expected values for several demographic factors and changing doctors if he/she stopped bulkbilling

<table>
<thead>
<tr>
<th>Category</th>
<th>n</th>
<th>Change GP (%)</th>
<th>Not change GP (%)</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>808</td>
<td>40.8</td>
<td>59.2</td>
<td>-</td>
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<tr>
<td>Gender</td>
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<td></td>
<td></td>
<td>NS</td>
</tr>
<tr>
<td>Male</td>
<td>280</td>
<td>42.9</td>
<td>57.1</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>528</td>
<td>39.8</td>
<td>60.2</td>
<td></td>
</tr>
<tr>
<td>Age group</td>
<td></td>
<td></td>
<td></td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>18-34 years</td>
<td>242</td>
<td>59.5</td>
<td>40.5</td>
<td></td>
</tr>
<tr>
<td>35-44 years</td>
<td>210</td>
<td>36.7</td>
<td>63.3</td>
<td></td>
</tr>
<tr>
<td>45-54 years</td>
<td>114</td>
<td>28.1</td>
<td>71.9</td>
<td></td>
</tr>
<tr>
<td>over 55 years</td>
<td>237</td>
<td>32.1</td>
<td>67.9</td>
<td></td>
</tr>
<tr>
<td>Geographical location</td>
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<td></td>
<td></td>
<td>NS</td>
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<tr>
<td>Urban</td>
<td>705</td>
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<td>59.0</td>
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</tr>
<tr>
<td>Rural</td>
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<tr>
<td>Australian State</td>
<td></td>
<td></td>
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<td>&lt;0.01</td>
</tr>
<tr>
<td>New South Wales</td>
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<td>57.3</td>
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</tr>
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<td>29.7</td>
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</tr>
<tr>
<td>Type of health insurance</td>
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<td></td>
<td>&lt;0.001</td>
</tr>
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<td>Private</td>
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<td>70.5</td>
<td></td>
</tr>
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<td>Medicare</td>
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<tr>
<td>Household head (male)</td>
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<td></td>
<td></td>
<td>&lt;0.05</td>
</tr>
<tr>
<td>Prof/self/white collar</td>
<td>246</td>
<td>32.9</td>
<td>67.1</td>
<td></td>
</tr>
<tr>
<td>Trades/unskilled</td>
<td>239</td>
<td>43.1</td>
<td>56.9</td>
<td></td>
</tr>
<tr>
<td>Retired/home/other</td>
<td>195</td>
<td>44.6</td>
<td>55.4</td>
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</tr>
<tr>
<td>Household head (female)</td>
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<td>Prof/self/white collar</td>
<td>186</td>
<td>38.2</td>
<td>62.8</td>
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</tr>
<tr>
<td>Trades/unskilled</td>
<td>135</td>
<td>41.5</td>
<td>58.5</td>
<td></td>
</tr>
<tr>
<td>Retired/home/other</td>
<td>397</td>
<td>41.1</td>
<td>58.9</td>
<td></td>
</tr>
<tr>
<td>Household composition</td>
<td></td>
<td></td>
<td></td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Single/married, no children</td>
<td>196</td>
<td>46.9</td>
<td>53.1</td>
<td></td>
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<tr>
<td>Single/married, with children</td>
<td>397</td>
<td>44.1</td>
<td>55.9</td>
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<tr>
<td>Single/married, children left home</td>
<td>210</td>
<td>29.0</td>
<td>71.0</td>
<td></td>
</tr>
</tbody>
</table>

NS indicates the difference between observed and expected values was not statistically significant at 0.05 level.
Discussion
This is the first Australian population-based study of the prevalence of seeing the usual doctor. In the light of the evidence that 56% of Australians saw two or more GPs in the last year (Health Insurance Commission 1992), it was a striking finding that over 85% of people said that they had seen their usual doctor or practice on the last visit. This result is comparable with the 1995 AMA survey estimate (Australian Medical Association 1995) and with international estimates of the proportion of a population who identify with a particular doctor (Ejlertsson and Berg 1984; McWhinney, Bass et al. 1988; Hjortdahl and Laerum 1992(b)).

People were more likely to have seen their usual doctor on the last visit if they were aged 45-54 years, held private health insurance, and had ever had children. These are separate bivariate analyses and it is probable that there will be confounding between these factors as older persons are more likely to be privately insured6 (Private Health Insurance Council 1993).

The finding that individuals who have ever had children were more likely to have seen a usual doctor on the last visit is interesting. It may indicate that a prior family relationship with a particular GP is robust, or that people who have had children are more likely to be relationship-oriented when choosing a doctor.

Although the sample was predominantly female, this is unlikely to have affected the results. There was a tendency for women to be nominated as the household spokesperson for matters related to Medicare. It is well recognised that women make many of the household decisions about health including decisions about the timing of medical consultations. The feminised nature of responsibility for the family's health has been documented by Dahlquist in Sweden (Dahlquist, Sterky et al. 1987). However in the present study, gender was not statistically significantly associated with either seeing the 'usual doctor' on the last visit, or on the likelihood of changing doctors.

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6 Over forty-four percent (44.2%) of people aged 65 years and over had private health insurance in June 1993 compared with 39.4% of the general population (Annual Report 1992-93 of the Private Health Insurance Administration Council; page 15).
In this study, information about private health insurance status related to the household. Thus if one person in the household held private health insurance, the entire household was recorded as privately insured. Private Health Insurance Administration Council (PHIAC) estimates of private health insurance status, in contrast, relate to individuals (see table 4.2). Because of the commercial confidentiality of these data, I was precluded from analysing private health insurance status for individuals in this study. However, following a conversation with the director of Minter Research (the firm that was commissioned to perform the 1993 Medicare Satisfaction Study) the company undertook an analysis of the private health insurance status of individuals in the study. They said that health insurance levels in their sample and PHIAC national data were comparable (Personal communication, G Minter).

Several factors influence an individual's decision to buy private health insurance. Financial means enable purchase, but income is not the sole determinant or predictor of health insurance status (Cameron and McCallum 1996). A perception of vulnerability to illness is determined in part by cultural factors and age, and these are reflected in an individual's level of health consciousness. In turn, health consciousness is related to an individual's likelihood of buying and maintaining health insurance. Cameron et al. showed that over half those currently holding private health insurance have done so all their adult life (Cameron and McCallum 1996).

Changing doctors if he/she stopped bulkbilling was least likely if individuals were aged 45-54 years, resident in the non-Eastern mainland states, the male head of household were employed in a 'white collar' job, held private health insurance, and the children had left home. Again there is a significant potential for confounding between several of these factors as state of residence, age, income, and holding private health insurance are correlated (Private Health Insurance Council 1993).

Generally, it appears that those people who were economically disadvantaged were more likely to state that they would change doctors if bulkbilling were not available. This finding suggests that these people are sensitive to co-payments and would seek GP services that were 'free at the point of delivery'. This is consistent both with international research showing that the principal effect of co-payments is on access to health services (Manning et al., 1987 and Lohr et al., 1986 quoted in (Richardson 1991) and with Richardson's view that the disadvantage of impaired access
to health services is disproportionately felt by the poor and sick (Richardson 1991).

**Summary and conclusions about the studies**

The principal findings of these studies were compatible and consonant with other published studies. They showed that utilisation of multiple GPs was more likely when the consumer expressed dissatisfaction with the last GP visit and when they had more GP visits during the previous 12 months. Also, consumers who were younger, female, and more highly qualified were more likely to have had multiple GP visits, while older consumers were both more likely to have seen their usual doctor on their last GP visit and only that doctor in the past 12 months. As well, multiple GP visits were less likely when good communication was cited as the reason for satisfaction with the last GP visit. The study *A doctor of one's own?* showed that the vast majority of Australians said that they saw their usual GP or attended their usual general practice on their last visit. It also suggests that economically disadvantaged people would be likely to change doctors if bulkbilling were not available at their usual practice.

However, these studies do not shed light on the process whereby consumers make decisions about which GP they visit nor whether different circumstances might lead to the same observable outcome of multiple GP use. The questionnaire format of these studies did not allow an explication of the consumers' responses when they cited dissatisfaction and good communication as the reasons why they saw particular doctors. Qualitative studies which ask people about their experiences are more likely to increase our understanding of what appear to be more complex and possibly interconnected issues. In the studies which follow, I asked people about their experience of these issues and how and why they decided to see another GP.
CHAPTER 5

Consulting colleagues and consumers

Although it is known that 82% of the Australian population attend a general practitioner (GP) at least once a year, and 56% of patients see two or more different GPs (Health Insurance Commission 1992), the reasons for this pattern of service use are poorly understood.

Australian research on the dynamics of choosing and changing doctors is sparse (see table 5.1). Accessibility issues and recommendation are cited as important considerations in the initial choice of a doctor (Dunt, Oberklaid et al. 1988; Lupton, Donaldson et al. 1991; Choice 1995). Lupton et al. found that some consumers changed doctors because they were dissatisfied with access to consultations, the doctor's competence, or the doctor-patient relationship (Lupton, Donaldson et al. 1991).

A little information has been gathered about the frequency with which Australians change their doctors. Lupton et al. found that 24% of respondents said that they had ever changed doctors and only a minority shared their reasons with the researchers (Lupton, Donaldson et al. 1991). The authors concluded that patients were dependent on and loyal to their GPs and rarely exercised the choice of GP that the Australian health system offers. Although this study was methodologically sound it used a convenience sample from six urban Australian general practices so the authors' conclusions may not be applicable to the wider population. However a recent national poll conducted for the Australian Medical Association (AMA) provides support for the proposition that the majority of Australians have stable associations with their GPs. The AMA survey found that 82% of people had a regular GP or family doctor and nearly half
had seen this same doctor for more than five years (Australian Medical Association 1995).

Internationally, research on choosing and changing doctors has been conducted in the United States of America (USA) and the United Kingdom (UK) (see table 5.2). In the USA, Kasteler et al. showed that 'doctor shopping' (defined as one or more family members changing doctors of their own volition without referral) was prevalent, occurring in 43% of families surveyed in 1976 (Kasteler, Kane et al. 1976). In this survey, changing doctors was linked to dissatisfaction with several aspects of care. These were a lack of confidence in the doctors' competence, unwillingness of doctors to spend time talking with patients, hostile feelings towards doctors, high cost of services, inconvenience of location and hours, and unfavourable attitudes toward doctors' personal qualities. Other studies have also shown that striving for convenient access to doctors and dissatisfaction were associated with decisions to change doctors (Ware and Davies 1983; Young, Wasserman et al. 1985; Salisbury 1989).

This chapter describes exploratory interviews with consumers and GPs that I conducted to examine the reasons why some consumers see several GPs annually. The methods and results for each study are presented below in the sequence they were conducted.
<table>
<thead>
<tr>
<th>Author</th>
<th>Year</th>
<th>Sample size</th>
<th>Subjects</th>
<th>Aim and Methods</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Dunt, 1988)</td>
<td>1988</td>
<td>592 patients</td>
<td>Patients visiting one of 8 general practices, a casualty or a community health centre in one city, Australia</td>
<td>Interview study about patients' views of primary medical care services in an industrialised area of low social amenity in Melbourne during 1983.</td>
<td>• Patients attending general practice were less likely to be in manual occupations or unemployed than those attending the casualty or community health centre. • Proximity to home or work, then recommendation were the most frequently cited reasons for choosing a service.</td>
</tr>
<tr>
<td>(Lupton, 1991)</td>
<td>1991</td>
<td>333 patients</td>
<td>Patients from 6 urban general practices, Australia</td>
<td>Exploratory cross-sectional qualitative survey using a questionnaire of patients' views about their selection and evaluation of GPs conducted in 1990.</td>
<td>• 96% of the sample said that they had a regular doctor. • Recommendation was the most frequently cited reason for choosing a doctor. • Affective reasons were most frequently cited for continuing to see that doctor. • 24% respondents had ever decided to change their doctor.</td>
</tr>
<tr>
<td>(Charles, 1992)</td>
<td>1992</td>
<td>Not reported</td>
<td>Not reported, Australia</td>
<td>Discussion of qualities of a 'good GP'.</td>
<td>• Qualities of a 'good GP' were listed without supporting evidence.</td>
</tr>
<tr>
<td>(Choice, 1995)</td>
<td>1995</td>
<td>Not reported</td>
<td>Not reported, Australia</td>
<td>Discussion of qualities of a 'good GP' to help with choosing a GP.</td>
<td>• Ways to assess issues including trust, confidence in the doctor's ability, prescriptions, range of services, communication, access and payment were listed without supporting evidence for their importance.</td>
</tr>
<tr>
<td>(Australian Medical Association, 1995)</td>
<td>1995</td>
<td>620 people</td>
<td>National survey, Australia</td>
<td>Survey of consumer perceptions about GP service usage, satisfaction, and allegiance.</td>
<td>• 82% of sample had a regular GP. • 84% thought having a choice of GP was important.</td>
</tr>
<tr>
<td>Author</td>
<td>Year</td>
<td>Sample size</td>
<td>Subjects</td>
<td>Aim and Methods</td>
<td>Results</td>
</tr>
<tr>
<td>------------------------</td>
<td>------</td>
<td>---------------</td>
<td>--------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| (Kasteler, 1976)       | 1976 | 576 families  | Stratified sample of high and low SES families in one city, USA          | Interview with household head or spouse about changes if any in physicians consulted during 1974, attitudes towards doctors and assessment of hypochondriasis. | • 48% of high SES families and 37% of low SES families had doctor shopped in the last year.  
• Doctor shoppers were more likely to have low confidence in doctors, be dissatisfied with the amount of time waiting & time doctors spent with them, than others.  
• High SES doctor shoppers were more likely to have hostile feelings towards doctors and adopt the sick role more readily than others. |
| (Ware, 1983)           | 1983 | 1) 323 persons 2) 432 persons 3) 279 persons 4) 1,314 persons all groups from USA | 1) Mainly black residents 2) Mainly white residents 3) Mainly white residents 4) Residents in California | Comparison of behavioural intentions re care for different symptoms among study groups in 1972, 1974 and 1979. | • Those rating financial arrangements and continuity favourably were significantly more likely to seek care for muscle aches.  
• With each 1-point decrease on the PSQ General Satisfaction scale there was a 3.4% increase in probability of provider change in the next year. |
| (Young, 1985)          | 1985 | 87 respondents | Parents of paediatric patients from 4 paediatric practices in one county, USA | Comparison of parent's explanations for changing paediatrician associated with moving, convenience & dissatisfaction, (study year not reported). | • Problems with communication are cited by parents who are dissatisfied enough to leave one paediatrician for another.  
• Convenience in the absence of dissatisfaction can precipitate a change of paediatrician. |
| (Salisbury, 1989)      | 1989 | 323 people    | Newly registered patients with 5 general practices in one region, UK     | Questionnaire survey of peoples' reasons for choosing their new practice.        | • Most patients exercised little active choice to register with a practice, registering with the nearest practice or one where other family members were registered.  
• Most people changed doctors because they moved but did not register until they became ill. |
The Consulting colleagues study

Aims
The preliminary interviews with GPs (Consulting colleagues) and consumers (Consulting consumers) had substantive and technical aims.

In both studies the substantive aims were to explore issues related to 'doctor shopping' and continuity of care, and to compare the perceptions of GPs and consumers.

The technical objectives for the Consulting colleagues study were to develop my research interviewing skills and to compare notetaking and audio-taping for data collection.

Method

Interview design
The interview schedule for the Consulting colleagues study is in appendix 5.1.

I began the interview by orienting the GP to their last consulting session so that he/she would be more likely to be remember particular patients. The initial question asked the GP to recall any patients whom (they) would describe as a 'doctor shopper'. Then, I asked, 'Why does that description fit in your mind (or seem appropriate)\?' Thus a 'working' definition was constructed from the factors or constellation of attributes each GP used to describe a 'doctor shopper'.

The next questions invited the respondent to contribute their ideas about a definition of doctor shopping, its prevalence, the characteristics of shoppers and the effects for both the consumer and the GP. Prompts were available for specific issues related to the process and content of general practice consultations if these were not mentioned spontaneously. GPs were asked about their experiences of sharing patients with partners, assistants, locums, and after hours services and for their ideas about those factors which may promote or diminish doctor shopping. Lastly demographic information about each respondent was sought including age, gender, details of their undergraduate training, current and past general practice and organisational affiliations.
Sampling
For the Consulting colleagues study a sample of 35 GPs was assembled.

Initially I constructed a list of 200 GPs who worked in various primary health care settings in the private, public, and the non-government sectors. The list also included GPs who were active in GP organisations, (the AMA, the RACGP and the Doctors' Reform Society (DRS)), and GP teachers from Universities and the (national) RACGP Family Medicine Program (now the RACGP Vocational Training Program). The 200 doctors included many who had thought about health system and policy issues.

I then purposively selected 35 GPs from the list of 200. The 35 were selected to include GPs from: at least five States, different geographical locations (urban, rural and remote communities), the three paid sectors in primary health care (private, public and non-government), and each type of general practice setting (solo, two-person practices, group and 'extended hours' clinic). The final consideration was that the sample include approximately equal numbers of male and female practitioners. The sample was intended to reflect the diversity of Australian general practice.

Table 5.3 shows the characteristics of the GP sample and table 5.4 compares selected demographic and professional characteristics of the GP sample with the profile of GPs from the Australian Morbidity and Treatment Survey (Bridges-Webb, Britt et al. 1992). Compared with the AMTS doctors, the GPs in this study were younger, there were more women, and more had earned the FRACGP qualification. Because a number of GPs in this study worked part-time, it is difficult to make meaningful comparisons about throughput between the two studies.

Conduct of the interview
I rang the 35 selected GPs, explained the purpose of the study and asked whether I could arrange for a 15-20 minute telephone interview. All agreed. I sought and obtained informed consent to tape record the 8th to 24th interviews. During the 17 recorded interviews I also took notes. Interviews 1-7 inclusive and 25-35 inclusive were recorded in note form only.
Table 5.3  Demographic and professional profile of general practitioners in the Consulting colleagues study

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>19</td>
</tr>
<tr>
<td>Female</td>
<td>16</td>
</tr>
<tr>
<td><strong>Australian State/Territory</strong></td>
<td></td>
</tr>
<tr>
<td>South Australia</td>
<td>14</td>
</tr>
<tr>
<td>Australian Capital Territory</td>
<td>10</td>
</tr>
<tr>
<td>New South Wales</td>
<td>7</td>
</tr>
<tr>
<td>Northern Territory</td>
<td>3</td>
</tr>
<tr>
<td>Victoria</td>
<td>1</td>
</tr>
<tr>
<td><strong>Geographical location</strong></td>
<td></td>
</tr>
<tr>
<td>urban</td>
<td>29</td>
</tr>
<tr>
<td>rural</td>
<td>4</td>
</tr>
<tr>
<td>remote</td>
<td>2</td>
</tr>
<tr>
<td><strong>Primary health care sector</strong></td>
<td></td>
</tr>
<tr>
<td>private</td>
<td>27</td>
</tr>
<tr>
<td>public</td>
<td>5</td>
</tr>
<tr>
<td>NGO1, community controlled</td>
<td>3</td>
</tr>
<tr>
<td><strong>Type of general practice</strong></td>
<td></td>
</tr>
<tr>
<td>solo</td>
<td>8</td>
</tr>
<tr>
<td>2-3 person</td>
<td>15</td>
</tr>
<tr>
<td>group 4+</td>
<td>7</td>
</tr>
<tr>
<td>'extended hours' clinic</td>
<td>2</td>
</tr>
<tr>
<td>casualty</td>
<td>3</td>
</tr>
</tbody>
</table>

1 NGO is a non-government organisation.
Table 5.4  Demographic and professional profile of GPs in the *Consulting colleagues* study and Australian Morbidity and Treatment Survey (AMTS)

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Consulting colleagues</th>
<th>AMTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>male</td>
<td>19 (54%)</td>
<td>80.5%</td>
</tr>
<tr>
<td>female</td>
<td>16 (46%)</td>
<td>19.5%</td>
</tr>
<tr>
<td>Age (years)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;35</td>
<td>12 (34%)</td>
<td>14.2%</td>
</tr>
<tr>
<td>35-54</td>
<td>18 (52%)</td>
<td>67.9%</td>
</tr>
<tr>
<td>55+</td>
<td>5 (14%)</td>
<td>18.0%</td>
</tr>
<tr>
<td>Years in practice</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;2</td>
<td>3 (9%)</td>
<td>1.7%</td>
</tr>
<tr>
<td>2-5</td>
<td>13 (37%)</td>
<td>9.7%</td>
</tr>
<tr>
<td>6-10</td>
<td>10 (28%)</td>
<td>20.3%</td>
</tr>
<tr>
<td>&gt;10</td>
<td>9 (26%)</td>
<td>68.3%</td>
</tr>
<tr>
<td>Place of graduation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Australia</td>
<td>30 (86%)</td>
<td>80.0%</td>
</tr>
<tr>
<td>Asia</td>
<td>2 (6%)</td>
<td>6.2%</td>
</tr>
<tr>
<td>UK</td>
<td>3 (8%)</td>
<td>9.7%</td>
</tr>
<tr>
<td>Other</td>
<td>0 (0%)</td>
<td>4.1%</td>
</tr>
<tr>
<td>Medical postgraduate qualifications</td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>13 (37%)</td>
<td>49.0%</td>
</tr>
<tr>
<td>FRACGP</td>
<td>9 (26%)</td>
<td>12.9%</td>
</tr>
<tr>
<td>Other</td>
<td>13 (37%)</td>
<td>38.1%</td>
</tr>
<tr>
<td>Membership of professional associations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>11 (31%)</td>
<td>22.4%</td>
</tr>
<tr>
<td>RACGP</td>
<td>18 (51%)</td>
<td>40.0%</td>
</tr>
<tr>
<td>AMA</td>
<td>14 (40%)</td>
<td>53.1%</td>
</tr>
<tr>
<td>DRS</td>
<td>1 (3%)</td>
<td>0.2%</td>
</tr>
<tr>
<td>Workload (encounters)/week *</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;50</td>
<td>14 (40%)</td>
<td>-</td>
</tr>
<tr>
<td>51-100</td>
<td>9 (26%)</td>
<td>-</td>
</tr>
<tr>
<td>101-150</td>
<td>6 (17%)</td>
<td>-</td>
</tr>
<tr>
<td>151+</td>
<td>6 (17%)</td>
<td>-</td>
</tr>
</tbody>
</table>

*In the AMTS study the mean number of encounters per week was 118 (95%CI 116-121).*
Analysis
I transcribed the taped interviews. The data from the other 18 interviews was in the form of detailed notes.

Participants' answers to each interview question were collated. Next I analysed the data for GPs' perceptions about the reasons why consumers see different GPs; the causes of consumer frustration with GPs; the prevalence of consumer dissatisfaction with GPs; the reasons why consumers might feel that GPs fail them; an understanding of satisfaction with GP care over time; and whether consumers would want continuity of care if they were satisfied with their GP care.

Results
Sixteen of the GPs had seen a patient in their last consulting session whom they described as a 'doctor shopper', and a further 11 had seen at least one person in the previous week. Six said that they had not encountered any 'doctor shoppers' and two resisted applying this label on the grounds that it was disparaging.

The GPs described several scenarios where people attended different doctors. These scenarios can be grouped according to the underlying reason: a consumer preference to match the health issue with a GP's expertise, drug-seeking, not having a 'usual doctor' and needing follow-up, a search to find a new GP, and dissatisfaction with previous consultations.

Several participants recognised that some people attended GPs for specific services, seeking consultations with the best available doctor eg for the management of child's recurrent earache, or for women's health issues. One GP called this pattern of use a 'consumerist' approach and explained that it was motivated by a desire to gain quality health care:

*I'm sure there's a group who move between doctors for different reasons ... they're very committed to getting good quality health care for themselves and their families and they go to the best doctor ... for the particular problem at the particular time. (Peter)*

Some GPs mentioned that they occasionally saw patients who were seeking drugs such as analgesics, tranquillisers, narcotics, and hypnotics that require a prescription. One GP distinguished between drug seekers who wanted the drugs for themselves, those who sold the drugs, and those who sent them to relatives overseas. While several of the GP participants expressed
frustration about seeing people who were seeking drugs, none described those people as frustrated:

(Some 'doctor shoppers' are) people who are chasing narcotics, sedatives or analgesics that are not medically indicated. (These) 'shoppers' have a preconceived idea of what they want from the doctor and may be aggressive about it: the doctor feels manipulated. (Michael)

A few GPs described patients who saw several doctors because they required follow-up after treatment in casualty or after being discharged from a public hospital. People in this group who didn't have a 'usual doctor' were characterised as being more likely to be unemployed with no permanent address.

Another group were people who were shopping briefly to find a replacement doctor. These people were usually described as looking for a new doctor because of changed circumstances, such as problems with access to the previous doctor or because of moving house.

The last group of people the GPs recognised were those who were dissatisfied with their previous visits to doctors. The doctors felt that the dissatisfaction was related to an inability to get to the bottom of the problem. Some GPs felt that these people were frustrated and that this caused their dissatisfaction:

I get the impression that she feels that she's often been ignored or her concerns haven't been looked at. ... I'm not sure that I know what her concerns are at this stage. ... There are hidden concerns and there are fairly important issues that we haven't got any where near yet. (Margaret)

The GPs described the problems of these 'doctor shoppers' as:

more complex problems which may have a lot of psychological overlay or which may have a lot of family stress ... (contributing to the complexity). (Charles)

The hidden nature of some people's concerns was used as a diagnostic pointer by one GP:

Alarm signals (go off) as soon as I find out that someone has seen a number of doctors or attended a number of clinics; that in itself I think is useful information. I begin to ... really wonder about what items are on that person's agenda and I'll be on the lookout for things like undiagnosed ...
post-traumatic stress disorders, or hypochondriasis, or abnormal illness
behaviour. I don't mind that - I think those things are entirely valid
diagnoses they're just harder to get to. (Alistair)

This GP indicated that uncovering the causes of the problem can be difficult
and that getting to grips with the problem was the key to subsequent
management:

A lot of them are a bit frustrating to treat because ... you never get to grips
with (the problem). Occasionally if you're prepared to be thorough and sit
down with them and work through it they will go through it with you and
eventually learn a bit more about their health or become satisfied with it - but
I don't think most ever will be. (Miranda)

These quotes suggest that time is needed for an understanding of the
problems to develop. One GP indicated that a flexible appointment system
allows time to deal with complex problems effectively. Another GP
commented:

If the doctor had more time to listen then maybe he could avoid jumping to
conclusions and over-investigation. (Charles)

Other GPs said that sometimes the difficulty of making a diagnosis was
exacerbated if the patient hadn't identified the 'real' problems. Several GPs
indicated that domestic violence and psychological difficulties could be
contributing factors when problems eluded diagnosis. Nine of the GPs
mentioned psychiatric diagnoses when they discussed 'doctor shoppers'.
These diagnoses included neurotic disorders, psychoses, hypochondriasis,
personality disorders, post-traumatic stress disorder, and Munchhausen's
syndrome. Some of the GPs felt that they were unlikely to be able to help
such patients:

The person ... has a problem that no-one can solve and therefore they're
looking for an answer that doesn't exist or they're looking for help that
hasn't been given ... and probably they won't get. (Charles)

Another GP indicated that both the GP and the patient end up being
frustrated:

You try hard to find out what it is they're wanting from the doctor but you
tend to get terribly frustrated. (Janet)
In summary, the GPs gave examples which showed that frustrated and unsatisfied consumers often continued to feel this way. This could be because of problems with the process of the consultation (particularly related to communication between the parties) or because a diagnosis and straightforward management plan were elusive.

There was a wide range in estimated prevalence of the circumstances where people were frustrated and unsatisfied with their general practice care. Seven GPs 'guesstimated' that the problem was uncommon and most suggested that it accounted for fewer than 10% of the patients they saw. At the upper end of the range, one full-time GP said the prevalence of such problems was more than 50% and one part-time GP thought it was over 70% of his usual case load.

Several GPs broached the question of whether people would stay with one doctor if they were satisfied with their general practice care. The GPs did not answer this question directly, but suggested that dissatisfaction might not be the sole motivating reason for consumers' visits to a series of doctors.

Those consumers who had a 'consumerist' orientation were likely to continue to see the best doctor for the circumstances. GPs varied in their reactions to this pattern of service use. One said he felt slightly narked (ie irritated) when they do it just for convenience. Another stated that the reasonably intelligent ones 'pick the eyes' out of the GPs they see and good luck to them! (Rick) Another view was expressed that 'consumerist' use was fine on some occasions when they go to other doctors because of my (un)availability or the time of day or whatever.

People who saw several doctors because of drug-seeking activity or for follow-up when they didn't have a 'usual doctor' were considered likely to continue with this pattern. One GP remarked that it was unusual for him to try to engage such people:

I feel less committed to the consultation and I'm less likely to be wanting to impress a patient who is only coming along on the one occasion with one problem than a patient who I see is going to return and I'm going to have to manage as a whole patient on many occasions. (Peter)

Those who undertook a brief search to find a new GP were considered likely to settle with a GP when they had found the one for them:
In their own mind these patients know what they want and try out a GP until they find one that 'fits'. (Miranda)

In contrast, people who were dissatisfied with previous medical management were considered less likely to stay with one doctor. Sometimes the GP's assessment was made on historical grounds. A few GPs felt that these dissatisfied consumers were seeking the unattainable:

*People who are looking for the 'ideal' GP will never have their expectations met. (Often they are) trying to find an answer to an unanswerable question.* (Rick)

One GP emphasised the importance of finding a satisfactory relationship, because he believed it was a prerequisite for a satisfactory treatment outcome:

*In the long run it must be good for them if they find a doctor who suits them and recommends a treatment that they're happy to have.* (Harvey)

Another GP agreed with this sentiment when he stated:

*All of us should look for the practitioner with whom we engage and with whom we feel there is a therapeutic resonance.* (Alistair)

I concluded that GPs were aware that some patients move from doctor to doctor and they regarded this utilisation pattern as a significant problem in general practice. It was clear that GPs perceived there were several reasons for this multiple GP use, including a consumer preference to match the health issue with a GP's expertise, drug-seeking, not having a 'usual doctor' and needing follow-up, a search to find a new GP, and dissatisfaction with previous consultations. It appeared that one group of consumers kept moving from one doctor to another, in part because they were dissatisfied.

Seven of the GP participants felt that the label 'doctor shopper' was derogatory. Two said they would not describe any of their patients as a 'doctor shopper' but readily identified individuals who had seen other GPs outside the practice and who were dissatisfied.
The Consulting consumers study

Aims
The substantive aims were to explore issues related to 'doctor shopping' and continuity of care, and to compare the perceptions of GPs and consumers.

The technical objectives for the Consulting consumers study were to determine the feasibility of recruiting consumers for the study from general practice surgeries, and to further refine my interviewing skills.

Method

Interview Design
The interview schedule was designed to mirror the questions asked of the GPs in the Consulting colleagues study. I piloted this interview schedule with two consumer advocates in Canberra. They found the questions clear and easy to answer. After these interviews I modified the interview schedule by altering one phrase in the opening question and adding a question.

The interview schedule for the Consulting consumers study is in appendix 5.2.

I began the interview by orienting the consumer to their experience of seeing doctors. The initial question asked them whether (they) had ever 'shopped around' for a GP. Then, I asked, 'What does the term 'doctor shopping' mean for you?' Thus a 'working' definition was constructed from the factors or constellation of attributes each consumer used to describe this phenomenon.

The questions which followed invited the person to contribute ideas on a definition of doctor shopping, its prevalence, the characteristics of shoppers and the effects and outcomes of the activity. Each consumer was asked whether he/she would prefer not to have to 'doctor shop' and for their ideas about the factors which may promote or diminish 'doctor shopping'. Lastly demographic information about each respondent was sought including age, gender, country of birth, language, education and training. Two questions were asked about their utilisation of general practice in the preceding year.
Sampling
For the Consulting consumers study a purposive sample of 35 consumers was sought. While I had no way of identifying 'doctor shoppers' a priori, I reasoned that 'doctor shoppers' would be likely to have sought a number of consultations so I restricted potential participants to those patients who had at least five visits to a GP in the preceding year. In 1991 the mean number of GP visits by each patient was 5 visits (Deeble 1991).

Initially I selected four contrasting general practices. The practices differed in: the number of GPs working in each, the type of practice, and geographical location. The practices were a private billing group practice of 8 (5 full-time equivalent) practitioners in an upper socioeconomic area of Sydney, a bulkbilling 'extended hours' medical centre with 5 GPs located in a mortgage belt region in Sydney, a group of 4 (3 full-time equivalent) practitioners in a rural town in New South Wales, and a private billing solo practice in Canberra.

I rang the GPs in the four practices, explained the purpose of the Consulting consumers study and asked whether I could recruit patients from the practice. All of the practices agreed to this request.

Participants were selected purposively according to age group and gender categories from 'frequently attending' patients at the four practices. Thirty-five people completed an interview out of the 38 people I approached. One elderly man from the rural practice declined involvement and another agreed to the interview but was in hospital with dysphasia after a cerebrovascular accident so I thanked him but decided not to proceed with the interview. A third elderly man from Canberra withdrew from the interview because of privacy concerns when I explained that I was interested in both the positive and negative factors which influenced people as they chose which GP they visited. Table 5.5 shows the demographic characteristics of the consumer sample for the Consulting consumers study.
Table 5.5  The demographic characteristics and practice of recruitment of the purposive sample of consumers for the *Consulting consumers* study

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>17</td>
</tr>
<tr>
<td>Female</td>
<td>18</td>
</tr>
<tr>
<td>Age group (years)</td>
<td></td>
</tr>
<tr>
<td>under 15</td>
<td>11</td>
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<td>15-64</td>
<td>15</td>
</tr>
<tr>
<td>over 65</td>
<td>9</td>
</tr>
<tr>
<td>Australian State</td>
<td>n</td>
</tr>
<tr>
<td>New South Wales</td>
<td>31</td>
</tr>
<tr>
<td>Australian Capital Territory</td>
<td>4</td>
</tr>
<tr>
<td>Geographical location</td>
<td></td>
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<tr>
<td>urban</td>
<td>24</td>
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<tr>
<td>rural</td>
<td>11</td>
</tr>
<tr>
<td>Type of general practice</td>
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</tr>
<tr>
<td>solo</td>
<td>4</td>
</tr>
<tr>
<td>2-3 person</td>
<td>11</td>
</tr>
<tr>
<td>group 4+</td>
<td>10</td>
</tr>
<tr>
<td>'extended hours' clinic</td>
<td>10</td>
</tr>
</tbody>
</table>
**Conduct of the interview**

With the help of the receptionist staff, I identified those patients attending the practice on that day whose records showed that they had five or more visits during the preceding twelve months. In the waiting area I spoke with consecutive 'frequent attenders'. I explained the purpose of the *Consulting consumers* study and asked whether they would agree to be interviewed for 15-20 minutes after their consultation. I conducted the consumer interviews face-to-face where possible and tape recorded the interviews after gaining the participant's informed consent.

Four people asked to be interviewed by telephone because they had other commitments on the day of their consultation, and two others agreed to the interview but asked that it be conducted in their home.

**Analysis**

Complete transcripts were made for 28 of the 35 interviews and partial records for the remaining 7 interviews (due to technical problems with those tapes). Identical analytical steps to those used for the *Consulting colleagues* study were performed (see page 99 in this chapter).

**Results**

The consumers described several situations in which they had seen GPs other than their 'usual one'. These were for straightforward or urgent health problems when their usual doctor was not accessible; when the usual doctor was leaving the practice; or because of dissatisfaction with previous care. These circumstances are explored in detail below.

Most consumers said that there were times when the usual doctor was not available or seeing them was not convenient, so they saw another doctor either in the same practice or elsewhere. Such problems were regarded as inevitable in contemporary Australian society. Consultations of this sort did not effect the consumer's identification with the usual doctor. Some consumers did not regard consultations within the usual practice as being with 'other' doctors. Often the consumer had assessed the problem and predicted the management would be straightforward:

*Yes - for more everyday type things I'm happy to go see him, (the other doctor); like he (child) was having problems with diarrhea and I couldn't get in here and I was happy to take him to the other doctor because I figured 'I know what you're gonna do - you're gonna write me a script for Flagyl (ie*
metronidazole) or something' and that'll be fine. So I was happy with that. (Dianne)

When a consultation was needed for urgent or semi-urgent problems, patients accepted that the 'usual' doctor may not be available. If another doctor were consulted in this situation, some consumers reported returning to their 'usual' doctor to verify the proposed management:

At the time it didn't really matter who we saw because the child was YUK... the child was that sick that I just wanted him to see a doctor anyway. The doctor across the road (the 'usual' doctor) saw him later. (Eva)

Consumers also described undertaking a brief search for a new doctor when the 'usual' doctor was sick, fading out, leaving the practice, retiring, or had died. Similar searches for a new doctor were undertaken when consumers moved home:

... no, no unpleasantness...just natural events: somebody leaving, somebody dying, somebody changing from general practice to specialisation...(Pam)

Sometimes a change in the consumer's circumstances meant that they needed to have their medical services bulk billed. However if this billing method were not be offered by the 'usual' doctor, they had to search for a new doctor.

The search for a new doctor may have been brief, but many experienced it as being prolonged:

You have a right to see who you want to see. ... I mean people change their hairdressers if they don't like things. ... It can be very frustrating, but I think different doctors appeal to different people. (Angela)

Bronnie: Did it take you quite a long time to find what you wanted?

Yes, probably four years because we don't go to the doctors that often, so I would try the different ones. Actually in the beginning I tried the different ones because I think if you don't know what the others are like you can't say anything about them. (Angela)

During the searching phase the consumer may evaluate their previous doctor and consider the qualities they desire in the new GP:
I'm glad we did it in a way. ... The lady that I saw was a very, very shy lady, ... I just feel that sometimes she didn't follow things through as well as she might, should have. (Rosemary)

Another reason for changing doctor was dissatisfaction with previous care. About half of the consumers described circumstances where they had become dissatisfied with their 'usual' doctor and had changed doctors. Eight women and five men agreed that they had 'shopped around for a GP' and another five answered 'not really' but went on to describe problems that they solved by changing doctors. Of these eighteen people, only one was aged over 65 years.

I asked each of the consumers about the label 'doctor shopping', its meaning and connotations. Many defined 'doctor shopping' functionally and some claimed it as a right:

I suppose finding a doctor that suits your needs that you can actually relate to. (Karen)

I suppose it would mean the concept of just looking around for a doctor. ... Normally when you think of shopping you're looking for the cheapest - I think in the medical situation, 'doctor shopping' to me means someone that you felt happy with. (Alan)

I think if you are paying for a service you have a right to shop around. (Angela)

Others who had not changed doctors remarked that they would do so if it were necessary:

Oh, looking around for someone that you think you are going to get along with. ... I think if I wasn't happy I would do the same thing (ie 'doctor shop'). (Gladys)

Nevertheless, it was clear that the label 'doctor shopping' did have negative connotations, as five people resisted applying it to their search for a new doctor. In all, eighteen consumers gave specific examples of situations that had caused dissatisfaction and resulted in them changing doctors. This narrative is by a middle-aged man, Andrew, who described searching for five years for a doctor who might help with his problems:
About six years ago I ... became ill with stomach pains, vomiting and all that and I saw a doctor across the road and he wanted me to go to a specialist. I went to the specialist ... and he done some tests on me and he told me they were all clear. Anyway the pain and vomiting and that went on for five years. ... I went from fifteen and a half stone down to eight stone. The doctors in between said it was all in my mind. ... Then I got disheartened in doctors; I didn't trust them until I found the right one. ... Well, I finished up having Crohn's disease of the bowel.

Andrew describes his attempts to demonstrate that his problems were 'real' and to find out about the illness:

The doctors told me it was all in my mind, to go home and ride it out, but I tried that. ... Oh, I told them my symptoms. ... I was sick every night and if I took the wife out for tea I was only in the restaurant for 15 minutes and then I would have to race to the toilet to vomit. ... We couldn't go out. ... I'm self employed and I had to close my business down fairly often because I was crook and had to go and see specialists and doctors. ... It was worse for them (my family) than myself really. They were so worried about it because two specialists said that it could be cancer and they sent me for tests and no-one knew what was going on. ... It's frustrating. Before I had the bowel disease (diagnosed), at one stage there I was thinking about suicide but I wasn't game enough. I drove out to a cliff and looked down but it was a bit too high, so I drove home again. This was because they were saying it was in my mind. I was that crook. I was sick all the time. Every night I was vomiting, non stop. ... A fair few doctors don't (spend time) they put you in and throw you out again like a herd of sheep. ... In the end (Dr X) wanted to send me to (another) specialist, that was the most he could do really because he finished up putting me onto the right chap. ... I just wanted to find out what the matter was.

Andrew's experience highlights several key factors. The disease was difficult to diagnose and most doctors concentrated their early efforts on making a diagnosis. The man describes the cursory treatment he was given by doctors who couldn't fathom the disease. His distress was not acknowledged but rather minimised, cast in terms of mental instability, and finally framed as not real, being in (his) mind. The marked effects of the man's illness on his family and his business were not addressed by the array of doctors even though at one point the man seriously contemplated suicide. In an understated tone he summarised:
I got disheartened in doctors; I didn't trust them until I found the right one.

The man comments that the eventual solution (a successful referral) came from the doctor whom he now regards as 'his' doctor. This doctor takes time with (him) and he comments that I'm quite happy. ... I really stay with the one doctor.

Consumers had differing goals for their search for a doctor. Many indicated that the point was to find a doctor who suited them and then stay with them:

*I think that a lot of people, once they're happy with a doctor, as long as they stay in that area, they generally stick to the same doctor or the same surgery anyway.* (Kerry)

'Sticking' with the same doctor was strongly linked to having confidence in the medical management and being able to communicate well. One way that this confidence was manifest was when a consumer asked their usual doctor about a treatment proposed by another doctor:

*We have on occasions had someone other than Dr M when he hasn't been here and that's fine. But we prefer to keep with the one doctor, partly because Daniel suffers from asthma and I want continuity in care from someone that knows what has been going on in the past. At one stage we did have a different doctor and Daniel ended up in hospital, partly because of my lack of confidence in the whole medical treatment that was given to him. I think that because doctors get to know their patients, patients get to know their doctors and you can be more confident with a doctor that you know who listens to you.* (Christine)

A couple of consumers felt that they related equally well to all the doctors in a practice, but the majority indicated that the medical records did not substitute for a doctor's personal knowledge of their medical history:

*My feeling is that you tend to like the idea of someone knowing your history rather than having to go the history all the way through again.* (Alan)

*You should see the same doctor all the time if possible ... for continuity of information between the patient and doctor is very important. Even though they’ve got the files and things - they don’t always read them through, of course.* (Gerald)
Consumers described three main components of satisfaction with general practice care: accessibility, instrumental issues and affective features. The accessibility aspects mentioned were the importance of being able to see a doctor any time; proximity; and the availability of bulkbilling. Instrumental features related to the consumer's assessment of the GP's competence. One woman summarised this as having the aptitude and the attitude. People mentioned specific medical skills including diagnosis, limiting investigations appropriately, taking an holistic view of the person's health, discussing medications, and making good referrals to specialists. Attitudes described as 'professional' were mentioned too: perseverance with difficult problems, acting conscientiously, and maintaining a calm exterior in the face of crisis:

Someone who came across as being a professional, ... somebody who was confident in what they were telling me and someone who sort of didn't want test after test after test done for something that seemed relatively simple to diagnose. (Elaine)

I was really badly postnataally depressed and he took all of that into account. He consulted me as a whole rather than just my depression or just the kids, and no doctor ... has ever done that before ... looked at the whole thing like, 'Did you have support?' (Dianne)

Many consumers felt that professional competence and effective communication were intertwined attributes. The affective features valued by consumers included rapport, communication, and allowing time to explore the person's concerns:

(A good GP will) develop a rapport with patients and I think that's very important. ... Doctors need to have an approach, not just what you have come in for that day, but perhaps to notice anything else that might be affecting the patient, if they are depressed or what ever. ... They need a more honest approach to their patients. (Christine)

Several consumers gave detailed descriptions of the approach they preferred from their GP. Parents of young children were particularly careful to watch the doctor's interaction with their child, and valued patience, understanding, gentleness and friendliness. Adults too, mentioned the importance of rapport which was sometimes signified by the use of first names, the doctor putting the consumer at ease, or sharing a joke. Some
adult consumers looked for a GP who listened to their opinion and took it seriously. Many consumers mentioned that they valued the GP who cared for the whole family, who was like a family friend, and who offered moral support (for example) ... he visited us sort of privately ... when Joe died. The two excerpts that follow describe rapport:

Well (I look for) friendliness because I am a nervous type person, I like someone that will put me at ease because I get very flustered otherwise when I am trying to tell all my symptoms or what ever it might be. (Rosalie)

If you feel that they've got the right patience and what have you for children - especially I think a bit more patience and understanding for children. ... An understanding of how to get around and how to look in their ears - you know the best way - how to poke a stick down their throat without them creating too much (fuss)... I think if anyone has children themselves they have a better understanding of children. (Kerry)

The next two quotations show the importance to these consumers of being accorded respect, an honest appraisal, and regarded as an equal contributor in matters pertaining to their health:

(I was watching) to see how they were going to react to me as a patient. ... Whether they were going to take me seriously, ... were they willing to listen to what I had to say to them, or whether they just formed an opinion without my consultation. (Elaine)

The doctor I see now seems like he has the time. He is hard to get into see him, but once you get in there he has got the time. I think some others, you could tell that they were rushing you. ... So rather than just rush off, they check it from every angle. They don't sort of make rushed decisions. Another thing is, if they don't know they say they don't know and they will refer you. ... And I think that's why you come to them because you know they are being honest. (Angela)

From the Consulting consumers study I concluded that it was common for consumers to move from one doctor to another in search of a better therapeutic relationship. Dissatisfaction with GP care arose from difficulties with accessibility, problems with aspects of the GP's competence (skills or attitudes), and communication troubles.
Technical findings from these studies
The early interviews went well but in the 9th-12th GP interviews I encountered problems with recording due to a faulty microphone connection. I developed a checklist to ensure the equipment was functioning and preceded each of the subsequent interviews with a recording 'test' that involved the participant. Despite this, I had problems achieving good quality recordings when background noise levels were high. These experiences highlight the importance of ensuring the adequacy of equipment and ongoing attention to the technical process.

During the GP interviews I made notes as the respondents answered. The records were mainly verbatim comments and information. My note taking was adequate for the content of the GP interviews but was inadequate to capture the sequence of an individual's ideas, the context of these comments, or the person's embedded attitudes and feelings.

In the Consulting consumers study all the interviews were taped with the participant's consent. This allowed me to focus on the interview process, so the flow was not interrupted by writing direct quotations or summaries. This finding was anticipated by and consistent with Wilson et al. who showed that audio tapes provided a more detailed record of consultations than doctors' notes (Wilson and McDonald 1994).

Listening to, and later transcribing, the tapes provided an opportunity for me to examine my research interviewing skills. Early in the series of interviews I tended to speak when the participant paused and to feedback and summarise statements in my language rather than using the informant's own words. By regularly reviewing the tapes I learned not to interrupt and to use techniques including funnelling, probing, non-answering, and recursive and analytic listening (Minichiello, Aroni et al. 1990).

Four of the interviews were conducted by telephone at the consumer's request. For a brief interview such as these were, there did not seem to be a marked difference between telephone and face-to-face modes. In both circumstances people answered questions in similar detail and included sensitive material when describing their adverse experiences of general practice care.
It was clear that audio recording the interviews compared with note taking both improved the quality of the interview process and provided accurate data.

Discussion
In this study, the sampling strategy identified those patients whose records showed that they had five or more visits to the participating practice during the preceding twelve months. However, it was probable that participants identified by this strategy were more satisfied than frequent attenders who had not returned to that doctor or practice since dissatisfaction has been shown to be a powerful predictor of changing doctors in the USA (Ware and Davies 1983). Despite this, many participants had experienced dissatisfaction with general practice care at some time so they were able to discuss those experiences, and their reasons for dissatisfaction. It was clear from these preliminary interviews that the sampling strategy was effective in allowing me to access participants who had experience of what I was provisionally calling 'doctor shopping' and continuity of care.

The preliminary interviews provided the vehicle for my transition from clinical interviewer to qualitative researcher. During the studies, I consciously and iteratively examined the interview process to refine my approach so that it would be facilitatory. I developed a research interviewing style in which the person's accounts, understandings, interpretations and meanings were the focus in the interview; and the words people used were seen to be centrally important. During the interaction I endeavoured to promote a sense of equality for participants by using a conversational process in the interview (rather than a structured questionnaire which relies on a more interrogative process). I indicated that my purpose was to learn about the person's experience (rather than confirm or disprove an hypothesis).

The preliminary interviews allowed me to begin exploring issues related to continuity of care. While discussing the satisfactory doctor - consumer/patient relationship, GPs and consumers emphasised trust and confidence based on sharing and evidence of mutuality. Both GPs and consumers spoke of 'the dyad that works'. One GP said that we all need to look for the practitioner with whom we engage and with whom we feel there is a therapeutic resonance. A consumer summarised the aim of this search: for a doctor that suits your needs and that you can actually relate to.
Both consumers and GPs recognised an association between dissatisfaction with GPs and changing doctors, and both groups readily distinguished 'seeing other doctors' from 'changing doctors'. Further there was a distinction between changing doctors due to circumstances (such as moving residence), and changing because of dissatisfaction. However there was some overlap. For example, one woman described changing doctors because she needed to have future GP services bulkbilled; she framed this as accessibility issue not one of dissatisfaction, initially. Subsequently she re-evaluated the previous GP's competence and described it as unsatisfactory in that the previous GP didn't follow things through as well as she might, should have.

Consumers expressed dissatisfaction with GPs for accessibility, instrumental and affective reasons. Accessibility problems included the GP not being available, poor proximity to the doctor and lack of bulkbilling. Instrumental reasons for dissatisfaction included problems with diagnosis, investigations or referrals; inadequate provision of information; and an offhand professional attitude. Affective reasons for dissatisfaction were expressed as a lack of patience; understanding; gentleness; friendliness; respect; honesty; and rapport. All of these could lead to ineffective communication.

There was an indication in this study that changing doctors following dissatisfaction was more prevalent among younger people compared with older ones. The GPs observed this tendency, and only one of the eighteen consumers who had changed doctors after having problems with their GP was aged over 65 years.

Finally, 'doctor shopping' emerged as an unsatisfactory term for some participants. Seven doctors thought it was derogatory and five consumers said they 'hadn't really shopped' but went on to describe the circumstances that resulted in their dissatisfaction and search for a new doctor. Following these observations I reflected on how some GPs used terms which were experienced as derogatory as a way of dealing with their own fears and stresses. After completing the interviews for this study, I avoided labels such as 'doctor shopping' and 'patient'. Instead I reverted to describing the activities that were central to my research interest and relied on terms like 'multiple use of GPs'.

This study raised questions about the nature of consumer and GP relationships over time, the proportion of consumers who change doctors
every year, and the role of various kinds of dissatisfaction in these decisions. These matters are explored in the studies reported in chapters 6-9.
CHAPTER 6

Seeing doctors survey

The preliminary interviews with consumers and general practitioners (GPs) (described in the preceding chapter) showed that both groups drew distinctions between people 'seeing several different doctors' and 'changing doctors'. Having examined these issues retrospectively, I wanted to explore these distinctions in more detail by asking consumers to complete a questionnaire about their choice of GP immediately prior to a consultation. This was the principal focus of the study that I have called Seeing doctors. Further, I sought volunteers from this respondent group with whom I could examine the issues affecting their choice of GP in more detail in subsequent interview and longitudinal studies (described in chapters 7 and 8).

Aims

The aims of this study were

- to explore the way in which consumers selected general practices and GPs
- to examine the sociodemographic and interactional factors associated with these choices
- to document the demographic and illness profiles of patients attending the selected general practices
- to recruit volunteers for the interview and longitudinal studies (which are described in chapters 7 and 8)

Method

Questionnaire design

The questionnaire for the Seeing doctors study sought information about the person who intended to consult a doctor (usually the same person who completed the questionnaire). I framed questions in the language, tone and
New South Wales population were in urban and one third in rural locations (Douglas, Dickinson et al. 1991(b)).

Nine general practices were selected by geographical location. As two thirds of the NSW population live in urban areas, I selected practices to reflect this distribution (three practices from rural areas and six in Sydney). The rural practices were located in towns designated 'rural, major' and 'rural, other' by the Classification of Statistical Local Areas (Department of Human Services and Health 1994). The practices in Sydney were selected from regions with contrasting socio-economic profiles as described in the Social Atlas of Sydney (Australian Bureau of Statistics 1989), and contrasting characteristics. The urban practices included a group practice with a clientele of multi-generational families, a vocational training practice, an extended hours clinic, a practice serving a non-English speaking clientele, a practice comprising female GPs, and a solo practice in an outer suburban area.

The family practice, training practice, women's practice and extended hours clinic agreed to participate in the research after I approached colleagues who worked at each of them. In western Sydney, I approached a division of general practice and asked for the names of colleagues in solo practice that had a non-English speaking clientele. I telephoned the first person on the list, met him to discuss the research proposal, and he agreed to participate in the study. He also suggested the name of a Spanish speaking medical receptionist whom I employed as a research assistant in that practice. In south-western Sydney I rang the chairperson of the division of general practice to contact colleagues in solo practice. After describing the aims of the study, he agreed to participate in the research. For the three rural practices, I approached colleagues in New South Wales towns that were within two hours' drive of Canberra (where I lived), and all agreed to participate. The only doctor that declined to be involved in the study was a solo practitioner with a South-east Asian clientele.

classification was developed to assist the evaluation of departmental services and programs in rural and remote areas of Australia; it is not a health-based classification.

3 The doctor and his wife, who was also the practice receptionist, had a newborn baby. As they were also actively involved in the newly emergent division of general practice in their area, they felt that they could not be involved in this research project.
Table 6.2 shows the practices involved in this study. It shows the number of individual GPs, number of full-time equivalent GPs and a description of the emphasis of each practice as indicated by the GP(s) in each practice. Where fewer than 50 patients were seen in a practice on the study day, I spent two consecutive days in that practice inviting people to participate in the study. (Consecutive days were spent in practices 2, 3, 5, 6, and 9.)

Table 6.1 Percentage of patients in NSW and Australia who consulted different general practitioners during 1992-93

<table>
<thead>
<tr>
<th>No. of different GPs consulted by the patient</th>
<th>NSW % of population</th>
<th>Australia % of population</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>39.01</td>
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<tr>
<td>2</td>
<td>28.16</td>
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<tr>
<td>3</td>
<td>15.63</td>
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<td>4</td>
<td>8.11</td>
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<tr>
<td>5</td>
<td>4.18</td>
<td>4.33</td>
</tr>
<tr>
<td>6+</td>
<td>4.91</td>
<td>5.21</td>
</tr>
<tr>
<td>Total</td>
<td>100.00</td>
<td>100.00</td>
</tr>
</tbody>
</table>

Source: Table 21 Medicare Statistical Tables in (Health Insurance Commission 1994)

Administration

All patients attending the practice on designated 'study' days were informed by practice staff that the practice was participating in a research project. Their attention was drawn to a coloured poster about the study and its aims. The poster included a photograph of the researcher and was displayed prominently (see immediately after appendix 6.1).

All patients were invited to advise the practice staff if they did not wish to be approached about the study. In turn, the staff advised me of those people who had declined. Once they were seated, I introduced myself to everyone who had agreed to be approached, and invited them to complete a questionnaire. Each questionnaire was on a clipboard that had a pen attached.
I was available to talk with respondents while they were completing the *Seeing doctors* questionnaire. This allowed respondents to discuss the context from which the questions were derived and provided them with additional information about the study and its aims.

If the person seemed hesitant or offered a comment such as, 'I haven't got my glasses', I offered assistance with recording their responses. A Spanish interpreter was employed to assist respondents in the practice that had a non-English speaking clientele. A research assistant was employed in the extended hours clinic to assist with the large number of clients seen there. This assistance was available so that individuals from non-English speaking backgrounds, those with poor literacy, and adults or children who were ill would not be precluded from participation by these factors. However the assistance was not offered in such a way as to coerce potential respondents who might not wish to be involved in the study.
Table 6.2 Description of the general practices involved in the 'Seeing doctors' study. The table shows the number of individual GPs, number of full-time equivalent GPs and a description of the emphasis of each practice.

<table>
<thead>
<tr>
<th>Practice</th>
<th>GPs</th>
<th>FTE*</th>
<th>Practice's emphasis**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urban</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Practice 1</td>
<td>10</td>
<td>6</td>
<td>Multi-generational family</td>
</tr>
<tr>
<td>Practice 2†</td>
<td>3</td>
<td>1.5</td>
<td>Vocational training</td>
</tr>
<tr>
<td>Practice 3</td>
<td>15+</td>
<td>11.5</td>
<td>Extended hours centre</td>
</tr>
<tr>
<td>Practice 4†</td>
<td>1</td>
<td>1</td>
<td>Solo, non-English speaking</td>
</tr>
<tr>
<td>Practice 5†</td>
<td>4</td>
<td>2</td>
<td>Women GPs</td>
</tr>
<tr>
<td>Practice 6†</td>
<td>1</td>
<td>1</td>
<td>Solo, suburban</td>
</tr>
<tr>
<td>Rural</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Practice 7†</td>
<td>3</td>
<td>1.5</td>
<td>Group, rural (pop. of 26,000 in district ie large country town: rural major)</td>
</tr>
<tr>
<td>Practice 8</td>
<td>7</td>
<td>5.5</td>
<td>Group, rural (pop. 11,150 ie medium country town: rural other)</td>
</tr>
<tr>
<td>Practice 9</td>
<td>4</td>
<td>3</td>
<td>Group, rural (pop. 9,600 ie medium country town: rural other)</td>
</tr>
</tbody>
</table>

* FTE = number of full-time equivalent GPs

** The description of the emphasis of the practice, as described by the GP(s) working in that practice.

† Where fewer than 50 patients were seen in a practice on the study day, I spent two consecutive days in that practice inviting people to participate in the study. Consecutive days were spent in practices 2, 3, 5, 6, and 9.
**Coding and statistical methods**

In order to 'ground' the patterns in peoples' responses, I waited until the questionnaires were completed before developing the coding frame for the open-ended questions. The range and nature of the responses to the questions about consumer's reasons for seeing a particular doctor were examined and then arranged in nominal groups. When multiple reasons for seeing the doctor were given, the first three of these were coded. These reasons were classified into three categories that were consistent with the frame developed for the study, *Consumer use of multiple general practitioners* (see chapter 4) and the responses given by participants in the preliminary interviews (see chapter 5).

Health problems were dichotomised by duration into acute (duration of less than 4 weeks) and chronic (duration of greater than 6 months), and separate values were assigned for unclassified problems and missing values. Health problems were coded according to the body system affected and values corresponding to ICPC chapter headings were assigned (Lamberts and Wood 1987). Up to three responses were coded for the problem(s) the patient was seeing the doctor about on that occasion, three responses for co-morbidity and one response for health problems of a baffling nature.

The responses to all questions, once coded, were entered and verified. Data were entered into Statistical Package for Social Sciences (SPSS 4.0) for analysis. All frequency data were tabulated with the number (N) of eligible respondents and the number of missing values (MV).

Bivariate analysis using the Chi-square test was performed to determine whether there was an association between respondents seeing their usual GP and the sociodemographic and health-related variables described above. Similar associations were examined for respondents who saw a doctor at their usual practice and for those who saw several GPs in the preceding 12 months. Significance was assessed at both the 0.05 and 0.01 levels, and both are reported.

Multiple logistic regression using a backwards stepwise procedure was performed using the SPSS 4.0 software. Three models were generated to examine the factors that were associated with respondents attending: their usual GP; their usual general practice; and more than one GP. The variables found to be significant at the 0.05 level on Chi-square testing were included...
in the initial model and the least significant variable was removed sequentially. In each case, the final model was chosen for its parsimony.

Next, using these final models, random effects logistic regression was performed in GENSTAT. This was modification adjusted for the cluster sampling technique used to recruit respondents from the nine general practices. That is, a random effects term was introduced to account for respondents being sampling from selected practices rather than randomly from the general population. In each of the three models, the random effects term was the practice of recruitment.

Results
Three quarters of respondents (74.9%) were seeing the GP themselves; the remainder were parents, partners or friends of the person seeing the doctor. Of the 802 patients, 61.7% were female. Table 6.3 shows the sociodemographic characteristics of the patients and table 6.4 compares the gender and age groups of patients in this study with the Australian Morbidity and Treatment Survey.

The participation proportion for this study was 95.5%. Participation varied by practice, ranging from 88.6% at practice 5 to 100% at practices 3 and 9. Table 6.5 shows the number of patients seen at the practices on the study day(s) and the proportion of questionnaire respondents.

Two hundred and ten people (26.3%) were assisted to complete the questionnaire. The acceptance of assistance varied by practice: the multi-generational family practice (10%); the training practice (17%); the extended hours centre (12%); the solo, non-English speaking practice (92%); the practice of women GPs (23%); the solo, suburban practice (55%); the practice in a 'rural major' town on coastal New South Wales (33%); the practice in a 'rural other' town on the Murray River downs (32%); and the practice in a Snowy Mountains town described as 'rural other' (16%). Individuals were more likely to be assisted to complete the questionnaire if they were elderly, had not moved home in the last five years, were retired or were not in paid employment, had only primary school education, were born outside Australia, immigrated to Australia within the last 20 years, spoke Spanish, attended the solo NESB practice, gave affective reasons for their choice of GP and had a cardiological presenting problem.
Fifty-five percent of patients were seeing their usual doctor and an additional 29% were attending a doctor in their usual practice on the study day(s). The remaining 124 patients (16%) were going to see another GP for the imminent consultation.

Table 6.6 shows the coding categories and associated nominal groups for the questions about consumer's reason for seeing a particular doctor.

Table 6.7 shows the patients' first named reasons, grouped in categories, for seeing that particular doctor for the imminent visit.

Seven hundred and seventy patients recorded the health problem(s) that they would discuss with the GP during the visit (see table 6.8).

Seven hundred and fifty-nine patients indicated the number of GPs they had seen over the previous 12 months. Almost ninety-eight percent of patients recalled having a GP visit in the preceding 12 months. Twenty-eight percent had seen no or one GP (n=212), 35% had seen two GPs, 17% had seen 3 GPs and 20% had seen four or more GPs (see table 6.9).
Table 6.3 Sociodemographic profile of patients in the *Seeing doctors* study

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>304</td>
<td>38.3</td>
</tr>
<tr>
<td>Female</td>
<td>489</td>
<td>61.7</td>
</tr>
<tr>
<td><strong>Age group (years)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 15</td>
<td>178</td>
<td>22.7</td>
</tr>
<tr>
<td>15-64</td>
<td>463</td>
<td>59.1</td>
</tr>
<tr>
<td>Over 65</td>
<td>142</td>
<td>18.1</td>
</tr>
<tr>
<td><strong>Geographical location</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urban</td>
<td>549</td>
<td>68.5</td>
</tr>
<tr>
<td>Rural</td>
<td>253</td>
<td>31.5</td>
</tr>
<tr>
<td><strong>Housing</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rented</td>
<td>176</td>
<td>22.7</td>
</tr>
<tr>
<td>Mortgage</td>
<td>257</td>
<td>33.2</td>
</tr>
<tr>
<td>Own home</td>
<td>234</td>
<td>30.2</td>
</tr>
<tr>
<td>Family &amp; other</td>
<td>107</td>
<td>13.8</td>
</tr>
<tr>
<td><strong>Times moved house in past 5 years</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No moves</td>
<td>384</td>
<td>50.1</td>
</tr>
<tr>
<td>1 move</td>
<td>174</td>
<td>22.7</td>
</tr>
<tr>
<td>2 or more moves</td>
<td>209</td>
<td>27.2</td>
</tr>
<tr>
<td><strong>Respondent's country of birth</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Australia</td>
<td>617</td>
<td>76.9</td>
</tr>
<tr>
<td>UK and Eire</td>
<td>53</td>
<td>6.7</td>
</tr>
<tr>
<td>Spain &amp; Latin America</td>
<td>40</td>
<td>5.1</td>
</tr>
<tr>
<td>Other</td>
<td>76</td>
<td>11.3</td>
</tr>
<tr>
<td><strong>Educational achievement</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary only</td>
<td>77</td>
<td>12.7</td>
</tr>
<tr>
<td>Some secondary</td>
<td>271</td>
<td>44.8</td>
</tr>
<tr>
<td>Completed secondary</td>
<td>257</td>
<td>42.5</td>
</tr>
<tr>
<td>Tertiary degree</td>
<td>64</td>
<td>10.6</td>
</tr>
<tr>
<td><strong>Occupational group</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White collar</td>
<td>190</td>
<td>29.7</td>
</tr>
<tr>
<td>Blue collar</td>
<td>109</td>
<td>17.0</td>
</tr>
<tr>
<td>Home and retired</td>
<td>341</td>
<td>53.3</td>
</tr>
</tbody>
</table>

* Gender N =793; missing values =9
† Age group: N =783; missing values =19
‡ Geographical location N =802; missing values =0
§ Housing N =774; missing values =28
¶ Times moved house in past 5 years N =767; missing values =35
** Respondent's country of birth N =786; missing values =16
†† Educational achievement, adults only N =605; missing values and children =197
‡‡ Occupational group, adults only N =640; missing values and children =162; white collar = managers, professionals, para-professionals and clerks; blue collar = trades person, sales and service workers, labourers.
Table 6.4 Comparison of the demographic variables (expressed as percentages) for the patients in the *Seeing doctors* study, the AMTS* and ABS** population estimates

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>present study</th>
<th>AMTS</th>
<th>ABS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender†</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>38.3</td>
<td>42.0</td>
<td>49.9</td>
</tr>
<tr>
<td>Female</td>
<td>61.7</td>
<td>58.0</td>
<td>50.1</td>
</tr>
<tr>
<td>Age group (years)‡</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 15</td>
<td>22.7</td>
<td>15.9</td>
<td>21.9</td>
</tr>
<tr>
<td>15-64</td>
<td>59.1</td>
<td>59.4</td>
<td>66.9</td>
</tr>
<tr>
<td>65 and over</td>
<td>18.1</td>
<td>24.7</td>
<td>11.2</td>
</tr>
</tbody>
</table>

*AMTS is the Australian Morbidity & Treatment Survey  
**ABS data is extracted from c-data, 1991  
† Gender: N =793; missing values =9  
‡ Age group: N =783; missing values =19

Table 6.5 Number of patients seen at the practices on the study day(s) and proportion of respondents to the questionnaire

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Patients</th>
<th>Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urban</td>
<td>N*</td>
<td>n† (%)‡</td>
</tr>
<tr>
<td>Practice 1</td>
<td>115</td>
<td>109 94.8%</td>
</tr>
<tr>
<td>Practice 2</td>
<td>36</td>
<td>36 100%</td>
</tr>
<tr>
<td>Practice 3</td>
<td>241</td>
<td>233 96.7%</td>
</tr>
<tr>
<td>Practice 4</td>
<td>56</td>
<td>51 91.1%</td>
</tr>
<tr>
<td>Practice 5</td>
<td>70</td>
<td>62 88.6%</td>
</tr>
<tr>
<td>Practice 6</td>
<td>59</td>
<td>58 98.3%</td>
</tr>
<tr>
<td>Rural</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Practice 7</td>
<td>76</td>
<td>76 100%</td>
</tr>
<tr>
<td>Practice 8</td>
<td>122</td>
<td>114 93.4%</td>
</tr>
<tr>
<td>Practice 9</td>
<td>65</td>
<td>63 96.9%</td>
</tr>
<tr>
<td>Total:</td>
<td>840</td>
<td>802 (95.5%)</td>
</tr>
</tbody>
</table>

* The number of people who attended that practice on the study day(s).  
† The number of respondents (ie people who completed the questionnaire).  
‡ The participation proportion expressed as a percentage.
### Table 6.6 Categories, codes and nominal groups for the coded responses to the questions about the consumer's reason for seeing a particular doctor (Q2 in appendix 6.1)

<table>
<thead>
<tr>
<th>Category</th>
<th>Nominal Group</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Access</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proximity to GP</td>
<td>Proximity to GP</td>
<td>The participant stated that the GP was close or 'handy' to their home or work place.</td>
</tr>
<tr>
<td>Convenience</td>
<td>Convenience</td>
<td>The participant cited convenience as an important factor influence their choice of GP eg 'I didn't have to wait for an appointment'; 'it suited me to come now'.</td>
</tr>
<tr>
<td>Bulk billing</td>
<td>Bulk billing</td>
<td>The participant said that bulk billing was an important factor in choosing this GP.</td>
</tr>
<tr>
<td>Availability of GP</td>
<td>Availability of GP</td>
<td>The participant stated that they were happy to see the first available GP.</td>
</tr>
<tr>
<td><strong>Technical skill</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GP Competence</td>
<td>GP Competence</td>
<td>The participant cited the competence of the GP as the main reason they chose that practitioner. eg 'they are on the ball with techniques and up to date with knowledge'; 'thorough in examination'; 'he's capable and refers if needed'.</td>
</tr>
<tr>
<td>Prevention</td>
<td>Prevention</td>
<td>The practitioner's skill in illness prevention &amp; health promotion was cited as important.</td>
</tr>
<tr>
<td>Practice organisation</td>
<td>Practice organisation</td>
<td>The participant reported that the practice organisation influenced their choice of GP eg 'this GP took the previous doctor's place'.</td>
</tr>
<tr>
<td>Special services</td>
<td>Special services</td>
<td>The participant reported that the availability of special services eg hypnotherapy, had influenced their choice of GP.</td>
</tr>
<tr>
<td><strong>Relationship issues</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GP gender</td>
<td>GP gender</td>
<td>The participant nominated the gender of the GP as an important factor when choosing that GP eg 'I prefer to see a lady doctor'.</td>
</tr>
<tr>
<td>Language preference</td>
<td>Language preference</td>
<td>The participant nominated the ability to speak a language other than English as important when selecting a GP eg 'he speaks Spanish and can explain better to me'; 'she speaks our language and shares our background'.</td>
</tr>
<tr>
<td>Communication</td>
<td>Communication</td>
<td>The participant cited the practitioner's ability to communicate well &amp; caring nature as the main factor influencing choice of GP eg 'explains what he is doing and why'; 'readily answers any questions'; 'very approachable'.</td>
</tr>
<tr>
<td>Medical history</td>
<td>Medical history</td>
<td>The participant reported that GP knowing the medical history was important eg 'she's my usual doctor so knows my medical history'; 'my medical records are here'.</td>
</tr>
<tr>
<td>Family GP</td>
<td>Family GP</td>
<td>The participant reported they selected the GP that other family members saw eg 'he's seen all my family'.</td>
</tr>
<tr>
<td>Recommendation</td>
<td>Recommendation</td>
<td>The participant reported they selected GPs on the basis of other people's recommendation.</td>
</tr>
</tbody>
</table>
Table 6.7  Respondents' first named reason for seeing that particular doctor for the visit on the day of the survey, grouped in categories

<table>
<thead>
<tr>
<th>Reason*</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access</td>
<td>235</td>
<td>30.7</td>
</tr>
<tr>
<td>Technical skill</td>
<td>137</td>
<td>17.9</td>
</tr>
<tr>
<td>Relationship issues</td>
<td>393</td>
<td>51.3</td>
</tr>
</tbody>
</table>

*missing values =36

Table 6.8  Respondent's first nominated health problem on the day of the survey

<table>
<thead>
<tr>
<th>Problem by ICPC grouping*</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respiratory</td>
<td>68</td>
<td>8.8</td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>49</td>
<td>6.4</td>
</tr>
<tr>
<td>Skin</td>
<td>65</td>
<td>8.4</td>
</tr>
<tr>
<td>Musculoskeletal</td>
<td>114</td>
<td>14.8</td>
</tr>
<tr>
<td>Digestive</td>
<td>41</td>
<td>5.3</td>
</tr>
<tr>
<td>Other†</td>
<td>203</td>
<td>26.3</td>
</tr>
<tr>
<td>General</td>
<td>230</td>
<td>30.0</td>
</tr>
</tbody>
</table>

*missing values =32
† other includes problems of psychological (n=12), endocrine (n=11), female genital (n=36), ear (n=32), reproductive (n=31), neurological (n=20), eye (n=18), urological (n=2), blood (n=1), social problems (n=2), male genital (n=21) and test results (n=1), miscellaneous other (n=16).

Table 6.9  Number of GP visits recalled by respondents for the preceding 12 months

<table>
<thead>
<tr>
<th>Number of visits*</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-2</td>
<td>131</td>
<td>16.9</td>
</tr>
<tr>
<td>3-5</td>
<td>236</td>
<td>30.5</td>
</tr>
<tr>
<td>6-10</td>
<td>241</td>
<td>31.1</td>
</tr>
<tr>
<td>11 or more</td>
<td>166</td>
<td>21.5</td>
</tr>
</tbody>
</table>

*missing values =28
Bivariate analysis

a) Respondent's choice of general practitioner for the imminent visit

Associations between respondent's choice of doctor for the imminent visit and their sociodemographic characteristics are shown in table 6.10. The bivariate analysis showed that respondents who were about to see their usual doctor rather than others were statistically more likely to be older, living in the country, speak Spanish, have been born outside Australia, have completed a primary education only, work in the home or be retired, own their home, have had five or more GP visits in the preceding year, have seen one GP only in the preceding year, attend a solo or an unopposed rural practice, give technical skill and relationship issues as reasons for their choice of GP, and have a cardiological presenting problem at this visit. Gender was not statistically significantly\(^4\) associated with respondent's choice of GP.

By contrast, respondents who chose a GP in their usual practice for the imminent consultation rather than other GPs were significantly more likely to be aged 15-64 years, living in the city, speak a language other than English, have been born in the UK and Eire, have completed all their secondary education, work in a white collar job, have a mortgage or be in rental accommodation, have had fewer than five GP visits in the preceding year, have seen two or more GPs in the preceding year, attend an extended hours medical centre, and give access reasons for their choice of GP.

Finally, respondents who chose another GP for the imminent consultation rather than one in their usual practice were significantly more likely to be aged 15-64 years, living in the city, speak a language other than English, have been born in Australia, have completed all their secondary education, work in a blue collar job, be accommodated with members of their family, have had fewer than five GP visits in the preceding year, have seen only one GP in the preceding year, attend an extended hours medical centre, and give access reasons for their choice of GP.

---

\(^4\) In the following description and discussion the qualifier 'significantly' means 'statistically significantly'.
b) Respondents having seen one or multiple GPs in the preceding year

Associations between respondents having seen one or multiple GPs in the preceding year and their sociodemographic characteristics are shown in table 6.11. The bivariate analysis showed that respondents who saw only one GP not several GPs were significantly more likely to be living in the country, own their home, have not moved residence in the past five years, have completed a primary education only, have had five or more GP visits in the preceding year, have chosen their usual GP for their imminent visit, attend a suburban solo practice, give technical skill and relationship issues as reasons for their choice of GP, and speak Spanish. However, respondents' gender, age group, country of birth, occupation, and the nature of their presenting health problem(s) were not significantly associated with having seen one or multiple GPs in the preceding year.

Respondents who went to the extended hours medical centre were significantly more likely to have seen two or more GPs than those who went to other practices. Those respondents who went to an urban solo practice were least likely to have seen several GPs (Chi square test, p<0.01).
Table 6.10 Associations between respondent's choice of doctor and sociodemographic characteristics (expressed as a row percentage)

<table>
<thead>
<tr>
<th>Category</th>
<th>n</th>
<th>Usual GP (%)</th>
<th>Usual practice (%)</th>
<th>Other (%)</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total</strong></td>
<td>802</td>
<td>55</td>
<td>29</td>
<td>16</td>
<td></td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>304</td>
<td>52.6</td>
<td>31.3</td>
<td>16.1</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>490</td>
<td>56.9</td>
<td>27.8</td>
<td>15.3</td>
<td>NS</td>
</tr>
<tr>
<td><strong>Age group</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 15</td>
<td>178</td>
<td>59.0</td>
<td>24.7</td>
<td>16.3</td>
<td></td>
</tr>
<tr>
<td>15-64</td>
<td>464</td>
<td>50.0</td>
<td>31.3</td>
<td>18.8</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Over 65</td>
<td>141</td>
<td>69.5</td>
<td>24.8</td>
<td>5.7</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td><strong>Geographical location</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urban</td>
<td>545</td>
<td>47.5</td>
<td>33.4</td>
<td>19.1</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Rural</td>
<td>253</td>
<td>71.9</td>
<td>20.2</td>
<td>7.9</td>
<td></td>
</tr>
<tr>
<td><strong>Housing</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rented</td>
<td>175</td>
<td>51.4</td>
<td>30.9</td>
<td>17.7</td>
<td></td>
</tr>
<tr>
<td>Mortgage</td>
<td>259</td>
<td>53.3</td>
<td>30.9</td>
<td>15.8</td>
<td></td>
</tr>
<tr>
<td>Own home</td>
<td>236</td>
<td>65.3</td>
<td>25.4</td>
<td>9.3</td>
<td></td>
</tr>
<tr>
<td>Family/other</td>
<td>107</td>
<td>46.7</td>
<td>26.2</td>
<td>27.1</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td><strong>Mobility</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No moves</td>
<td>388</td>
<td>56.7</td>
<td>27.1</td>
<td>16.2</td>
<td></td>
</tr>
<tr>
<td>1 move</td>
<td>175</td>
<td>55.4</td>
<td>30.9</td>
<td>13.7</td>
<td></td>
</tr>
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NS indicates the difference between observed and expected values was not statistically significant at 0.05 level.
‡ not all questions were answered by every respondent; missing values ranged from 4 to 63
† results for adult respondents only
Table 6.10 (continued) Associations between respondent's choice of doctor and sociodemographic characteristics (expressed as a row percentage)

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Table 6.11 Associations between respondent's visiting no and one or multiple GPs in the preceding year and their sociodemographic characteristics (expressed as a row percentage)

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NS indicates the difference between observed and expected values was not statistically significant at 0.05 level.
† not all questions were answered by every respondent; missing values ranged from 14 to 58
‡ results for adult respondents only.
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<td>34.7</td>
<td>65.3</td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>645</td>
<td>27.0</td>
<td>73.0</td>
<td>NS</td>
</tr>
<tr>
<td>Digestive</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Present</td>
<td>52</td>
<td>23.1</td>
<td>76.9</td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>714</td>
<td>28.6</td>
<td>71.4</td>
<td>NS</td>
</tr>
<tr>
<td>General</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Present</td>
<td>246</td>
<td>28.0</td>
<td>72.0</td>
<td>NS</td>
</tr>
<tr>
<td>None</td>
<td>520</td>
<td>28.3</td>
<td>71.7</td>
<td></td>
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<tr>
<td>Other</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Present</td>
<td>226</td>
<td>27.4</td>
<td>72.6</td>
<td>NS</td>
</tr>
<tr>
<td>None</td>
<td>540</td>
<td>28.5</td>
<td>71.5</td>
<td>NS</td>
</tr>
</tbody>
</table>
**Multivariate analysis**

Logistic regression using a backwards stepwise procedure was utilized to generate a model for factors that were significantly associated with respondents' decisions to see their usual GP rather than another doctor. Similarly, models were developed to determine the significant factors associated with choice of a doctor in the usual general practice (either their usual GP or another doctor in the respondent's usual practice). A third model was developed to determine the significant factors that were associated with respondents seeing multiple (two or more) GPs in the preceding twelve months. However these three models ignored respondent clustering by practice. The three models were fitted again in GENSTAT with the respondent's practice of recruitment as the random effects term to adjust for the cluster sampling.

a) Respondents seeing their usual general practitioner

Table 6.12 shows the final models for factors associated with the decision to see the usual doctor. Model 1 was developed ignoring clustering of patients by practice and model 2 was developed to take this into account.

Model 2 shows that reasons for choice of GP, and cardiological presenting conditions were the significant factors associated with respondents seeing their usual GP. Age and gender were not significant factors but were retained to account for the demographic structure of the sample. Language and frequency of GP visits were significant factors in model 1 but not in the random effects model.

b) Respondents seeing a doctor in their usual general practice

Table 6.13 shows the multivariate models that were used to determine the factors that were associated with respondents seeing a doctor in their usual general practice (either their usual GP or another doctor in the respondent's usual practice). As above, model 1 is a multiple logistic regression model that was developed using a backwards stepwise procedure and model 2 includes the adjustment for clustering by practice.

Model 2 shows that frequency of GP visits, and reasons for choice of GP were significantly associated with respondents seeing a doctor in their usual general practice. Age and gender were not statistically significant factors but were retained to account for the demographic structure of the sample.
c) Respondents seeing two or more different doctors in 12 months

Table 6.14 shows the multivariate models that were used to determine the factors that were associated with respondents seeing two or more different doctors in the preceding year. The first model was developed in SPSS, and the second model includes the random effects term to adjust for clustering by practice.

Model 2 shows that the youngest age group, frequent GP visits, and reasons for choice of GP, were the significant factors associated with respondents seeing multiple (two or more different) doctors in 12 months. This model also shows that respondents attending an urban solo practice compared with all the others were significantly less likely to have seen several GPs. Gender was not a statistically significant factor but was retained to account for the demographic structure of the sample.
Table 6.12  Multivariate models of factors associated with respondents seeing their usual GP

<table>
<thead>
<tr>
<th>Terms</th>
<th>Model 1 (n = 725)</th>
<th>Model 2 (n = 721)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>OR</td>
<td>95% CI</td>
</tr>
<tr>
<td>Female vs Male</td>
<td>1.01</td>
<td>0.69-1.49</td>
</tr>
<tr>
<td>Age group†</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0.58  * 0.37-0.93</td>
<td>0.02</td>
<td>0.75</td>
</tr>
<tr>
<td>0.90  0.49-1.66</td>
<td>0.7</td>
<td>0.91</td>
</tr>
<tr>
<td>Frequent attenders‡ vs not</td>
<td>1.63** 1.13-2.37</td>
<td>0.01</td>
</tr>
<tr>
<td>Reason for seeing GP§</td>
<td>&lt;0.0001</td>
<td></td>
</tr>
<tr>
<td>14.91** 8.58-25.91</td>
<td>&lt;0.001</td>
<td>8.88** 5.50-14.35</td>
</tr>
<tr>
<td>17.92** 11.16-28.79</td>
<td>&lt;0.001</td>
<td>11.85** 7.93-17.70</td>
</tr>
<tr>
<td>Cardiological presentation vs not</td>
<td>2.55* 1.19-5.45</td>
<td>0.02</td>
</tr>
<tr>
<td>Language Spanish vs English</td>
<td>3.56** 1.37-9.26</td>
<td>0.009</td>
</tr>
<tr>
<td>Other language vs English</td>
<td>1.11  0.44-2.79</td>
<td>0.8</td>
</tr>
</tbody>
</table>

† Individuals were assigned to age groups: under 15 years (age group 1); between 15 and 64 years (age group 2); and 65 years and over (age group 3).
‡ Persons who recalled having more than five GP visits in the preceding year were described as frequent attenders.
§ Reason for choosing the GP was divided into access (reason 1), technical skill (reason 2) and relationship issues (reason 3).
* indicates that this factor was significant at the 0.05 level.
** indicates that this factor was significant at the 0.01 level.
Table 6.13  Multivariate models of factors associated with respondents seeing a GP in their usual practice (either their usual GP or another doctor in the respondent's usual practice)

<table>
<thead>
<tr>
<th>Terms</th>
<th>Model 1 (n = 731)</th>
<th></th>
<th>Model 2 (n = 727)</th>
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</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>OR</td>
<td>95% CI</td>
<td>p value</td>
<td>OR</td>
</tr>
<tr>
<td>Female vs Male</td>
<td>1.06</td>
<td>0.69-1.62</td>
<td>0.8</td>
<td>0.97</td>
</tr>
<tr>
<td>Age group†</td>
<td></td>
<td></td>
<td></td>
<td>0.02</td>
</tr>
<tr>
<td>2 vs 1</td>
<td>0.82</td>
<td>0.50-1.34</td>
<td>0.4</td>
<td>0.86</td>
</tr>
<tr>
<td>3 vs 1</td>
<td>2.63*</td>
<td>1.08-6.37</td>
<td>0.03</td>
<td>2.09</td>
</tr>
<tr>
<td>Frequent attenders‡</td>
<td></td>
<td></td>
<td></td>
<td>2.20**</td>
</tr>
<tr>
<td>vs not</td>
<td></td>
<td></td>
<td></td>
<td>2.13**</td>
</tr>
<tr>
<td>Reason for seeing GP§</td>
<td></td>
<td>&lt;0.0001</td>
<td></td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>2 vs 1</td>
<td>4.15**</td>
<td>2.08-8.29</td>
<td>0.0001</td>
<td>3.69**</td>
</tr>
<tr>
<td>3 vs 1</td>
<td>3.00**</td>
<td>1.93-4.67</td>
<td>&lt;0.0001</td>
<td>2.59**</td>
</tr>
</tbody>
</table>

† Individuals were assigned to age groups: under 15 years (age group 1); between 15 and 64 years (age group 2); and 65 years and over (age group 3).
‡ Persons who recalled having more than five GP visits in the preceding year were described as frequent attenders.
§ Reason for choosing the GP was divided into access (reason 1), technical skill (reason 2) and relationship issues (reason 3).
* indicates that this factor was significant at the 0.05 level.
** indicates that this factor was significant at the 0.01 level.
Table 6.14 Multivariate models of factors associated with respondents seeing multiple GPs

<table>
<thead>
<tr>
<th>Terms</th>
<th>Model 1 (n = 709)</th>
<th>OR 95% CI</th>
<th>p value</th>
<th>Model 2 (n = 709)</th>
<th>OR 95% CI</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female vs Male</td>
<td></td>
<td>1.26 0.86-1.84</td>
<td>0.2</td>
<td></td>
<td>1.23 0.88-1.72</td>
<td>0.2</td>
</tr>
<tr>
<td>Age group†</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 vs 1</td>
<td></td>
<td>0.64 0.39-1.05</td>
<td>0.08</td>
<td></td>
<td>0.71 0.47-1.09</td>
<td>0.1</td>
</tr>
<tr>
<td>3 vs 1</td>
<td></td>
<td>0.42** 0.49-1.66</td>
<td>0.005</td>
<td></td>
<td>0.48** 0.28-0.82</td>
<td>0.007</td>
</tr>
<tr>
<td>Frequent attenders‡</td>
<td></td>
<td>4.15** 2.82-6.11</td>
<td>&lt;0.0001</td>
<td></td>
<td>3.61** 2.59-5.04</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Reason for seeing GP§</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 vs 1</td>
<td></td>
<td>0.53* 0.30-0.94</td>
<td>0.03</td>
<td></td>
<td>0.56* 0.34-0.92</td>
<td>0.02</td>
</tr>
<tr>
<td>3 vs 1</td>
<td></td>
<td>0.46** 0.29-0.73</td>
<td>0.001</td>
<td></td>
<td>0.49** 0.33-0.73</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Practice¶</td>
<td></td>
<td>&lt;0.0001</td>
<td></td>
<td></td>
<td>&lt;0.001</td>
<td></td>
</tr>
<tr>
<td>2 vs 1</td>
<td></td>
<td>0.93 0.35-2.48</td>
<td>0.9</td>
<td></td>
<td>0.92 0.51-1.68</td>
<td>0.8</td>
</tr>
<tr>
<td>3 vs 1</td>
<td></td>
<td>1.48 0.76-2.87</td>
<td>0.2</td>
<td></td>
<td>1.36 0.71-2.63</td>
<td>0.4</td>
</tr>
<tr>
<td>4 vs 1</td>
<td></td>
<td>0.46 0.21-1.03</td>
<td>0.06</td>
<td></td>
<td>0.52 0.24-1.14</td>
<td>0.1</td>
</tr>
<tr>
<td>5 vs 1</td>
<td></td>
<td>1.61 0.66-3.90</td>
<td>0.3</td>
<td></td>
<td>1.35 0.56-3.24</td>
<td>0.5</td>
</tr>
<tr>
<td>6 vs 1</td>
<td></td>
<td>0.15** 0.07-0.33</td>
<td>&lt;0.0001</td>
<td></td>
<td>0.17** 0.07-0.37</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>7 vs 1</td>
<td></td>
<td>0.79 0.38-1.65</td>
<td>0.5</td>
<td></td>
<td>0.82 0.40-1.70</td>
<td>0.6</td>
</tr>
<tr>
<td>8 vs 1</td>
<td></td>
<td>0.58 0.29-1.16</td>
<td>0.1</td>
<td></td>
<td>0.63 0.32-1.24</td>
<td>0.2</td>
</tr>
<tr>
<td>9 vs 1</td>
<td></td>
<td>0.81 0.36-1.80</td>
<td>0.6</td>
<td></td>
<td>0.84 0.38-1.87</td>
<td>0.7</td>
</tr>
</tbody>
</table>

Footnotes for table 6.14 on the next page
Footnotes for table 6.14  Multivariate models of factors associated with respondents seeing multiple GPs

† Individuals were assigned to age groups: under 15 years (age group 1); between 15 and 64 years (age group 2); and 65 years and over (age group 3).
‡ Persons who recalled having more than five GP visits in the preceding year were described as frequent attenders.
§ Reason for choosing the GP was divided into access (reason 1), technical skill (reason 2) and relationship issues (reason 3).
¶ indicates the practice of recruitment. These were: the multi-generational family practice (practice 1); the vocational training practice (practice 2); the extended hours centre (practice 3); the solo, non-English speaking practice (practice 4); the practice of women GPs (practice 5); the solo, suburban practice (practice 6); the practice in a 'rural major' town on coastal New South Wales (practice 7); the practice in a 'rural other' town on the Murray River downs (practice 8); and the practice in a Snowy Mountains town described as 'rural other' (practice 9).
* indicates that this factor was significant at the 0.05 level.
** indicates that this factor was significant at the 0.01 level.
population did so. These findings are not surprising as respondents were recruited from general practices where frequent attenders are prevalent!

Coding of the open-ended questions was straightforward for consumers' reasons for seeing a particular doctor and listing of current and past health problems. However, the division of presenting problems into acute and chronic was difficult post hoc and only 29 of 773 valid responses could be assigned with confidence. Consequently, this study cannot answer the question as to whether consumers choose GPs differently for acute and chronic health problems. Further research is needed to explore this aspect of consumer choice of GPs.

These data on the number of GP visits and the number of different GPs seen relied on each participant recalling this information without the aid of written records or other memory prompts. As with other retrospective techniques for data collection, such information may have been affected by recall difficulty or bias and the problems inherent in retrospective delineation of events (McCallum, Lonergan et al. 1993). McCallum et al. have shown that respondents tend to under-report general practice services compared with Health Insurance Commission records of services. (McCallum, Lonergan et al. 1993) so they are likely to have had at least as much recent experience of visiting GPs as they stated.

However, it was the nature of consumers' experiences when visiting GPs and the ways in which these experiences influenced respondents' decision making (rather than the exact number of GP visits) that were important for this study. Also, decision making for the imminent consultation was explored immediately prior to the visit so these data were not affected by recall bias, problems of focus or retrospection.

The 'loss' of significance in the random effects models compared with the standard multiple logistic regression ones was anticipated as one expects that people attending a particular general practice are more similar than people at random would be. This correlation between individuals effectively reduces the sample size, resulting in larger standard errors and wider confidence intervals as can be seen in tables 6.12, 6.13, and 6.14.

The multivariate analysis showed that reasons for choice of GP, and cardiological presenting conditions were the only significant factors associated with respondents seeing their usual GP for the imminent visit so
that the other associations found to be significant on chi square testing were correlated.

In the AMTS, cardiological problems including the need for a cardiological checkup and hypertension, were the fifth most common group accounting for 7.2% of all patient reasons for encounter (Bridges-Webb, Britt et al. 1992). In this study cardiovascular complaints were associated with consumers seeing their usual GP for the forthcoming visit.

Consumers' important reasons for seeing their usual GP rather than another doctor were distilled into communication issues and technical skill. This indicates that consumers' choice of GP is based on experience and particular factors that would be likely to positively influence the outcome of the forthcoming consultation.

Those respondents who were going to see a GP in their usual practice for the imminent visit rather than to a different GP were more likely to have made frequent GP visits and to have mentioned the doctor's technical skill as an important factor. Consumers from the three rural practices were more likely than their urban counterparts to choose a doctor in their usual practice. This possibly reflects the relatively few options for primary medical services available to rural consumers.

Compared with those who had seen only one doctor in the preceding 12 months, respondents who recalled seeing several GPs were more likely to have had five or more GP visits, and mention that access issues influenced their decisions to see a particular GP. Conversely, respondents aged over 65 years, and those attending the suburban solo practice were significantly less likely to have seen multiple GPs.

This model suggests that pragmatism influenced people who see several GPs annually. Older people who have more chronic and life-threatening illnesses were less likely to have seen multiple GPs. This is consistent with results from international studies which have shown that continuity has been associated with scheduled rather than emergency visits, the elderly, and persons with some chronic conditions particularly cardiovascular disease, diabetes and mental illness (Shortell 1976; Shortell, Richardson et al. 1977; Boyle and Rockhold 1979; Ejlertsson 1980; Ejlertsson and Berg 1984; Smedby, Smedby et al. 1984; Mattsson and Westman 1987; Chao 1988; Freeman and Richards 1993).
With regard to practice organisation it was interesting that respondents from the solo suburban practice had significantly less prevalent use of multiple GPs. This utilisation pattern may reflect the ready availability of the GP at convenient times for the consumers and a satisfactory relationship between the parties. This is consonant with the widely held view in Australia that solo GPs provide personal care and is consistent with international studies (Gray 1979; Roos, Roos et al. 1980; Roland, Mayor et al. 1986; Freeman and Richards 1993). However it may be noteworthy that this solo suburban GP sold the practice within months of this study and moved to work in an urban group practice where the burden of availability was shared.

A comparison of the results of the present study with the satisfaction study (reported in chapter four) showed that frequent attenders and younger age groups were more likely to have seen multiple GPs. However in this larger NSW study, gender and educational achievement were not significant associations. This suggests that the Canberra population is distinctive demographically and that educational advantage might be reflected in particular GP utilisation preferences that the present study could not detect.

The Seeing doctors study highlighted the importance of consumers' perceptions of GPs' communication and technical skills and the way these perceptions effected their decisions to see a particular doctor. The study raised further questions about aspects of these factors, their interaction over time, and the effects of chronic conditions on consumers' decisions to see a particular GP. These issues were explored in the detailed interviews reported in chapters 7 and the longitudinal study (chapter 8).

---

5 In the satisfaction study, respondents were more likely to have seen multiple general practitioners if they had more general practitioner visits; were dissatisfied with their last general practitioner consultation; were younger; were female; and were highly qualified. Further, respondents who described good communication as the rationale for their satisfaction rating for their last general practitioner visit, were less likely to have seen multiple general practitioners.
CHAPTER 7

Detailed interviews with consumers and GPs

There are many reasons why consumers might see several general practitioners (GPs) during a year. In the preliminary interviews (chapter 5) most consumers indicated they had seen other doctors on occasions such as when their usual GP was not available or when seeing that doctor was inconvenient. Some also described seeing several doctors because they chose different GPs for different health issues or because of dissatisfaction with care. The GPs believed that consumers saw two or more GPs because they were searching for a new GP, needed follow-up but did not have a usual doctor, were seeking drugs, or had been dissatisfied with previous consultations. One GP added that some consumers had what he called a 'consumerist' approach to seeing doctors, meaning that the consumer matched the GP they visited with their particular health problem. Both consumers and GPs thought that dissatisfaction was the principal reason for changing one's usual doctor.

This chapter explores in detail consumers' and GPs' views about continuity and discontinuity of care, and examines the idea of the management of uncertainty, concepts of ideal care and the reasons why many consumers see several GPs.

Aims
The aims of this study were to explore consumers' and GPs' own views of ideal and contemporary general practice care, and to describe the effect of consumer-GP interactions on subsequent consultations. I also wanted to examine the various kinds of dissatisfaction associated with general practice visits from both a consumer and GP perspective.
to an interview. The three people who declined were otherwise engaged during the study period.

Table 7.2 shows questionnaire completion and volunteer proportions, by practice. Table 7.3 shows the social and demographic profile of consumer participants in the interviews.

Figure 7.1    Steps in recruitment of consumers for interviews

Patients attending the 9 practices on study day(s)  (n= 840)  

↓

Questionnaire offered (Step 1)

Respondents (n= 802)  Non-respondents (n= 38)

↓

Q: number of GP visits in 12 months

Frequent attenders*  Infrequent attenders†

(n= 458)  (n= 317)

Invitation to volunteer for interview (Step 2)

Volunteers (n= 168)

↓

Random quota sampling (Step 3)

Consumer participants for interview (n= 24)

* 5 or more visits in last 12 months
† missing data n=27
### Table 7.1  Protocol for sampling consumers for interviews

<table>
<thead>
<tr>
<th>Practice</th>
<th>Female &lt;60 yrs</th>
<th>Female &gt;60 yrs</th>
<th>Male &lt;60 yrs</th>
<th>Male &gt;60 yrs</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 (urban)</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>2 (urban)</td>
<td>1</td>
<td>1</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>3 (urban)</td>
<td>1</td>
<td>-</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>4 (urban)</td>
<td>-</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>5 (urban)</td>
<td>1</td>
<td>-</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>6 (urban)</td>
<td>-</td>
<td>1</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>7 (rural)</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>8 (rural)</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>9 (rural)</td>
<td>-</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>TOTAL</td>
<td>6</td>
<td>6</td>
<td>6</td>
<td>6</td>
</tr>
</tbody>
</table>

Practice 1 catered for multi-generational families, practice 2 was a vocational training centre, practice 3 was an extended hours clinic, practice 4 was staffed by a solo GP from a non-English speaking background, practice 5 was staffed by women GPs, practice 6 was a solo, suburban practice, and practices 7, 8 and 9 were group practices in rural NSW.
Table 7.2  Numbers of patients, questionnaire respondents and volunteers for interview and diary keeping, by practice

<table>
<thead>
<tr>
<th>Practice</th>
<th>Patients</th>
<th>Respondents</th>
<th>Volunteers</th>
</tr>
</thead>
</table>
|          | N*       | n† (%)‡     | v§ (%)
| Urban    |          |             |            |
| Practice 1 | 115      | 109 94.8    | 12 18.5    |
| Practice 2 | 36       | 36 100      | 17 65.4    |
| Practice 3 | 241      | 233 96.7    | 29 26.6    |
| Practice 4 | 56       | 51 91.1     | 25 75.8    |
| Practice 5 | 70       | 62 88.6     | 17 48.6    |
| Practice 6 | 59       | 58 98.3     | 19 46.3    |
| Rural     |          |             |            |
| Practice 7 | 76       | 76 100      | 17 41.5    |
| Practice 8 | 122      | 114 93.4    | 12 17.1    |
| Practice 9 | 65       | 63 96.9     | 20 52.6    |
| Total:    | 840      | 802 (95.5%) | 168 (36.7%) |

*N is the number of patients seen at the practice during the study period
† n is the number of patients who completed the questionnaire
‡ is the percentage of patients who completed the questionnaire at the practice
§ is the number of respondents who volunteered for an interview and diary keeping
¶ is the number of volunteers expressed as a percentage of those eligible to volunteer.
Table 7.3 Social and demographic profile of consumers interviewed*

<table>
<thead>
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<th>Characteristic</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age group (years)</td>
<td></td>
</tr>
<tr>
<td>under 15</td>
<td>2</td>
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<tr>
<td>15-64</td>
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</tr>
<tr>
<td>over 65</td>
<td>7</td>
</tr>
<tr>
<td>Geographical location *</td>
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<tr>
<td>urban</td>
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</tr>
<tr>
<td>rural major</td>
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</tr>
<tr>
<td>rural other</td>
<td>6</td>
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<tr>
<td>Country of Birth</td>
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</tr>
<tr>
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<tr>
<td>UK and Eire</td>
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<tr>
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<tr>
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<td>18</td>
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<tr>
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<tr>
<td>Years attending the practice</td>
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</tr>
<tr>
<td>&lt;1</td>
<td>6</td>
</tr>
<tr>
<td>1-4</td>
<td>9</td>
</tr>
<tr>
<td>5-9</td>
<td>4</td>
</tr>
<tr>
<td>&gt;10</td>
<td>5</td>
</tr>
<tr>
<td>Educational achievement † (n=22)</td>
<td></td>
</tr>
<tr>
<td>primary</td>
<td>3</td>
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<td>12</td>
</tr>
<tr>
<td>tertiary (degree)</td>
<td>4</td>
</tr>
<tr>
<td>Housing</td>
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</tr>
<tr>
<td>renting</td>
<td>6</td>
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<tr>
<td>home mortgage</td>
<td>4</td>
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<tr>
<td>own home</td>
<td>11</td>
</tr>
<tr>
<td>family and other</td>
<td>3</td>
</tr>
<tr>
<td>Times moved house in past 5 years</td>
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</tr>
<tr>
<td>no moves</td>
<td>15</td>
</tr>
<tr>
<td>1 move</td>
<td>3</td>
</tr>
<tr>
<td>2 or more moves</td>
<td>6</td>
</tr>
<tr>
<td>Occupation ‡</td>
<td></td>
</tr>
<tr>
<td>white collar</td>
<td>14</td>
</tr>
<tr>
<td>blue collar</td>
<td>6</td>
</tr>
<tr>
<td>study</td>
<td>3</td>
</tr>
<tr>
<td>home</td>
<td>1</td>
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* Gender and geographical location were used to stratify the sample (details in chapter 6).
† Educational achievement excludes 2 children currently at school.
‡ Occupational group: white collar = managers, professionals, para-professionals and clerks; blue collar = trades person, sales and service workers, labourers.
Table 7.4  Comparison of demographic and professional profiles of study GPs with those in AMTS†

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Practice*</th>
<th>Region*</th>
<th>AMTS (%)</th>
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<tr>
<td>Gender</td>
<td></td>
<td></td>
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<tr>
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<tr>
<td>female</td>
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<td>19.5</td>
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<tr>
<td>Age</td>
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<td></td>
</tr>
<tr>
<td>&lt;35</td>
<td>1</td>
<td>2</td>
<td>14.2</td>
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<tr>
<td>35-54</td>
<td>9</td>
<td>9</td>
<td>67.9</td>
</tr>
<tr>
<td>55+</td>
<td>2</td>
<td>1</td>
<td>18.0</td>
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<tr>
<td>Years in practice</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>&lt;2</td>
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<td>0</td>
<td>1.7</td>
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<tr>
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<tr>
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<tr>
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<td>1</td>
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<tr>
<td>Membership of professional associations</td>
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<td>RACGP</td>
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<tr>
<td>DRS</td>
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<tr>
<td>Workload (encounters)/week§</td>
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</tr>
<tr>
<td>&lt;50</td>
<td>4</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>51-100</td>
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<td>2</td>
<td></td>
</tr>
<tr>
<td>101-150</td>
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<td></td>
</tr>
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<td>151-200</td>
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</tr>
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<td>200+</td>
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<tr>
<td>GP visit for self past 12 months</td>
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<td></td>
</tr>
<tr>
<td>yes</td>
<td>5</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>no</td>
<td>7</td>
<td>11</td>
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</tbody>
</table>

* these variables were used to stratify the sample

† Morbidity and treatment in general practice in Australia 1990-1991 (AMTS) (Bridges-Webb, Britt et al. 1992)

‡ 4 Fellows of the RACGP in practices also had Dip RACOG and 2 Fellows of the RACGP in the regions also had Dip RACOG

§ In the AMTS, the mean number of encounters per week was 118 (116-121)
**Interview design and conduct**

The interviews were semi-structured and conducted in a style which allowed participants to describe their experiences and explore issues at a pace and depth that was comfortable for them. Typically the interviews took one hour (range 40 - 90 minutes). All of the interviews were audio taped for transcription.

The interview schedule provided a framework for discussion and allowed me to explore similar scenarios and issues with both consumers and GPs. Also there were opportunities for each person to explore related (and other) issues as they wished.

In one of the preliminary interviews, Andrew had described how a health problem that eluded diagnosis had generated uncertainty both for him and his GPs (page 110). His experience with these sort of problems brought his interactions and relationships with GPs sharply into focus. In this study I asked consumers and GPs whether they'd had similar experiences.

I began each interview by asking the consumer about their last general practice consultation to 'ground' the discussion in a contemporary interaction. Usually this consultation had taken place within the preceding few days. The next part of the interview was exploratory. I asked each person whether he or she had experienced a health problem for which the cause was not clear, to reflect on the significance and consequences of the care given for that problem, and to speculate about alternatives that might have led to more satisfactory outcomes.

Each participant was asked to describe his or her life history of general practice use and alternative health care use, and views about alternative health practitioners. Alternative health care was not defined; instead I invited people to describe any interactions with health care advisers or providers whom they would describe as alternative. Finally, I asked them to begin to generate visions of future, more ideal, interactions in general practice and to describe an ideal patient, an ideal GP visit, ideal GP, and ideal doctor-patient relationship. The consumer interview schedule is in appendix 7.1.

The GP schedule was analogous to the consumer schedule (see appendix 7.2). I began by asking the doctors to recall several patients each of whom had 5 or more general practice visits over the preceding 12 months. The
GP's recollection of the reasons for each patient's last consultation, their satisfaction with that consultation and perceptions of the patient's reaction to the consultation were sought. Next I asked about their experience as a GP and invited them to describe and comment on their management of patients for whom the cause of their problem(s) was not clear. The next group of questions focussed on those selected patients they had discussed earlier in the interview. The GP was asked about their knowledge of that person's life history of general practice and alternative health care. The GP's opinion about alternative practitioners was sought also. As with the consumers, the GP was asked to reflect on their 'ideals'. Finally, information to construct a social, demographic and professional profile of the GP and their practice was collected. This included the GP's age, gender, university of graduation, years in hospital practice and general practice, number of hours spent per week seeing general practice patients, and number of patients seen each week, details about vocational registration status, qualifications, membership of professional associations, and information about consultations other than in the rooms.

Participating GPs were asked whether they had personally attended a GP within the preceding 12 months, and those who had were asked to complete a Seeing doctors questionnaire2.

Analysis

Development of the coding frame

The interview recordings were transcribed by people who were resident outside NSW to protect participants' confidentiality. I edited the transcribed tapes and entered them into the Nud•ist 3.0 software package. A single line of text was selected as the text unit.

A coding frame was created by use of an open coding technique (Strauss and Corbin 1990). I summarised each text unit in each of four documents (two consumer and two GP interviews) and named the issues and events to form concepts. Those concepts which described properties and dimensions of a phenomenon were grouped into categories. Next categories were arranged in tentative relationship to each other. Further transcribed interviews were

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2 Only seven of the 24 GPs recalled having one or more GP visits in the preceding year. This was an interesting finding but there was insufficient data for further analysis.
read and the draft coding frame was applied. Examples were sought of concepts that could not be classified in the proposed coding frame and revisions were made accordingly.

Next I summarised my understanding of the participants' views on staying with or changing doctors. I examined the coding frame to see whether it would provide an account of the issues which the respondents had identified. I particularly noted topics that were omitted and areas of overlap.

The coding framework was modified through iterations of the two processes described above. The final coding frame was achieved after 7 iterations (see appendix 7.3). Each document was indexed by assigning text units to relevant nodes (the term for a category preferred by the designers of Nud•ist). Each of the 158 nodes represented a category. When the 50 documents were indexed, each node was printed to display all the text units relevant to that category. A description of participants' views about the particular category was created and then differences and patterns of conceptualisation were explored. In this way it was possible to identify which individuals or groups had discussed (or had been silent in) a particular category.

Construction of ideal types
Weberian ideal types are analytic tools created by the researcher that are intended to draw out the features of a particular kind of social action (such as the use of general practice) in ways that illuminate the normative expectations clustering around it. They are intended to be unambiguous and clear-cut, and to illuminate meaningful purity in each category (Cuff and Payne 1979; Broom, Bonjean et al. 1990). The types are defined by the similarities and differences between them and through an explication of the way each type functions. They are therefore 'ideal' in the sense that they represent a standard or normative typification. They are not necessarily 'ideal' in any moral sense, nor do they necessarily carry positive or negative connotations. Real people do not fit such types exactly although aspects of their actions may approximate them in their practice.
Findings and discussion

Ideal types
I generated four ideal types to describe the patterns of consumer visits to GPs. In the first type of utilisation a consumer visits only one GP. The second type occurs when all visits are to one practice, and in the third type the consumer visits a variety of GPs. The fourth type occurs when a consumer has a visit-by-visit approach to health care. The ideal types are distinguished by the locus of responsibility and the extent to which the participating GP and consumer orient to a relationship in the context of health care. These are described below.

One GP
Where the consumer has all their visits to one GP, the health arrangement in this typification is thought of as an exclusive one. The responsibility for health management may be seen as lying principally with the GP and the consumer’s task is to follow the doctor’s recommended management. It is assumed by both the consumer and GP that the next visit will be with the same GP so there is a mechanism for review of previous treatment and the consumer’s progress. Over time, the visits result in a mutual recognition of the therapeutic relationship so that the GP will call that consumer ‘my patient’ and the consumer will refer to the doctor as ‘my GP’.

One practice
When a consumer visits GPs in one practice, the health arrangement is thought of as being exclusive to that group of GPs. The responsibility for health management is held mutually between the group of GPs and the consumer. The next visit will be with the same practice so whichever GP is consulted will rely on both the consumer and the medical record to review previous treatment and progress since the last visit. The relationship is more diffuse than in the model where visits are all to the same GP. Nevertheless there is mutual recognition and the consumer will refer to 'my practice' and the GPs will identify the consumer as 'a patient of the practice'.

A variety of GPs
In the third ideal type a consumer visits and relates to a variety of GPs whom they know, often for different purposes. In this case the responsibility for coordinating health management is seen as lying principally with the consumer while each of the GPs provides care and
advice for the problem that the consumer presents. The next visit with the same GP will provide an opportunity for review of progress in the interim although intercurrent visits to the other GPs may not be mentioned. The consumer tends to be more relationship-oriented than the GPs they select so the consumer may refer to the variety of GPs as 'my doctors' while the GPs refer to the consumer as 'an occasional patient'.

Visit-by-visit
In the visit-by-visit approach to health care the consumer decides which doctor they will see at the time they want a consultation. Each consultation is regarded as a service that might be provided equally well by any GP. The main focus of the visit is on the presenting problem and the management available for it. There is no expectation about the next visit and there is no mechanism for further feedback for either the consumer or GP. Consequently there is no sense of responsibility nor relationship that extends beyond that particular consultation.

Ideal types and stereotypes
These ideal types are often reflected popularly as stereotypes. The value of stereotypes is that they are immediately recognisable and provide a shorthand, popular way of distilling certain aspects of situations. However stereotypes also tend to include a derogatory connotation as they portray peoples' actions in a narrow way and as predictable, even habitual, rather than as being in response to a complex array of influences. Also stereotypes usually include contested value judgments, so they may imply desirability or undesirability when there is not (nor is there likely to be) agreement about these.

One GP shared a stereotypical typology to illustrate different patterns of GP utilisation and consumers' different propensities for loyalty. This example both serves to focus this discussion about the typology and to provide a contrast with some of the conclusions of this research:

*The dogs are your loyal ones and really it is about 30% of your (traditional general) practice. The cats are the ones that, well they are sort of loyal but they will always 'shop around' and try someone else and the rats are the ones who have just got no loyalty at all and they will just try anyone.* (Gill)
In this anthropomorphic typology, dogs could be likened to the model where visits are to the same GP or same practice, cats to visits to a variety of GPs, and rats to a visit-by-visit approach. This quotation refers to other common stereotypes in which visits to one GP are associated with (desirable) loyalty while visits to a variety of GPs are called (undesirable) 'doctor shopping'.

*Types-in-practice*

The ideal types outlined above are modified in practice by GPs and consumers to create types-in-practice. Next I discuss and illustrate the advantages and disadvantages of each and the circumstances which may facilitate or necessitate change from one type to another.

*One GP in practice*

This type of actual usage appears to epitomise the traditional notion of continuity. While in the idealised type, responsibility for the consumer's health is identified as resting with the GP, in practice this type may also accommodate consumers and GPs who see such responsibility as resting jointly within the therapeutic relationship.

One GP described mutually held responsibility and the special relationship that can develop when a consumer visits one GP:

> With ... these patients, I feel like ... we've shared a period of (our) lives, and ... that's been quite satisfactory ... a unique time together. (Alexandra)

The advantages of this type of actual practice are the familiarity that develops during the exclusive therapeutic relationship. This encourages consumers to discuss their intimate feelings and concerns with the one GP. Over time, this type of utilisation can assist the GP to gain an overview of the consumer's health problems and an understanding of the interplay between the complex influences on the consumer and their health. Visits to one GP over time also provide an opportunity for the GP to use the evolution or 'rhythm' of the illness as a diagnostic aid. Most GPs and consumers feel that the visits with the same doctor are best for consumers who have ongoing health problems.

An elderly woman described how the benefits of familiarity with one doctor influenced her preference for seeing the same GP. She said that she found it difficult seeing several doctors, even in the same practice:
(They are) very fine doctor(s) but the thing is ... I get a bit uptight when I have to see a different doctor all the time you know. It just gets me a bit nervous. (Ruth)

A young woman of non-English speaking background explained why she too preferred to relate to one GP for all her visits:

*I would rather keep going to the same doctor than going to one doctor at one time and another at another time. ...You don't have to keep repeating yourself. ... Obviously they keep records and things like that, but ... instead of reading the records obviously (the) doctor is going to ask you about (the problem in detail), and sometimes you feel, 'Really oh I've got to repeat this all over again'. ... And sometimes it is very difficult to talk about your problems to different doctors all the time, you feel, 'Oh God, such and such doctor knows about it and I would rather that I just speak to him or her' rather than talking about my problems to one hundred and ten people. (Bella)*

GPs, as well as consumers, identified the benefits of patients having one doctor. Many GPs highlighted the value of seeing the person over time to gain an understanding of their particular illness and reaction to it. One female GP from an urban practice said:

*If they stick to that one person for long enough that one person will get them right and it makes it actually easier to do that, for that doctor to be able to see the rhythm of the illness. Every other doctor has to start again and try again. (Gill)*

Lorraine identified that seeing the same GP was beneficial as the doctor gained an overview of her health and acted as a sounding board for her:

*I think, yes, especially for parents or anyone I guess who has concerns about their health or who has health problems that are sort of recurring or ongoing, to have someone that they can go and talk to not just about specific symptoms but how they are feeling. (Lorraine)*

However there are disadvantages of this type-in-practice that relate to the inflexibility of the arrangement so it becomes difficult to match the consumer's and GP's availability. In addition, some consumers find that
this arrangement means that the GP retains power and therapeutic responsibility in spite of their wish to exercise more autonomy in health-related matters.

A GP who preferred that a consumer saw her for all visits was clear that this arrangement was optimal, but was unlikely to be lifelong. This type-in-practice contrasts with the idealised notion of a lifelong family doctor:

If they were to leave and go somewhere else even now I wouldn’t feel distressed because I would have felt we had come to some conclusions, ... moved a little bit. ...It has ... been satisfactory for the period ... (and) we have shared some experiences. I certainly don’t expect to hold on to these people for an awful long time. (Alexandra)

GPs were not always able to sustain this type-in-practice either, as they too left practices or local areas.

In practice, the one GP type of utilisation was regarded as the most common by GPs and consumers alike. Many consumers and GPs also thought that this type of utilisation was the best in the sense that it met their health needs more effectively than other types-in-practice. Nevertheless it became clear that the period over which a consumer had 'all' visits with a doctor whom they considered as 'my GP' could vary from weeks or months to a number of years.

One practice-in-operation
In this type of actual utilisation a consumer attends one particular practice but does not necessarily visit or select a specific doctor. The medical records are available to all doctors in the practice and GPs may discuss peoples' problems and management between themselves. Responsibility is held jointly between the group of GPs and the consumer but, for this to be effective, specific structures and strategies must be in place to assist communication among GPs.

In this study the doctors at the feminist practice consciously adopted collective responsibility for their consumers. Their collective practice relied on three strategies. The GPs had a regular hand-over of information about the progress of people who were likely to need more visits, each GP wrote detailed medical records which were used by the other GPs in assessing treatment and progress, and consumers were encouraged to use (or assisted
to develop) the skills that enabled them to participate in their ongoing management.

Some of the rural GPs, and many part-time GPs, who practised in groups also described similar collective responsibility and practice, especially in relation to seriously ill patients.

An advantage for consumers who have all their visits to one practice is that a GP whom they know, or at least recognise, would be likely to be available. Also in a group the GPs are likely to have different expertise and interests so there is some scope for the consumer to match their health problem with the GP's particular skills. One urban GP described how his practice had responded to the preference some consumers express for seeing diverse practitioners depending on the nature, severity and urgency of the problem. The practice had actively sought female partners so a wider choice of practitioners was available and consumer preferences were more likely to be accommodated.

One young woman said she preferred to relate to a practice rather than to a particular doctor because the practice accommodated her need to fit medical visits into her busy life. She could match her need for visits with the doctors' availability because of the quality of care provided by the group:

*There are (a) number of staff that (we) would probably ... be happy to see (who are) familiar with his history and how he reacts to various things. ... We have been going to that practice for ten years.* (Lorraine)

Although she indicated that she had less interest in continuity with one doctor, she described her relationship with GPs at the practice in classical terms of continuity and quality of care:

*Well I suppose (the ideal is) much the relationship that I feel I have with the doctors there at the (practice). Yes, just being able to be quite open and honest and confident that ... you will be listened to and that a good service will be provided and feeling happy about going back ... or phoning up if ... I think things aren't working or ... you're not happy with whatever has gone on as result of the consultation.* (Lorraine)
Several consumers who attended the feminist practice agreed that seeing one GP during an episode of illness was helpful but this did not deter them from relating to the group on most occasions.

The disadvantages of this type of utilisation occur when the lines of responsibility become blurred as may occur when collective responsibility is not philosophically or structurally supported in the practice, or when communication between the doctors or with the consumer is interrupted. The jointly-held responsibility can be overturned so that consumer's preferences for seeing a particular GP in the group are not elicited or enacted. Such eventualities may result in confusion for the consumer and the GP group which tends to increase the likelihood that treatment will be symptomatic and illness prevention checks (eg Pap smears) and procedures (eg immunisations) will be allowed to lapse.

An elderly man described how the practice receptionist intervened in his utilisation at the practice by steering him to a new doctor who had recently joined the group:

\[\text{I didn’t have a great deal (of say), I don’t think I had a choice ... it didn’t worry me cause I could see what they were trying to do. (It) came from J in the office ... 'You’d have to wait three days to see (your 'usual' doctor), but you can see Dr B now. Would you like to see Dr B?' So I just accepted it. (Ken)}\]

People described problems with this utilisation model, for example if GPs accepted a diagnosis (which was incorrect) and continued management without reassessment. Such problems associated with a diffusion of responsibility were clearly described by Christopher, who said:

\[\text{The thing with medical centres is if you have an ongoing problem you are often seeing different doctors each time and ... I worry about the ... consistency even though they take your notes and that sort of thing while they are seeing you. I’ve been asked the same questions a number of times by each successive doctor, ‘What medications are you allergic to?’ - those sorts of things and they all seem to repeat the same the same things without actually reading and getting familiar with ... your history. ... I’ve even actually said, ‘Look I want to find out what’s causing this’ and I’ve got no positive response; they’ve just signed a prescription}\]
and said, 'Well that will fix you up until next time'. So I've been getting increasingly frustrated with ... not having the real causes found out. It is more treating the symptoms rather than anything else. (Christopher)

For some consumers, visits to their usual practice during an episode of illness had not been satisfactory. Lorraine describes how seeing different GPs during an episode had been difficult:

Sometimes it was a bit of an issue if ... he was in ... an asthma episode and ... we'd see someone one day and they'd say, 'Look try so and so (treatment) and bring him back in two days and review it' and it was a different person. It was just in terms of knowing what noises there were in his lungs or just overall if he seemed a bit on the mend. (Lorraine)

Other consumers described difficulties when they had ongoing health problems. For one woman (Patricia), review by another doctor within the practice had meant that a chronic condition was not reassessed and for another (Bella), an important new symptom was not elicited. In both these circumstances, further consultations with other doctors were necessary before appropriate management was instituted.

An elderly man from a non-English speaking background described how, despite frequent attendance at his usual practice, his chest pain was managed as indigestion:

When I appeared there and ... he (the usual doctor) was busy or there was no-body else around, I'd take the next one in line so I wasn't particularly fussy 'cause I wasn't attached to the guy then. ... Well, I realised a little later that all they did was pick up my file - doesn't matter who the doctor was - and read my file, like I was diagnosed (and) that it was good enough for him and away he went. (Reynard)

Much later, Reynard's problem was diagnosed as angina and he had coronary artery bypass surgery.

The model of visits to one practice may tend towards the one GP type under certain conditions. For example, all the GPs who practised in groups said that consumers could see any GP in the practice but those who had chronic
health problems were encouraged to see one doctor most of the time to overcome the difficulties associated with diffusion of responsibility. One GP explained:

A lot of people who come to this practice will choose one of the other doctors if their first choice of doctor isn't free. ... If they’ve got chronic problems which I feel need continuity of care I ... put it to them that they’d be better off, they’d get better care, if they chose one doctor and stayed mainly with that doctor. I usually try not to tell them which doctor it ought to be, but just give them the idea that continuity is important for their care. (Alan)

In some ways many consumers' actual use of visits to one practice may represent a blend of one GP attendance and safe (approved of) in-house visits to a variety of GPs. Overall, few consumers spoke enthusiastically about the one practice model as they experienced difficulty in asserting a preference for a particular doctor, they felt that they were treated symptomatically rather than holistically, and their care seemed fragmented. Similarly, most of the GPs spoke of this mode of utilisation as a backup, rather than as their preferred way of practising. This suggests that there was considerable dissonance between the idealised one practice type and actual usage of this type because it was difficult to organise on a day-to-day basis.

A variety of GPs-in-practice
Consumers describe this type of actual utilisation in terms of their decision to consult one of several particular doctors depending on their assessment of the health problem. In this model the potential benefits and problems of each consultation are weighed by the consumer as part of their decision-making about which GP they will consult. Selection depends on the nature and severity of the problem, the consumer's assessment of that doctor's expertise in relation to the particular problem, and practical constraints such as time and money.

This type of utilisation appears to work well for those consumers who take responsibility for coordinating their own health care. It has the advantage that the consumer can match their needs with the doctor's availability and skills and this reinforces their sense of autonomy in health-related matters.

One consumer described her version of visiting a variety of GPs:
I have been seeing that particular GP ... because I just needed somebody very close to where I worked and I had another GP at my community health centre ... but she is just that little bit more inaccessible. She is a wonderful GP and I continue to go to her for a lot of things (but) I used to have to wait for nearly an hour for her sometimes and ... it was too time consuming so anyway I found Dr D and I have found him to be good enough ... for the nuts and bolts things. (Yvette)

Some consumers may be exercising this form of 'choice' because individual GPs have specialised or do not provide the range of skills required for more holistic practice.

Three GPs gave qualified support to this model, but were careful to distinguish it from the visit-by-visit approach. One GP, explained that her support for this model stemmed from her view that the present social fabric demanded flexibility of general practice:

I have a very consumerist approach to medicine. ... I think that we live in a highly mobile society. (Our practice is located in) an inner-city suburb so we have a lot of boarding houses, we have a lot of couples who are buying their first home who'll maybe have the children there but as soon as children are able to ride tricycles and bicycles they will move. We have a lot of people who are drug dependent, (and we) have a lot of professional people who are getting shoved around by their work. Some people need to keep parts of themselves compartmentalised, particularly psychiatric stuff. I also accept that I can be the other GP for people who might be close to work but they'll see their other GP who is close to home. (Sue)

Against this background Sue explained her view that consumers should be able to choose to coordinate their GP services from various sources, if they preferred:

I want there to be more interaction between general practitioners and ... I certainly want to set up the ethos within our practice that people can say, 'I saw this other doctor' and they don't have to ... launch into an apology as though they have committed a sin. It's
just not fair. ... I never say as a matter of policy, 'If you see other doctors don't bother coming back to me'. (Sue)

She concluded by explaining why she qualified her support for this approach to general practice care:

I say to people who do use a variety of practitioners that there are risks involved. Would they like me ... (to) write down things (like) blood pressures, recording weights, opinions about moles and things so that another practitioner could look and say, 'Well ... your blood pressure is showing an increase or ... you are creeping up in weight'. (Sue)

The disadvantages of this model relate to problems with coordination of care. For example, if a consumer is unaware of the recommended illness prevention and health promotion checks, these may be overlooked by the consumer and the various GPs. Also, many participants mentioned that they had experienced GPs undermining this approach by ridiculing them or refusing to see them. An urban GP said:

I would also hear, 'if he (my usual GP in the country) finds out I have been here he says he won't ever come, I can't see him again'. (Sue)

Three GPs spoke strongly against this utilisation model because they felt professionally and financially disadvantaged by it. One commented:

I tend to discourage that because I think all they are doing is they're tending to just abuse me or the system and I don't think ... they get such good care anyway. I don't think it is appropriate to ... just see people when they are really sick and bothered ... and then (they) "chop off" elsewhere for minor complaints. (Nicholas)

Visit-by-visit-in-practice

Consumers who obtain services from GPs on a visit by visit basis decide when and whom they consult once the need for a visit becomes apparent. In this type of actual utilisation the main factors governing choice of doctor may be identified as access, cost and time. The main focus of the visit is on the immediate impact of the consultation and management.
The advantage of this utilisation type is that it is flexible so that consumers' convenience can be accommodated. In this quotation a consumer explained the circumstances in which he used this approach:

*I went there (to an extended hours medical centre)... because it was open. It was early in the morning before I needed to go to work and ... I was happy to see any doctor who was available. I didn't specifically go ... to see the one I saw ... (I) can't even remember his name. ... It's a matter of a lucky dip who's available when you happen to be there. (Christopher)*

Although consumers identify a kind of lottery element in the visit-by-visit approach to GP use, they explain that they use this method of consulting because they haven't found a satisfactory GP:

*A lot of people I know don't have a regular GP that they have been able to find and feel satisfied with and keep going to ... they tend to go to medical centres as I do or 'shop around'. ... I've been unable ... to find a GP that I would say, 'Well that person I really have a high regard for'. (Christopher)*

Some GPs mentioned changes in the general practice environment (which are particularly marked in some urban centres) that mean there are more doctors than previously, and general practice is seen to be competing with services provided by specialist doctors and other health care professionals. They expressed the opinion that these factors have encouraged some consumers to adopt a visit-by-visit approach to health care. One GP said:

*Probably ten years ago you could say well if you had a patient that ... attended you, you would basically expect them to keep on attending you. But these days I think that with people having more access to their own transport and the fact that there are so many other GP's available particularly these clinics that ... advertise in a sense that ... you have got no waiting time etc. I think there are just some people ... that small group that you never thought were really that loyal but they are certainly much more likely to say, 'Right well ... I won't wait'.

We can then tell them over the phone ... 'You can see the doctor but it will be in one and a half hours' ... they'll tell the
receptionist, 'Well look I'll go down the road or go down to (a medical centre)'. (Vaughan)

The disadvantages of this utilisation type result from the inherent lack of feedback from such visits. The GP is unlikely to get any feedback about the consultation, or whether the consumer followed the management plan, or if the treatment were efficacious. One GP likened the visit-by-visit approach to utilisation of casualty services. He indicated that this form of practice placed a responsibility on the doctor to document management carefully so that subsequent doctors could access this information:

It's the same as working in a hospital in casualty. You get ... people coming in and asking for advice, and you deal with them the best you can. If they would like to come back to see you then you arrange for them to come and see you next time they're here, but if they need more urgent follow-up then you leave adequate notes ... to make sure that the follow-up is appropriate. (Terry)

Terry went on to describe frustration with lack of follow-up:

It's very frustrating when you have an interesting case and you send them over to the hospital, and that's the last you ever hear of it. You don't know whether your assumptions and diagnoses are correct or not, because you don't know what happens to them. (Terry)

Another GP who had worked in a traditional group practice prior to his current position at a medical centre also commented on the lack of coordination of care. He said:

I see that every day. People come down (to the medical centre) and they're wanting something heavy that's going to require a specialist consultation and it may ... (require admission to) hospital and ... I say to them, 'Do you have your own doctor? Where do you think the specialist will send all these heavy notes to?' They don't know. (Daniel)

These disadvantages mean that many GPs prefer not to practise in this mode and those who do may be disaffected (for example, see Jason below) or disenfranchised (for example by being ineligible for vocational registration). Another GP acknowledged that he had been hurt by people changing
doctors so he had adopted what he called a 'service mentality'. He said he acceded to consumers' requests (such as for prescriptions and sickness certificates) provided he judged it was safe and ethical to do so. Working in this mode he rarely gave a consumer an explanation for their health problems, nor were education materials or specific preventive strategies offered or self-help agencies mentioned. This GP said:

"I had this actually happen, one of the top ten of my patients in terms of rapport ... going through things together, not necessarily highly emotional things, but ... house calls after hours, Sunday mornings. (This person) took themselves off to a bulk billing centre about 6 months to a year ago ... never to return. ... So, when you get hurt like that, you think, well, ... I don't want to think that anything's permanent with my patients, you know. ... This 'doctor-shopping', it's almost better, 'wham-bam, thank you maam', five minutes, ten minutes, whatever you wanted, or ... maybe it's more complicated than that, but ... there's a bit (of) bliss in that, you know. (Jason)

Jason suggests that visit-by-visit utilisation is straightforward, not intellectually demanding on him but is immediately satisfying for consumers.

However consumers are not necessarily happy with this type of consulting. Visits to different doctors often means they receive many different treatments and conflicting advice. Further, as the focus is on the visit itself, issues such as addiction or problems with the immune system that might otherwise be addressed in ongoing therapeutic relationships might be overlooked. At times this results in diagnostic inaccuracy, the consumer being treated symptomatically rather than according to a diagnosis, over-medication (with the attendant risk of adverse drug reactions), and consumer confusion.

A young mother whose baby had a gastrointestinal upset saw several GPs about the problem. The doctors had differing opinions and she said she felt confused as a consequence:

"I was really confused, I thought, 'Well which one of these people knows?' ... I just didn't think it was really good at all. And I thought ... there were so many different views coming in so... I'd..."
ring up my mother and I'd say, 'Well this one said that, and that one said this, what do you think I should do?' (Shelley)

Other GPs said that this visit-by-visit approach mitigated against continuing care of intercurrent problems and the absence of clear responsibility meant that management might be compromised. This quotation is from a GP who practised in an urban setting:

There is one particular person who is a ... drug addict ... who has also had some perianal problems. ... He obviously isn’t 100% happy with the surgical care ... I have (had) no contact from the surgeon about (this) because he is not really my patient. ... So he is a very difficult patient to follow because he doesn’t stick to one GP and I know for a fact that he is seeing quite a few. So his management for his surgical problem is obviously ‘stuffed up’ because nobody knows what anyone else is doing. (Rita)

Thus in comparison with the non-problematic idealised visits-by-visits approach in a free market where GPs have standard skills, in practice this type of utilisation has a range of clear advantages and disadvantages. It may be that for many consumers this type of utilisation is not a lifelong choice, but one more likely at an early life stage prior to settling down geographically and into a pattern of use with a GP (or GPs) who are identified as 'a good match'.

Distinguishing between the types-in-practice
It can be seen from the preceding discussion that the visit-by-visit approach places emphasis on the health problem whereas the other modes emphasise (more or less) the relationship between the consumer and doctor(s). In the idealised types responsibility was seen as resting primarily with the GP in the visits to one GP mode, jointly in the visits to one practice type, and mainly with the consumer when utilisation involves visits to a variety of GPs. However in practice, the locus of responsibility is less fixed, and it is possible to have more egalitarian relationships in the visits to one GP, one practice and variety of GPs types.

Mixed utilisation over time
The four utilisation types described above are not mutually exclusive and fixed. Actual utilisation may involve the simultaneous use of two models or change from one type to another in response to personality differences,
access and convenience factors, the nature of the health problem and life stages. Both GPs and consumers are more far mobile than was common 50 years ago. In addition, consumers are more educated, particularly about health matters, and they have more ready access to the vast amount of health and illness information. These considerations make actual utilisation more varied than the types-in-practice might suggest.

As discussed above, utilisation is often modified during an episode of illness or when chronic illness supervenes. In those circumstances many consumers and GPs change from visits at one practice to visits with one GP.

Some consumers combine a visit-by-visit approach with seeing the same GP. In this kind of use the consumer assesses the health problem and decides whether the responsibility and relationship orientation could be traded for a more timely service. A man from a non-English speaking background explained why he saw a particular doctor to get a repeat prescription:

*We just need... a prescription, because sometime when you want to go to Dr A you have to wait so long (laugh) so we don't want to wait that long. I mean just because we just need a prescription.*

Question: Right, So if it is something straightforward and you know what you need then you might go to the 24 Hour Clinic?

*Yeah sometimes it is quicker.* (Vince)

This particular visit epitomised a visit-by-visit approach to GP use. However Vince preferred to visit his usual GP for problems that were not straightforward, and added that seeing another doctor when he really wanted to see his usual GP (for example out of hours) often meant two consultations were needed because he wanted to verify the opinion of the other doctor:

*If it happens in week-end it happens. In weekend like Saturday night or Sunday morning so ... I had to go to the 24 Hours. It's not because I like it's because ... Dr A does not work on the weekend. ... I say, 'I can't believe those people' - that's when I went that day to Dr A to see (whether he agreed with the treatment that was recommended at the 24 Hours clinic). (Vince)*

This example shows that Vince's decision to use a visit-by-visit approach was finely regulated and restricted to minor problems. Some of the GPs
recognised this pattern of use too. Enrico, a Spanish speaking GP, explained that some of his patients saw other doctors (visiting either a variety of GPs or using a visit-by-visit approach) but they chose to see him when detailed discussion in Spanish and cultural considerations were important:

*A number of my patients do tell me straight out that because of the distance they usually see a local doctor but they like to pop in now and then for a little bit of a chat or some other problem that they want to discuss. The main reason for that I guess is the language.* (Enrico)

**Types of utilisation available from GPs**
The majority of GPs I interviewed described a preference for practising in the visits to one GP mode. However, this did not mean that they practised in this way exclusively. Some said they enjoyed a mixed practice where they backed up other GPs in their group using the visits to one practice mode, had a special interest, such as obstetrics, which allowed them to practise in the variety of GPs mode and saw people on holidays or with emergency health problems in a visit-by-visit mode.

The GPs who consciously practised collectively to deliver high quality care in the visits to one practice type, also said they worked in the one GP and variety of GPs modes.

**Seeing other doctors**
Sometimes seeing other doctors afforded consumers an opportunity to 'test' doctors by comparing and evaluating their different medical and personal styles, as illustrated above. In some cases this evaluation became the basis for a decision to change doctors. These situations reveal a great deal about the process of GP selection and add further to the understanding of the types-in-practice in contrast to the idealised types (or stereotypes).

Incidents that provide an opportunity for consumers to reassess their GP(s) were described by both GPs and consumers as critical. They might range from seeing a locum GP to situations where emergency treatment was required from a 24 hour clinic or hospital. A hospital-accredited GP recalled that in her experience consumers tended to reassess their usual GP after seeing another GP during a period of hospitalisation:

*(The patient might change doctors) ... if she was dissatisfied with ...the care that she had been given (previously) or maybe even if*
she was more satisfied with the care that she was given by the people who looked after her when she came into the hospital. (Janice)

A rural GP, Fairlie described seeing a patient while she was acting in a locum position. The consultation provided an opportunity for that patient to experience another doctor's approach and afterwards she decided to change doctors. This is an example of a consumer's decision to change from one GP to another within the model of visits to one GP.

Second opinions
When consumers seek the opinion of another GP they have two similar experiences to compare and so can evaluate both doctors' performance. Two rural GPs commented favourably on consumers seeking second opinions as this increased the likelihood of the patient being correctly diagnosed so effective management could be planned:

On the whole it's quite positive to get somebody else's viewpoint on a patient, particularly a patient who comes often, where you seem to get a bit stale on them and their problems, or start to miss things because you see them so often. ... Generally I find if a patient sees another doctor it often helps them and me to get new insights into what's going on. (Rebecca)

This GP said that she assimilated the information gained from the other visit but made a point of focussing on the present consultation:

I'm not sure (where she got the referral) because there's nothing in the notes between when I saw her and when she came back again yesterday to say who referred her or what happened. ... I didn't chase it up when I saw her yesterday. I mean I was just happy that she was satisfied and it had been resolved. (Rebecca)

Although they readily agreed that it was a consumer's right to do so, many GPs had negative reactions to consumers seeking second opinions from other GPs. Several presented the benefits of choosing one doctor to the consumer and implied that the consumer should choose between doctors expeditiously, as Theo did:

No, I don't try to influence them. I say, 'Whoever you are most comfortable with, stick to (them).’ (Theo)
Some of the GPs felt that consumers seeking another opinion reflected adversely on their professional expertise. Among those who strongly endorsed the one GP model were several who indicated that they felt challenged by contradictory advice given to 'their patient' by other doctors. At least two issues arose. Firstly there was a sense that the advice was competing with theirs so the GP became defensive about their own management. Secondly GPs sometimes had difficulty explaining the evidence and rationale for the different plans. The task of negotiating with the consumer to develop a new management strategy was demanding and may be difficult when GPs felt they should 'save face' with the consumer. In this complex situation some GPs adopted the position of dispassionate judge, even though they also acknowledged that their empathic support was crucial for the consumer. For these reasons some GPs regarded second opinions as threatening and feared they would be found wanting by the consumer, lose business and suffer financially.

Because the GPs recognised that second opinions had these negative connotations, they all were more at ease discussing them as the doctor providing the second opinion, rather than as the doctor whose opinion was being reviewed.

One GP said she had a reputation for providing second opinions for consumers who were contemplating surgery or gynaecological treatments. Kyra described an increasing demand for this service over the last five years. Usually she endorsed the first GP's management, but some consumers changed doctors after seeing her. She said:

_There is a certain category of patients ... who come (for) a second opinion ... and they might have their own regular GP or they might have seen perhaps four, five or six GP's and decided, 'Right, I have got to come and get your opinion regarding this.' ... And quite often in that instance we go through a story, we find that what has been done for them is really, in my opinion, quite correct and proper. I certainly tell them, 'Look this is exactly right. You should go back and see your own doctor unless for some reason you really don't want to continue (at) that practice because (I) can't fault what that doctor's doing.' ... If we do any tests or investigations ... we actually send a copy of the results back to their own GP as well._ (Kyra)
In contrast to the men in this study, many of the women GPs described examples of consumers returning to their usual doctor after seeking a second opinion:

*She'd certainly shopped around a bit, but basically she keeps coming back to her own GP ... to sort of guide on-going treatment.*

(Rebecca)

This suggests that the important factor in whether a consumer decides to change their doctor is the GP's reaction to them seeking a second opinion not the information gained from the other opinion.

### Changing one's doctor

Commonly consumers changed GPs for a range of reasons such as maternity, separation or divorce, retirement, or death, or moving house. For many there was a combined effect from other factors too such as dissatisfaction or difficulties with accessing services. Examples of these factors were difficulties with access (eg when transport was a problem), a change in consulting hours, or finding that a particular service was not provided by that doctor (eg maternity care). Other consumers noted that the cost of consultations had become the catalyst to change doctors if they needed their consultations bulkbilled.

An elderly man described changing GP after he moved to another suburb. He gave priority to ready access to the GP once he had established that he was satisfied that the new GP provided good quality care:

*Dr S, I had him all the time until we came here, course I would have to run down there every time I wanted to see him and it's not worth it. I mean this doctor's just as good.* (David)

Consumers were pragmatic when discussing what might be termed circumstantial reasons for changing doctors, perhaps because such reasons are commonplace. However many expressed a sense of frustration and loss and some had difficulty accepting the need for a change particularly if they had developed a strong relationship with their GP. People with special needs (eg individuals with chronic conditions, mental illness, and those from ethnic backgrounds) often expressed distress if they had to change doctors. A young mother from a non-English speaking background said:
It was really difficult for me when I found a GP whom I was comfortable with and she stopped practising and she moved out of my area. And I thought, 'Oh no, not again' and ... I had to run around trying to find a doctor. It's amazing the number of phone calls you make, the number of visits you make, just to find out if it is the right person to go to. (Bella)

A combination of factors
Some consumers described a subtle linkage between matters of convenience and dissatisfaction, indicating that the decision to change doctors could be more complex than it first appeared. Reynaud said he had been considering changing doctor for some time and decided to make the change while undergoing treatment in casualty for an emergency:

Oh I had major thumb injuries ... and I finished up in the ... hospital here to have this stitched and he was doing the job. And I wasn't very happy with my previous doctor at all so I was going to switch any way to the other surgery so I did there and then. He asked me who my doctor was and I said, 'I think you will do' and that was it. (Reynaud)

Annette described a change of GP when her doctor couldn't deliver her baby in the local country hospital as the maternity unit had been closed:

Well I was actually going to a GP in X (a small country town) at first and over at X now ... you can't have babies over there; they've closed the maternity section down. My doctor over there ... referred me to Dr M so I have been going to him and I find him very good. (Annette)

Later during the interview Annette indicated that there were additional reasons that had prompted her to change doctors. She had lost confidence in the practice when her usual doctor's partner prescribed incorrectly for her son resulting in his emergency admission to hospital.

A chain of events
Other consumers described a chain of events that precipitated a change. Stella, whose mode of use was with one practice, mentioned that a lack of a familiar doctor at her usual practice prompted her decision to try out a medical centre. She traced her decision-making weighing her unfamiliarity with a locum doctor against the convenient location, extended hours and
affordability of the GP services at the medical centre. Having tried the medical centre, she was satisfied with the whole situation and changed doctors. She explained:

I was off colour again and I rang for an appointment and they said Dr W was away but that there was a GP there (whom) they said (was) very good. But I said, 'No I don't think I'll bother' cause I thought if we are just going to anyone indiscriminately we may as well go down to the medical centre which after all is a lot cheaper. And also we were doing meals on wheels that day and it was right next door to the medical centre which after all is a lot cheaper. Really I... don't know who I saw that day but I was very impressed with the whole situation and we've (my husband and I have) never been back to ... Dr W, have we? (Stella)

Critical incidents
Some consumers described major illness such as a stroke, myocardial infarction or breast cancer as significant incidents that could trigger a change of doctors. For these people it was not the illness itself, but the doctor's approach to it, that prompted the change. They felt that the doctor had not helped them understand or adjust to the illness. Adele said:

So many doctors just don't volunteer any information and you have got to ... ask questions and sometimes even when you ask questions you almost feel as though you had no right to ask even though it is your body and your blood pressure. (Adele)

Such critical incidents usually involved one doctor and the resulting dissatisfaction was often strongly felt. Frequently consumers chose to see a doctor in another practice (rather than seeing another doctor in the same practice) as they did not want to see, or be confronted by, that doctor again. An elderly woman from a non-English speaking background explained:

He's better, he is more understanding than where I was before. She (the former GP) didn't (understand). When I went there (she) couldn't understand and she said to me once, 'This is just in your head' but my blood pressure was always high, it is not in my head is it? So I changed the doctor. (Adele)

Julia, an urban GP, described another incident that illustrates a consumer's decision to change from visit-by-visit use to visits with one GP. In this
example a patient attended a medical centre near her home following an assault. The consumer said that the treatment left her with a feeling that things were all up in the air so she returned to Julia whom she had visited previously. Although the consumer judged the presenting problem was urgent but straightforward, on reflection she felt that the management at the medical centre was unsatisfactory so she changed doctors.

Other reasons
Sometimes there was no critical incident but ongoing consumer disquiet. One GP hinted at this when she described how some patients would see other doctors if attempts to support them were not consistent:

If I wasn’t available she’d see whoever was (available) and I think if she... wasn’t happy with the treatment, if she felt that we were getting no-where, she’d be quite likely to shop around. ... Because she’s the kind of lady who’s always going to have symptoms, it’s the depression I think. (I’m) sure that she’s always going to have some pain or worry and when one’s resolved another one will pop up. If she’s not being continually treated and supported she probably would shop around. (Rebecca)

Both GPs and consumers recognised that consumers could find it difficult to trust any doctor when trust had been broken by another GP due to a missed diagnosis, failed treatment, or unwillingness to explore their expectations and concerns. Confidence in doctors could be hard to re-establish once it had been breached, as Stella explained:

Well (sigh) I nearly died with my gall bladder problems (biliary colic and ductal obstruction) ... I’d been in the local hospital with severe pains and vomiting but they just thought I was over it and sent me home again. It had gone on for months ... I was losing weight. ... They thought that I was a malingerer (laugh) but it really got that bad that I was quite yellow (before I had the cholecystectomy). ... I got very stressed. It seemed to have effected me psychologically as much as physically.
Well I was getting frustrated and of course my attitude to doctors changed completely after that. You’d never, you’d never trust them again to the same extent.
The other time ... I had a detached retina and I knew it was detached ... and I went to the GP on Monday morning and it was
Friday before I got the operation. Well it was too late and it should have been done before then of course to have been effective and I've lost the central vision of that eye ... but I couldn't sort of convince them ... what the problem was.

Stella now prefers to retain responsibility for managing her health care and is keen to see specialist doctors for all but the most straightforward problems. She described her ideal GP in terms of linkage with the wider health system:

They certainly have to know what they are doing and also they have to send you to a specialist if they are in any doubt. ... I suppose it's important that they know about ... which hospital to get you into or ... which services to get to get in touch with.

Limitations of this study
A useful picture of the complexities of general practice utilisation has been derived from the participants in this study, but these people may not be representative of either patients or doctors in the general population.

Consumers were eligible to volunteer for an interview if they recalled having five or more GP visits in the preceding year. Thus participants were more likely than average patients to have serious illnesses. They were also more likely to have been satisfied with their present care, since dissatisfied consumers are more likely to change doctors (Ware and Davies 1983) or reduce their utilisation. Consumers who have been infrequent attenders at general practice may have had different experiences and reasons for their visits, so further studies are required to explore the views of a wider cross-section of people.

Similarly the GPs in this study were volunteers. The participants differed from GPs who responded to the AMTS survey in that women, middle-aged, Australian-trained GPs who were qualified and members of the RACGP were over-represented in this study. These characteristics may explain the high participation proportion (96%) among the GPs approached but the effect on their views is impossible to estimate.

The effects of consumers' age, gender, socioeconomic status, geographical and illness groupings on the typology of GP utilisation have been explored in a preliminary way in this study, but there are likely to be other
characteristics such as ethnicity and personality that influence utilisation and these have not been examined.

Summary
This study developed out of the insights gained in the preliminary study (chapter 5). The stereotypic duality of lifelong 'loyal patients' and 'doctor shoppers' has given way to a more complex understanding of the balance between consumers' ideal and actual practices which have been arranged around a four-fold typology of GP utilisation. The four utilisation types are described as consumer visits to one GP, one practice, a variety of GPs and visit-by-visit use. These four types have been traced from the Weberian idealisations to types-in-practice and their variants including mixed utilisation.

By examining the complex and contingent nature of consumers' actual choices I have shown that they feel there are advantages and disadvantages of each utilisation type-in-practice. Consumers strive to make the best possible choices they can within the constraints of the 'real world'.

The advantages of continuity were seen clearly in the utilisation type where all visits were with one GP. These advantages were familiarity, the facilitation of discussions about intimate feelings and concerns, the achievement of an overview of the consumer's health problems, and an understanding of the interplay between the person's health and the complex influences on them. Many doctors also appreciate developing a relationship and seeing the results of their work. Similar advantages can be gained from the utilisation types where a consumer visits one practice or a variety of GPs indicating that these two types-in-practice can support a form of continuity too. However, special commitment is required if continuity is to be developed and maintained in these types.

In this study I have shown that consumers visits to several doctors are inherent in three utilisation types (visits to one practice, a variety of GPs and visit-by-visit use) and such visits also occur when consumers cannot visit 'their GP' in the visits to one GP model. When seeing other doctors in this way or after seeking a second opinion, consumers are able to evaluate GPs' medical and personal styles. Such visits can be a prelude to a consumer's decision to change their GP.
This study was based on participants' reconstruction of earlier judgments and supplied a rich field of new understanding about the complexities that effect consumers' selection of and visits to GPs. My interest in studying consumers' prospective decisions to see GPs stemmed from a desire to see how this decision-making took place as it occurred. Initially this was planned as a check on memory, but the study using health diaries (reported in the next chapter) emerged as a major examination of the way preferences are played out and modified in practice. It also supplied an opportunity to plot the trajectories of consumers' 'careers' in the utilisation of GP services.
However diaries have also been criticised in six ways. Difficulties gaining and keeping respondents' cooperation, conditioning effects, concerns about data quality and cost, and problems with data collection, processing and analysis have all been reported (Marcus 1982; Norman, McFarlane et al. 1982; Verbrugge 1984; Bentzen, Christiansen et al. 1987).

Of these disadvantages the principal concern has been with two conditioning effects, sensitization and fatigue. Sensitization occurs when involvement in a study influences a participant to change his/her health perceptions, attitudes or behaviours. Although sensitization is possible, Alpert has asserted that merely interviewing families periodically does not change their health-related attitudes (Alpert, Kossa et al. 1970) and Verbrugge has shown that health behaviours were relatively unaffected by keeping diaries (Verbrugge 1980). Fatigue occurs when participants tire of keeping the diaries and become less thorough with diary recording (Mooney 1962). This effect has been shown to become more pronounced with increasing duration of a study, especially if it is longer than one year (Marcus 1982; Norman, McFarlane et al. 1982; Verbrugge and Balaban 1989; Douglas, Woodward et al. 1994). Thus sensitization can be reduced by focussing on health related actions, and fatigue minimised by limiting recording to periods of less than one year.

Despite their utility, health diaries have been used rarely in Australian general practice research. Bridges-Webb (1972) utilised them in the Traralgon health and illness survey (Bridges-Webb 1973; Bridges-Webb 1974; Bridges-Webb 1974). However they have been used more widely for Australian epidemiological studies (for example, (Douglas, Woodward et al. 1994; Pilotto 1994)) and recording information about costs associated with symptom management (for example, (Goulston, Dent et al. 1991)).

In this study the health diaries were chosen as a tool to help people record information that they could refer to during interviews in which they reflected on their decisions and discussed whatever had effected their choice of GP. They were not used in any sense to check up on participants although the details they recorded about numbers of visits to health providers and numbers of different providers gave me an opportunity to explore both the qualitative and quantitative nature of GP visits to providers.
Continuity indices have been used to quantify relationships between numbers of visits to health providers and numbers of different providers. Some indices focus on the concentration of care (Breslau and Reeb 1975; Bice and Boxerman 1977; Godkin and Rice 1984) and others on the sequence of care (Steinwachs 1979; Smedby, Smedby et al. 1984). These were reviewed in detail in chapter 2.

None of these indices have been used on data sets which include information from consumers about their reasons for visiting one provider rather than another. That is, the relationship between numbers of visits and providers has been quantified without concurrent research into the meaning of, or rationale for, the therapeutic relationship. This study provided an opportunity to examine continuity in both qualitative and quantitative ways.

Aims
The aims were to explore prospectively the factors affecting consumer's choice of GPs, and to refine the typology of general practice utilisation developed in the interview study (chapter 7). An additional aim was to calculate seven continuity indices and compare the indices with each other and the diary-derived information for each of the participants.

Method

Design of the health diaries
Health diaries were designed to serve both as a primary data source and as a memory aid that participants were able to refer to during monthly telephone interviews. Participants were asked to record the date of their primary medical care visits, the name of the doctor they consulted, the reason(s) for each visit, and any comments.

Several formats were trialed with volunteers from one Sydney general practice where some of the preliminary interviews (chapter 5) were undertaken. The pilot work reinforced the importance of the diary design. It was evident that the format should be simple and the task clear, to minimise fatigue. Ultimately a ledger format was adopted so the information could be held in a plastic photograph holder and kept in a prominent place. A copy of the health diary is in appendix 8.1.
Study population and sampling
Participants were recruited between February and June 1992 from the nine general practices that participated in the Seeing doctors study (chapter 6). Volunteers for this study were recruited in a three step process that mirrored recruitment for the interview study described in chapter 7 and is summarised in figure 8.1.

Briefly, the volunteers were sought from those respondents to the questionnaire who recalled having five or more GP visits in the preceding 12 months\(^1\). Participants for the interviews and diary recording were randomly selected from the group of consumer volunteers according to age and gender quotas (see the schedule shown in table 8.1).

There were no eligible volunteers for diary-keeping among men in practice 6 aged 60 years and over, or from women at practice 8. Instead I randomly selected from the eligible urban volunteers in the first case and from eligible rural volunteers for the other two.

All consumer participants in the detailed interviews (chapter 7) were asked to keep diaries and 48 out 49 volunteers (representing 68 individuals) agreed to participate. The person who declined felt that the length of time commitment was too onerous.

Conduct of the study
Participants recorded information about all of their primary medical care visits and then reported on the information during telephone interviews that were held approximately monthly. In addition, participants were asked open-ended questions about each GP consultation. These questions drew upon the information recorded in the diary. All of the telephone interviews were audio taped and transcribed.

The time taken to contact each participant was considerable since up to 12 phone calls were necessary to achieve one follow-up. Generally the telephone interviews took only a few minutes if there had been no primary medical care visits in the interval, and approximately five to ten minutes if

\(^1\) Participation proportions: 95.5% (n=802) of patients completed a questionnaire; and 36.7% (n=168) of the frequent attenders (n=458 or 57.1% of the questionnaire respondents) volunteered for participation in the interview and diary studies.
there had been one or two. On a few occasions the interviews lasted longer than one hour when a participant had complex medical and social problems. For example, one long interview with Hilary occurred soon after a screening mammogram had detected a breast carcinoma, and two lengthy interviews with Eleanor occurred when she was experiencing acute grief and multiple health problems during early widowhood.

Originally I planned that individuals would be asked to continue the diary keeping for twelve months since utilisation of general practice is known to vary with seasonal factors (Bridges-Webb, Britt et al. 1992; Health Insurance Commission 1992; Underwood, Ward et al. 1992). In December 1993, however it appeared that data saturation had occurred for those participants who were recruited first and who had by then completed nine months of diary recording (Morse 1994). By saturation I mean that those participants were not advancing new rationales or novel factors to explain their choice of doctor. In addition, the recruitment period had spanned five months so truncation of the recording period at nine months meant that it spanned fourteen calendar months. Thus, in view of data saturation, the time involved in the monthly interviews, and the coverage of more than a year by the cohort, I decided that nothing of significance would be lost by truncating the diary recording at nine months. The last follow-up interviews were held in March 1994.

Analysis and findings

Participation

Forty-five out of 48 families, that is 61 of 68 individuals, completed the health diary recording for the nine month period requested. Differential attrition was not evident. Table 8.2 shows the sociodemographic profile of participants in this study.
Figure 8.1  Steps in recruitment of consumers for the *Health diary study*

Patients attending the 9 practices on study day(s)  (n= 840)

\[ \text{Questionnaire offered (Step 1)} \]

Respondents (n= 802)  Non-respondents (n= 38)

\[ Q: \textit{number of GP visits in 12 months} \]

Frequent attenders*  Infrequent attenders†
(n= 458)  (n= 317)

\[ \text{Invitation to volunteer for diary keeping (Step 2)} \]

Volunteers (n= 168)

\[ \text{Random quota sampling (Step 3)} \]

Diary keeping participants (n= 68 ie 48 families)

* 5 or more visits in last 12 months
† missing data n=27
Table 8.1  Protocol for sampling of consumer volunteers for the *Health diary study*

Volunteers

<table>
<thead>
<tr>
<th>Practice</th>
<th>Female &lt;60 yrs</th>
<th>Female &gt;60 yrs</th>
<th>Male &lt;60 yrs</th>
<th>Male &gt;60 yrs</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 (urban)</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>2 (urban)</td>
<td>1</td>
<td>1</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>3 (urban)</td>
<td>1</td>
<td>-</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>4 (urban)</td>
<td>-</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>5 (urban)</td>
<td>1</td>
<td>-</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>6 (urban)</td>
<td>-</td>
<td>1</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>7 (rural)</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>8 (rural)</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>9 (rural)</td>
<td>-</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>TOTAL</td>
<td>6</td>
<td>6</td>
<td>6</td>
<td>6</td>
</tr>
</tbody>
</table>

Practice 1 catered for multi-generational families, practice 2 was a vocational training centre, practice 3 was an extended hours clinic, practice 4 was staffed by a solo GP from a non-English speaking background, practice 5 was staffed by women GPs, practice 6 was a solo, suburban practice, and practices 7, 8 and 9 were group practices in rural NSW.
Table 8.2  Sociodemographic profile of participants in the *Health diary study*

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>30</td>
</tr>
<tr>
<td>Female</td>
<td>38</td>
</tr>
<tr>
<td>Age group* (years)</td>
<td></td>
</tr>
<tr>
<td>under 15</td>
<td>19</td>
</tr>
<tr>
<td>15-64</td>
<td>25</td>
</tr>
<tr>
<td>over 65</td>
<td>24</td>
</tr>
<tr>
<td>Geographical location*</td>
<td></td>
</tr>
<tr>
<td>urban</td>
<td>40</td>
</tr>
<tr>
<td>rural</td>
<td>28</td>
</tr>
<tr>
<td>Housing†</td>
<td></td>
</tr>
<tr>
<td>rented</td>
<td>16</td>
</tr>
<tr>
<td>mortgage</td>
<td>11</td>
</tr>
<tr>
<td>own home</td>
<td>21</td>
</tr>
<tr>
<td>family &amp; other</td>
<td>20</td>
</tr>
<tr>
<td>Times moved house in past 5 years†</td>
<td></td>
</tr>
<tr>
<td>no moves</td>
<td>33</td>
</tr>
<tr>
<td>1 move</td>
<td>12</td>
</tr>
<tr>
<td>2 or more moves</td>
<td>23</td>
</tr>
<tr>
<td>Respondent's country of birth</td>
<td></td>
</tr>
<tr>
<td>Australia</td>
<td>49</td>
</tr>
<tr>
<td>UK and Eire</td>
<td>6</td>
</tr>
<tr>
<td>Spain &amp; Latin America</td>
<td>8</td>
</tr>
<tr>
<td>Other</td>
<td>5</td>
</tr>
<tr>
<td>Educational achievement‡ (n= 49)</td>
<td></td>
</tr>
<tr>
<td>primary only</td>
<td>4</td>
</tr>
<tr>
<td>some secondary</td>
<td>19</td>
</tr>
<tr>
<td>completed secondary</td>
<td>26</td>
</tr>
<tr>
<td>tertiary degree</td>
<td>6</td>
</tr>
<tr>
<td>Occupational group§(n= 47)</td>
<td></td>
</tr>
<tr>
<td>white collar</td>
<td>26</td>
</tr>
<tr>
<td>blue collar</td>
<td>15</td>
</tr>
<tr>
<td>home and retired</td>
<td>6</td>
</tr>
</tbody>
</table>

*Gender, age group, and geographical location were used to stratify the sample
† Housing and the number of times they moved in five years were recorded for the family
‡ excludes 19 children in preschool age group or at school. All 6 participants who had a degree had completed their secondary schooling.
§ excludes 21 children in preschool age group, and those at school or tertiary institutions
Figure 6.3

A trajectory of general practice use (Hillery)
sixth and eighth to thirteenth visits were a broken sequence during which their developing relationship foundered. The locum visits were one-off encounters that addressed immediate health problems. The last three visits saw the establishment of another relationship with a GP who became established as Hilary's preferred GP.

Second stage of analysis - Trajectory patterns
In the second analytical stage I arranged the 68 trajectories in patterns. They were sorted in ten different ways, as detailed below, according to

a) colours (that is, one GP was distinguished from another by colour coding); so that those trajectories with all visits to one GP were distinguished from those trajectories with visits to two or more different GPs.

b) practice; so that those trajectories with all visits to one practice (that is, visits all above the trajectory line) were distinguished from those trajectories with visits to two or more different practices.

c) frequency of visits; so that those trajectories with greater than the mean number of visits to GPs were distinguished from those trajectories with fewer than the mean number of visits to GPs.

d) intensity of visits; so that those trajectories with several visits to GPs in a month were distinguished from those trajectories with no or few visits to GPs. The high intensity users were further divided in to those with consistently high use and those with sporadically high use.

e) use of special GP services; so that those trajectories with use of special GP services such as home visits, and hospitalisation under the GP's care were distinguished from those trajectories without such use.

f) use of telephone services with the GP; so that those trajectories with telephone communication between the GP and consumer were distinguished from those trajectories without such use.

g) use of casualty services; so that those trajectories with use of casualty visits were distinguished from those trajectories without such use.

h) use of specialist services; so that those trajectories with use of specialist services such as physicians, surgeons, and ophthalmologists, were distinguished from those trajectories without such use. The medical specialist users were further divided in to those who subsequently were
followed up by the specialist and those whose ongoing care was managed by GPs.

i) consumer factors such as gender, age group, and geographical location.

j) consumer families; so that the trajectories for members of the same family were grouped and these were distinguished from other families and from the trajectories of individuals.

I found each of the trajectories could be assigned to one of four groupings that corresponded to the four GP utilisation models (described in chapter 7). This proved to be a valuable way of understanding the diary material. These groupings were firstly all visits to one GP, secondly all visits to one practice, thirdly repeated visits to GPs in different locations (which corresponds to visits to a variety of GPs), fourthly single visits to different GPs in differing locations (which corresponds to visit-by-visit use). Each pattern is described with an example, below.

Visits to one GP
The trajectories of 14 consumers (21%) fitted this pattern in which all visits were with one GP.

This pattern is exemplified in figure 8.4 by Nancy’s trajectory. It shows that she had 12 GP visits to the same GP. There was an episode of illness associated with the cluster of visits in the second and third months. On the eighth GP visit, her GP asked a colleague in the practice to give a second opinion and this is shown by his symbol in blue above the line. Nancy also had 7 specialist visits during the study period.

Visits to one practice
The largest number of trajectories fitted this grouping. Twenty-six trajectories (38%) showed visits that were with two or more GPs from one practice.

Ruth’s trajectory in figure 8.5 shows continuity within the practice. This particular trajectory includes eight GP visits of which two were home visits. There were two episodes of hospitalisation under the care of GPs from the practice, and three phone consultations with practice GPs. The trajectory illustrates visits with the practitioner of first choice (coloured red) for an episode of illness in the fourth and fifth months. There were also five
specialist visits which were associated with a disruption to GP visits in the latter part of the trajectory.

Visits to a variety of GPs
Ten consumers (15%) had visits to a variety of GPs who worked in different locations.

Sonia's trajectory is an example of this pattern (see figure 8.6). Sonia had seven visits to a Spanish speaking GP, depicted above the line in red, and two visits to the GP from another practice whom she preferred for straightforward or emergency visits, shown below the line in blue.

Visit-by-visit GP use
Nine consumers (13%) had this pattern of GP use where they saw different GPs in differing locations but did not return consistently to them.

An example of the visit-by-visit approach to seeing GPs is shown in the trajectory which is seen in figure 8.7. This complex trajectory shows 23 visits by Clarissa beginning with 14 visits to a first choice GP (shown in red) but during this time she also had one visit to another GP in another practice for reasons of convenience (depicted below the line in blue). This visit is an example of a visit-by-visit approach in what otherwise appears to be consistent visits to one GP. In the fifth month Clarissa moved residence and saw a new doctor of first choice (illustrated below the line in green) but also saw other GPs for reasons of convenience, availability, bulkbilling and gender preference. These visits are alternated above and below the line and in different colours to indicate selection of GPs on a visit-by-visit basis rather than visits to particular GPs.

Trajectories that could not be grouped
Nine of the consumer trajectories (13%) could not be classified as the participants had only one GP visit or none during the 9 month study period.
Figure 8.4

Visits to one GP
Visits to a variety of GPS

Figure 8.6
Visit-by-visit basis
Visits to GPS selected on a
Table 8.3 summarises the number and percentage of trajectories in each utilisation grouping.

### Table 8.3  Number and percentage of trajectories in each utilisation grouping

<table>
<thead>
<tr>
<th>Utilisation type</th>
<th>Number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Visits to one GP</td>
<td>14</td>
<td>21</td>
</tr>
<tr>
<td>Visits to one practice</td>
<td>26</td>
<td>38</td>
</tr>
<tr>
<td>Visits to a variety of GPs</td>
<td>10</td>
<td>15</td>
</tr>
<tr>
<td>Visit-by-visit use of GPs</td>
<td>9</td>
<td>13</td>
</tr>
<tr>
<td>Unclassified</td>
<td>9</td>
<td>13</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>68</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

**Development of the typology of GP utilisation**

In the third analytical stage I examined the reasons consumers gave for their prospective choice of GPs, their utilisation preferences, and whether their actual utilisation was the same as or different from their preference.

Consumers' reasons for their choice of GP

I examined the eight conditions and issues affecting choice of GP identified from the detailed interviews with consumers and GPs (chapter 7) to determine whether they were used by consumers to explain their prospective choice of GP. These eight issues were consumer access to the doctor; cost of the consultation; GP availability; the medical component of the presenting problem; communication; the influence of family changes; sociodemographic and cultural matters including class, gender, politics, ethnic background, religion and language; and interactions with the wider health system. I found that these issues were advanced spontaneously by consumers during the sequential interviews and that these categories covered all the reasons given by participants. Table 8.4 shows examples of these conditions and issues.
Table 8.4  Conditions and issues effecting choice of GP, descriptions of each and positive and negative examples

<table>
<thead>
<tr>
<th>Condition or issue</th>
<th>Example(s) (positive)</th>
<th>Example(s) (negative)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Access</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proximity to GP</td>
<td>'It fits in if I'm on my way home from night duty or whatever'.</td>
<td>'I prefer to see Dr X but I didn't feel well enough to catch the train to see him'.</td>
</tr>
<tr>
<td>(Proximity of the consumer's residence and workplace to the surgery)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Special services</td>
<td>'He does home visits when we need him and he said he'll come at any time'.</td>
<td>'He don't make house calls'.</td>
</tr>
<tr>
<td>Physical access</td>
<td>'I can walk across the road to the surgery; we don't have any transport at present'.</td>
<td>'We had to walk him up the side path which is quite broken and uneven and then there were steps to get up with no rail'.</td>
</tr>
<tr>
<td>(The extent to which the consumer had access to public/private transport, and whether there was wheelchair access to the surgery.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Cost</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Price and affordability of the consultation</td>
<td>'Normally I pay but he's decided from now on that he'll bulkbill me so that was nice'.</td>
<td>'I didn't go back to him for the injection because he didn't bulkbill'.</td>
</tr>
<tr>
<td><strong>Availability</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consumers described reconciling their own availability with the doctor's consulting hours, and waiting time prior to consultations.</td>
<td>'It fits in if I'm on my way home from night shift... generally there's not a long wait at that time of the day'.</td>
<td>'I might have to wait two or three days to get in to the doctor of my choice'; 'We didn't see Dr X' cause we were late and he had to go and see a patient so he just left a lady doctor with us'; 'You have to wait because there's so many people waiting for him, but nothing else you can do'.</td>
</tr>
<tr>
<td>Condition or issue</td>
<td>Example(s) (positive)</td>
<td>Example(s) (negative)</td>
</tr>
<tr>
<td>--------------------</td>
<td>-----------------------</td>
<td>-----------------------</td>
</tr>
<tr>
<td><strong>Medical component of the presenting problem</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>GP Competence</strong></td>
<td>Consumer's assessed the problem or issue for which they wanted to visit a GP. Then they made a judgement about the appropriateness of the GP (in terms of the consumer's understanding of the doctor's knowledge, skills, insight and awareness) for that problem.</td>
<td>'You wonder whether the more mature doctors are still as up-to-date; 'I think he's just got a little bit beyond it. I mean when you get well into your seventies, I think it's about time'.</td>
</tr>
<tr>
<td><strong>Uncertainty</strong></td>
<td>An important consideration mentioned by many consumers was their experience of uncertainty in relation to health problems, and their experience of a particular GP's management of medical problems that were ambiguous.</td>
<td>'She couldn't really tell me very much; she just said, 'Well all we can do is try another one&quot;.</td>
</tr>
<tr>
<td><strong>Communication</strong></td>
<td>Consumers considered the way GPs listened, shared information, and communicated respect for the consumer.</td>
<td>'He wouldn't really listen to what we've been through. He had his own ideas and that was it'; 'I couldn't get across to him how much it was distressing me'; 'I didn't like his negative comments. There is being truthful and there is being brutal. He said, 'Don't think that after you've had all this surgery and radiotherapy and everything ... that the cancer won't flair up again in a year or two&quot;. 'He really didn't like me taking control of my own health problem'. 'I probably don't know him well enough to indulge in what I call my sense of humour'.</td>
</tr>
<tr>
<td><strong>Consumer seeks equality in the relationship</strong></td>
<td>'How kind, how considerate she was, taking the time to explain what had happened and what the treatment would entail'.</td>
<td>'It's really nice to be able to communicate with the doctor so that's there's a two way process going on; 'I always use the royal plural with Dr O; I said, 'Well it looks as if we've finally got the blood pressure stabilised, which is good&quot;.</td>
</tr>
</tbody>
</table>
Table 8.4, continued

<table>
<thead>
<tr>
<th>Condition or issue</th>
<th>Example(s) (positive)</th>
<th>Example(s) (negative)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Family changes</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Separation, divorce, moving house, birth and death were all described by participants as factors that influenced their choice of GP.</td>
<td>'I saw Dr V because I was weeping all over the place (days after her husband's death) - when I came out of there, I felt as though I could cope'.</td>
<td>'I heard that Dr Y was going through quite a nasty little divorce and I thought that could probably explain a lot of his moodiness'.</td>
</tr>
<tr>
<td><strong>Sociodemographic and cultural matters</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Class, gender, politics, ethnic background, religion and language were powerful influences on choice of GP.</td>
<td>'I think it's because he speak Italian'; 'I come from a different country but we speak the same language (Spanish)'; 'I went to see her for my Pap smear because I wanted a female doctor'.</td>
<td>'I don't really have a problem with other races or ethnic people'.</td>
</tr>
<tr>
<td><strong>Interactions with the health system</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Re interactions with the bureaucracy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Re conduct of referred (specialist) doctor</td>
<td>'Now I've got to make an application to the Health Dept for a (back) brace which I can't understand'.</td>
<td>'I went back to my GP and said I didn't think his (the specialist's) behaviour was appropriate - it was bordering on sexual harassment'.</td>
</tr>
<tr>
<td>Re conduct of other doctors in practice</td>
<td></td>
<td>'I did think he was huffy that I put his wife (also a doctor) in preference ahead of him'.</td>
</tr>
</tbody>
</table>
It was clear that while there was considerable overlap, consumers in each of the trajectory groupings emphasised different conditions and issues when they explained their choice of doctor. These are described, below.

Each of the 14 participants whose trajectory pattern showed visits to the same GP described the importance of good communication with their GP and gave examples to illustrate this. All but two also mentioned the significance to them of their GP’s technical competence and management of medical uncertainty. This group had the lowest number of GP visits on average ($\mu = 5$). Cultural issues were highlighted by six participants; three for their GP’s facility to speak a language other than English, two chose a female GP and one chose a male GP. Three mentioned issues of the GP’s availability, one referred to cost and another to access, and none mentioned family changes.

Four of the consumers whose visits were with one GP described dissatisfaction. One person’s dissatisfaction was associated with delayed investigation of symptoms, another’s was due to an adverse reaction to medication, one described uncertainty relating to the nature of her health problem, and the other person was dissatisfied with the GP’s reticence to refer them to a specialist doctor for a second opinion.

All of the 26 participants with trajectories that showed visits to one practice described the importance of good communication with the GPs. The vast majority (24/26) also mentioned that the GP’s competence and the medical component of the presenting problem were salient. Also 18 participants said that they were conscious of the availability of the GPs; eight had encountered problems with GP availability. In this grouping ten participants discussed access issues affecting their choice of GP and for four consumers this had been a problem. Five consumers described how interactions with the wider health system affected their choice of doctors. Only one consumer described a preference for a female GP, and none mentioned cost or family changes.

Fifteen consumers who saw GPs in one practice described dissatisfaction with their GP visits. The most common problems related to GP availability after hours, difficulties with access, and understanding information in the consultation. For example one consumer described a visit in which his questions about diabetes mellitus were not answered and test results were not explained.
As with the two previous groupings, all ten consumers, whose trajectories fitted the use of a variety of GPs, emphasised that they valued good communication with those GPs and that this effected their choice of doctors. Nine of the ten highlighted the medical component of the presenting problem, while eight discussed the effect of GP availability and seven mentioned access when explaining what determined their selection of GPs. Three consumers said that their choice of GP was affected by cultural matters and two by family changes. Two others spoke about the importance of interactions with the wider health system and one mentioned cost as a consideration in their choice of doctors.

Eight participants who visited a variety of GPs described dissatisfaction in relation to their visits. They described dissatisfaction with access, GP availability, the GP's communication (including poor listening by the doctor, inadequate information sharing, and lack of respect for the consumer), the GP's examination technique (including rough handling, omitting BP measurement), and lack of assistance with complying with health bureaucracy demands.

Seven of the nine consumers whose trajectories showed visit-by-visit use mentioned the importance of good communication but six described dissatisfaction principally due to problems communicating with GPs. Six emphasised the importance of seeing the first available GP and five mentioned access and three cost issues when explaining their decision-making. Five discussed the medical component of the presenting problem and its impact on the choice of GP for that consultation. Three consumers in the group had visits for which they chose to see a female GP, one consumer mentioned that family changes impacted on her choice of doctor, and another described how interactions with the wider health system effected his choice of doctors.

The dissatisfaction described by this latter grouping often included the sense that the doctor did not listen to them and that their problem was not taken seriously. Several consumers said that the GP did not explain what the problem was or what the treatment entailed. Others described visits in which they felt the GP did not show them respect or their desire to participate in their health care was not acknowledged.

Table 8.5 summarises consumers' volunteered reasons for their choice of GP by utilisation grouping.
Table 8.5 Consumers' volunteered reasons for their choice of GP and frequency of dissatisfaction by utilisation grouping*

<table>
<thead>
<tr>
<th>Reason</th>
<th>One GP (n=14)</th>
<th>One practice (n=26)</th>
<th>Variety of GPs (n=10)</th>
<th>Visit-by-visit (n=9)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access</td>
<td>1</td>
<td>10</td>
<td>7</td>
<td>5</td>
</tr>
<tr>
<td>Cost</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Availability</td>
<td>3</td>
<td>18</td>
<td>8</td>
<td>6</td>
</tr>
<tr>
<td>Medical aspects</td>
<td>12</td>
<td>24</td>
<td>9</td>
<td>5</td>
</tr>
<tr>
<td>Communication</td>
<td>14</td>
<td>26</td>
<td>10</td>
<td>7</td>
</tr>
<tr>
<td>Family changes</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Sociodemographic and cultural</td>
<td>6</td>
<td>1</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>matters</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interactions with the health</td>
<td>1</td>
<td>5</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>system</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dissatisfaction</td>
<td>4</td>
<td>15</td>
<td>8</td>
<td>6</td>
</tr>
</tbody>
</table>

* 9 participants were unclassified as they had none or one GP visit during the study
Consumers' utilisation preferences
While the trajectories clarified actual utilisation patterns, participants also contrasted their use-in-practice with their preferred utilisation during the sequential interviews. For example, participants identified one doctor as their own in statements such as, 'Well I prefer to go to Dr W, my own doctor' and 'Yes, Dr X, I’ve sort of settled in with him'. The participants were very clear about this point and no ambiguity was encountered. Similarly, evidence was forthcoming for identification with a practice or a variety of GPs.

Table 8.6 summarises participants' GP utilisation preferences, and shows the proportion, gender and age distribution of participants in each preference grouping.

<table>
<thead>
<tr>
<th>Preferred utilisation grouping</th>
<th>One GP (n=41)</th>
<th>One practice GPs (n=15)</th>
<th>Variety of GPs (n=3)</th>
<th>Visit-by-visit (n=7)</th>
<th>Unclassified (n=2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender F/M (n)</td>
<td>24/17</td>
<td>10/5</td>
<td>1/2</td>
<td>2/5</td>
<td>1/1</td>
</tr>
<tr>
<td>Mean age (yrs)</td>
<td>39</td>
<td>33</td>
<td>-</td>
<td>27</td>
<td>-</td>
</tr>
<tr>
<td>Age range (yrs)</td>
<td>0-85</td>
<td>1-73</td>
<td>56, 69, 76</td>
<td>0-69</td>
<td>30, 50</td>
</tr>
<tr>
<td>&lt;15 yrs (n)</td>
<td>11</td>
<td>6</td>
<td>0</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>15-59 yrs (n)</td>
<td>13</td>
<td>5</td>
<td>1</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>&gt;60 yrs (n)</td>
<td>17</td>
<td>4</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>
Forty-one people (60%) identified one doctor as their own, and of these, three fifths were women. The mean age of the grouping was 39 years and the range was 0-86 years. On average they were the second oldest category. Those who identified with one GP had more chronic health problems (27/41; 66%) than others and these problems were serious, as ten individuals had life-threatening conditions and five had psychiatric conditions. However the mean number of visits over the study period was least of all categories (n=41, µ=6.0, range 0-19 visits; or if those with less than 2 visits were excluded, n=37, µ=6.5, range 2-19). Summaries of the health problems of consumers who preferred seeing one GP are in appendix 8.2.

Fifteen people (22%) indicated that they preferred to relate to one general practice rather than to an individual doctor. Two thirds were women and three were from rural practices. Their ages ranged from one to 73 years; the mean age of the group was 33 years. Practices 1 (the practice catering especially for multi-generational families) and 6 (a solo suburban practice) were not sites where participants had a preference for practice GPs.

Participants in the grouping where visits were to one practice were less likely to have chronic health problems (7/15; 47%) than others. Only one individual had a life-threatening condition and none had psychiatric conditions. Their health problems included asthma, arthritis and leg ulcers. The mean number of visits over the study period was second highest of all the classes (n=15, µ=7.5, range 0-23 visits; or if those with fewer than 2 visits were excluded, n=11, µ=9.9, range 2-23). Summaries of the health problems of consumers who preferred visits to one practice are in appendix 8.3.

Three people (5%) indicated a preference for visiting a variety of GPs. Their ages were 58, 69 and 76 years, all three were from urban practices, and all had chronic health problems although these were not life-threatening conditions. All participants described a specific reason for choosing one of the GPs. One was for chosen for cultural reasons, one for bereavement counselling, and one because that GP did home visits. The mean number of visits over the study period was highest in this grouping (n=3, µ=11.0, range 5-22 visits). Summaries of the health problems of consumers who preferred seeing a variety of GPs are in appendix 8.4.

Seven people (10%) opted for a visit-by-visit approach to seeing GPs. Males predominated in this category (5/7) and three consumers were from rural
practices. Participants' ages ranged from birth to 69 years; the mean age of the grouping was 27 years. These consumers attended four of the nine practices. Three individuals attended extended hours medical centres as one of the several practices they visited.

As a category, consumers who preferred visit-by-visit use were intermediate both in the likelihood of having chronic health problems (4/7; 57%) and in the mean number of visits (n=7, μ=7.0, range 2-23 visits) compared with others. Participants in this group had less serious health problems such as asthma and allergy, infant feeding difficulties, and hypercholesterolaemia, and none had a life-threatening or psychiatric condition. Summaries of the health problems of consumers who preferred a visit-by-visit approach are in appendix 8.5.

Summaries of the health problems of the two individuals (3%) whose preferences could not be classified are in appendix 8.6.

Comparison of consumers' preferred and actual utilisation
Table 8.7 presents a comparison of participants' preferred utilisation with their actual utilisation as shown by their trajectory pattern.
Table 8.7  Comparison of participants' preferred utilisation and trajectory pattern

<table>
<thead>
<tr>
<th>Preferred utilisation</th>
<th>Trajectory pattern</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>One GP (n=41)</td>
<td>one GP*</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>one practice</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>a variety of GPs</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>visit-by-visit</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>unclassified</td>
<td>4</td>
</tr>
<tr>
<td>One practice (n=15)</td>
<td>one practice*</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>a variety of GPs</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>visit-by-visit</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>unclassified</td>
<td>3</td>
</tr>
<tr>
<td>A variety of GPs (n=3)</td>
<td>a variety of GPs*</td>
<td>3</td>
</tr>
<tr>
<td>Visit-by-visit (n=7)</td>
<td>visit-by-visit*</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>one practice</td>
<td>1</td>
</tr>
<tr>
<td>Unclassified (n=2)</td>
<td>unclassified</td>
<td>2</td>
</tr>
</tbody>
</table>

* indicates those participants who had the same preferred and actual utilisation.

Thirty-three participants (half of those for whom a preference could be determined) had concordant preferred and actual utilisation.

Univariate analysis using the Chi-square test was performed to determine whether there was an association between respondents having concordance or discordance between their preferred and actual utilisation and their sociodemographic profiles. Significance was assessed at the 0.05 level.
There was no statistically significant association between consumers' gender, educational achievement, occupation and age grouping and concordance or dissonance in preferred and actual utilisation. However rural compared with urban participants were less likely to have the same preferred and actual utilisation (χ² = 3.97, p<0.05).

There was a trend (but this did not reach statistical significance at the 0.05 level) indicating that participants who had completed secondary education and who were white collar workers were more likely to have concordant preference and utilisation patterns compared with those who had less education and were blue collar workers.

Consumers' reasons for choice of GP by preferred and actual utilisation

Next I constructed matrices for each preference grouping to examine the relationship between the conditions and issues that participants said had influenced their actual choice of GP and whether that participant's actual utilisation was the same as or different from their preference.

Consumers who expressed a preference for one GP

Only 14 of the 41 participants who indicated that they preferred one GP saw that GP on every visit during the nine month study period. (This subgroup had both a trajectory showing traditional continuity and identified with one particular GP.) The subgroup comprised eight women and six men. The mean age of the subgroup was 42.4 years making it the oldest on average of the groupings. Consumers in this subgroup attended only five of the nine practices and half of the consumers attended rural practices (ie practices 7-9). Three of the consumer-GP pairs involved a female GP and eleven were with a male GP (but due to the cluster sampling technique employed in the study those eleven consumers saw 5 different male GPs).

Twenty-seven consumers clearly identified with one GP but their trajectories included visits with other GPs. For 23 of these people the visits to doctors other than their own were because that GP was not available. The consumers were well informed about the reasons for their own doctor's absence and described these in a straightforward, accepting manner. The reasons that the GP was not available included them being on holiday, not being available during the night or over the weekend, working part-time or being in semi-retirement, and leaving the practice.
Nineteen of these 23 consumers saw another doctor in the same practice when their own GP was not available. Three consumers were faced with their GP leaving the practice during the study period. Two decided to see the doctor who succeeded the original GP, while the other sought out their GP at the new practice and travelled to see him there.

Six consumers who identified with one GP saw doctors in different practices during this study. Two consumers chose GPs in practices that were close to their homes as transport was a consideration, one saw a GP while on holiday, one saw a GP at an extended hours centre, one saw a GP with acupuncture skills, and one consumer (Hilary) chose a new first preference GP in another practice.

Of the forty-one participants who identified with one doctor, only seven expressed dissatisfaction, and the majority of these described difficulties with the GP's availability or with interactions with the wider health system. Generally the tone of their dissatisfaction was mild or couched in resigned terms such as when their GP was heavily booked and unavailable:

(There) seemed a bit of a delay in getting some of these things processed (viz tests to investigate back pain) but nothing of a detrimental kind. (Anthony)

Oh I just see who I can get into. 'Cause it was over a week wait; you can never get in. (Sharron, mother of Billy)

Consumers who expressed a preference for one practice
Ten participants (of 15) preferred and actually visited GPs from one practice during the study. One participant saw another GP while on holiday and one had several casualty visits plus another visit to a 24 hour medical centre. Three others expressed a preference for one practice but they had one or no visits so their trajectories were unclassifiable.

Six participants in this preference group described aspects of their consultations which caused dissatisfaction. These included GPs' unfriendly, even rude, manner towards them; problems with communication about repeat prescriptions; inadequate information about prescribed medications; and rough examination technique:

He examined the wound and bullied me. He was telling Betty (my wife), 'Be tough with him, make him do things for himself!' ... (But it was said only) part(ly) in jest. (Ken)
Some consumers described a feeling of competitiveness between GPs working in the same practice that was translated into a pressure to choose and stick to one GP. One said:

*If I'm not the best (I prefer to see) either Dr A or Dr B. ... But I did think that he (Dr C) was a bit huffy that I put his wife (Dr A) in first preference instead of him.* (Neville)

Several consumers experienced problems arising from conflicting advice or differing management styles of the various doctors in the same practice. Many consumers said that doctors whom they saw less frequently gave insufficient information or explanation:

*Kylie had a sore throat and (was) just off her bottles a bit and I just wanted her checked out to make sure she didn't have thrush or anything like that in the mouth. ... She (Dr D) didn't seem to check her out thoroughly enough. ... Dr D said she had a sore throat; she said she didn't believe in commercial nose drops which, that's fine by me, (and) she gave me an alternative of cool water and salt and put a drop in each nostril. But for the throat she wrote out a script for antibiotics.*

*Dr E (our usual GP) is one of the doctors that doesn't believe in giving antibiotics all the time unless absolutely necessary and I couldn't understand why she (Dr D) didn't believe in commercial nose drops and then turned around and gave out a script for a sore throat. I left the doctors more confused than when I went there. I didn't give the antibiotics to Kylie.* (Annette)

Sometimes the GP did not recommend action that was needed:

*I went to see Dr F to hear the results of the ultrasound (that had been arranged by a more familiar doctor in the practice, Dr G). ... Well I wasn't all that impressed (with Dr F). ... I believe that Dr F when I saw him on the Monday should have taken some action. He just made the arrangements for a referral but nothing specific (and the aortic aneurysm ruptured the following Saturday).* (Ken)

Also, six consumers mentioned difficulties with access, such as long waiting times before consultations and lack of after hours service provision, while nine described problems with GP availability.
Consumers who expressed a preference for a variety of GPs

All three individuals in this group emphasised the importance of ready access to GPs and they achieved this in visiting a variety of GPs. While none described dissatisfaction with their consultations, difficulties with after hours service provision, GP availability and bureaucratic inconsistencies were mentioned:

Well I rang (to make an appointment to see Dr H) and she hadn't come back from South Africa so I thought it was not as though I am feeling physically poor; I am just feeling miserable. ... I can only see Dr J on Mondays and Thursdays ... and on Monday when I walked past the surgery it was full and I thought, 'No I will leave it until after Christmas and get her to give me a check up' (Eleanor).

Consumers who preferred a visit-by-visit approach to seeing GPs

All seven individuals in this group emphasised the importance of ready access to GPs and three mentioned that the cost of consultations was an important consideration in their choice of doctor. However the majority of people in this group of participants (5/7) described dissatisfaction with some of their visits. The dissatisfaction was usually related to impaired communication with the doctor such as feeling that the doctor did not listen to them or that there was inadequate care and respect shown. Examples included absence of an explanation regarding the cause of their problem; lack of discussion of pathology, imaging investigations and diagnosis; and refusal of a request for specialist referral. None of these consumers returned to that particular doctor after these potently dissatisfying consultations.

Christopher explains the reasons for his dissatisfaction with the first GP he saw using a visit-by-visit approach and his subsequent decision to see the doctor he regarded as 'his GP' in his youth:

Well I saw the first available doctor. I don't really think he listened to what I was saying. I mean, I really was extremely ill and the pain I was getting from swallowing I really thought could have been something really serious and this bloke was looking down my throat and saying, 'Well you have got a bit of infection in your throat, it's pharyngitis'. And I said, 'What about the pain in my stomach?' He said, 'Oh some of the infection must be down in your stomach.' I thought it was a bit poor. I really thought that some tests might be warranted because it had got progressively worse during the week. So I wasn't really satisfied with the visit to the medical centre.
When I was still feeling off colour during the second week I had this bleeding. I was in major panic mode. I did not want to go back to the medical centre because I just was not happy with the two previous visits so I thought I would go back to the old family GP who I had seen for many, many years.

He gave me a complete examination and he took my symptoms seriously. He recommended blood tests to see what was wrong and (said) that I should have a colonoscopy immediately. ... I was very impressed with the way I was treated. He was quite caring, he was concerned, he was willing to listen to my feelings which I thought was important, and he took some action which I thought was necessary. (Christopher)

After this experience Christopher said that he would not be happy to continue with a visit-by-visit approach to utilisation. However the search for a suitable GP seemed to daunt him as he could not envisage seeing 'his GP' from his youth in the longer term because of access difficulties. He had not developed an affiliation with a GP, practice or variety of GPs by the end of the study.

Consumers who remained unclassified
Two people, one man and one woman, had only one visit during the study period. I could not identify a utilisation preference from their sequential interviews nor did they mention the factors which might influence their future decisions about seeing GPs. Their ages were 30 and 50 years respectively and both lived in urban locations.

Variants in consumers' actual utilisation
During this study four participants had mixed utilisation. This utilisation variant was identified in the interview study (chapter 7) and is seen when the consumer uses two types-in-practice over a short time period.

Three participants (Brian, Ken and Neville) who had their visits to one practice nevertheless saw only one of the GPs during an illness episode. One of these consumers described a preference for seeing the principal GP in the practice for coordination of his medical care but was happy with visits to other doctors (many of whom were GPs in training) in the group. He has regular gold injections for rheumatoid arthritis and so needs ongoing haematological monitoring:
It's good to see Dr A 'cause I don't see him a real lot unless I specifically ask for him. ... I think it's always good to see the doctor that really looks after you. ... A lot of them (the other doctors in the group) are trainees. They're all very good but it's always good to see Dr A and let him have a look. ... Everything's fine, I'm not going too bad. Like, all me blood tests and everything are reading quite good. (Brian)

Immediately after the nine month cut-off of this study Jonathon and Regina each had one visit where they saw a convenient GP for a straightforward problem but both retained their affiliation to their respective practices:

(I had one visit) to get some malaria tablets for overseas, that's all. ... I just went to the doctor down the street here. He was good. He knew straight away what to give me and he was friendly. ... But most of my history is out at (the practice) so I'd probably go back there unless there was some reason I couldn't get out there, you know for transport or something like that. (Jonathon)

This visit shows that Jonathon's utilisation combines visit-by-visit use with visits to one practice. Thus the clear distinction between utilisation types in the trajectory groupings can be seen to be a reflection of the relatively short observation period in this study. Over time, it is likely that more participants would have mixed utilisation.

Changes in consumers' utilisation

Three participants, who were all recruited from the one practice, needed to find a new GP during the study period because their GP sold the practice (see page 214). Two of these people saw the incoming GP and liked him so they continued their affiliation with the practice, while the other one sought out her GP at his new practice and travelled to see him there.

Moving house also necessitated a change of doctors for five participants. One elderly woman (Hazel) moved into a nursing home during the study and she indicated that she would change doctors afterwards. However she was reluctant to do this and in the only follow-up interview after the move she had returned to visit a GP in her usual practice. The Hall family (Shelley, Adrian, Zac, Deborah) moved from a rural area to a capital city, and while they ended their involvement in the study at that point, they would have needed to change doctors too.
Five of the 68 participants changed their utilisation type in an effort to better accommodate their needs. Three consumers (Bob, Reynard and Beryl) began with an orientation to one practice but each developed a preference for visits to one GP and their utilisation accorded with this. Reynard’s discussion details his evaluation of the visits and how he developed an affiliation with Dr B:

*(I saw) Dr B that day ... because he was the man who referred me to (the specialist). I’m quite impressed with him (Dr B) at all times really. He takes a very much personal interest in your health. ... (We talked about) my problem, why I finished up in hospital and the medication I’m on.*

A month later during the telephone interview he said:

*I saw Dr B. He’s the only choice now. ... He wanted to see me and hear how the drug was reacting. ... And I haven’t felt better. ... Dr B is very thorough. He checks you out completely. He follows up on the things he does and he takes a sort of personal interest in you, you know. And this is what I appreciate more then anything. (Reynard)*

Another consumer (Adrian) altered his utilisation type from visits to a variety of GPs, then to one practice and finally to one GP during the study. Early in the recording period he visited a variety of GPs but after he was hospitalised with pericarditis his visits were at one practice and then he began seeing a doctor that he called ‘his GP’ at that practice.

One participant changed her preference for GPs twice but always preferred to have her visits with one GP (see Hilary’s trajectory and the accompanying discussion on pages 192-4).

Although the number of participants who changed their type of utilisation was small, it was interesting that they all developed an affiliation with a particular GP rather than with a practice or variety of GPs. This may be partly explained by the serious nature of their medical problems and their recognition that health care coordination was simplified when they had all visits to one GP.

**Comparison of the typology of GP utilisation and continuity indices**

Having completed the analytical work on the trajectories, I calculated seven individual and visit-based continuity indices for each of the participants in the study. The various indices are defined and presented in appendix 8.7.
The continuity indices are descriptive of utilisation in that they show various mathematical relationships between the number of GP visits and the number of different GPs seen. However, they were found to be of very limited use. Each index was inadequate as a summary measure of the information contained in the individual trajectories because they could not reflect sequencing nor the temporal relationship of visits. In addition, combinations of indices were not useful in distinguishing any of the trajectory pattern and preference groupings.

Table 8.8 compares the indices and ranges for each trajectory and preference combination. Participants who had a trajectory pattern and preference for one GP were distinctive in that they had an MCI > 0.5, COC and UPC of one, and all sequential indices (SECON, SGP and KGP) of one. The group who were most similar were those participants who had a trajectory pattern and preference for a variety of GPs. They too had an MCI > 0.5 and SECON and KGP of one. There were no distinctive patterns of indices for one practice and one GP, one practice trajectory and preference, visit-by-visit trajectory and preference, and variety of GPs and one GP. The numbers of participants for the other combinations were too small to permit analysis of their groupings.

None of the indices demonstrated predictive power between the first half and second halves of the trajectories. Nor could the continuity indices singly or in combination indicate quality of GP care. This is a consequence of the indices inability to incorporate information about individual's preferences and their insensitivity to the various conditions and issues affecting choice of GP.

I concluded that the continuity indices did not contribute to the refinement of the typology of GP utilisation.
<table>
<thead>
<tr>
<th>Number of participants in grouping</th>
<th>Trajectory pattern</th>
<th>GP preference</th>
<th>n</th>
<th>S</th>
<th>MCI</th>
<th>COC</th>
<th>UPC</th>
<th>FOC</th>
<th>SECON</th>
<th>SGP</th>
<th>KGP</th>
</tr>
</thead>
<tbody>
<tr>
<td>14</td>
<td>one GP</td>
<td>one GP</td>
<td>2-12</td>
<td>1</td>
<td>&gt;0.5</td>
<td>1</td>
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</tr>
<tr>
<td>15</td>
<td>one practice</td>
<td>one GP</td>
<td>2-17</td>
<td>2-3</td>
<td>&gt;0 to .883</td>
<td>-1 to .47</td>
<td>0 to .883</td>
<td>0 to .883</td>
<td>1</td>
<td>6 had 1</td>
<td>9 had 1</td>
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<td>one practice</td>
<td>1-22</td>
<td>1-10</td>
<td>0 to .791</td>
<td>-1 to .38</td>
<td>0 to .737</td>
<td>0 to .429</td>
<td>7 had 1</td>
<td>3 had 1</td>
<td>5 had 1</td>
</tr>
<tr>
<td>3</td>
<td>variety of GPs</td>
<td>variety of GPs</td>
<td>5-22</td>
<td>2-5</td>
<td>&gt;0.5</td>
<td>.15 to .47</td>
<td>.4 to .833</td>
<td>.091 to .833</td>
<td>1</td>
<td>2 had 1</td>
<td>all had 1</td>
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<tr>
<td>6</td>
<td>visit-by-visit</td>
<td>visit-by-visit</td>
<td>4-23</td>
<td>2-7</td>
<td>.025 to .697</td>
<td>-1 to .17</td>
<td>0 to .75</td>
<td>0 to .4</td>
<td>4 had 1</td>
<td>1 had 1</td>
<td>3 had 1</td>
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<tr>
<td>6</td>
<td>variety of GPs</td>
<td>one GP</td>
<td>4-19</td>
<td>2-6</td>
<td>.025 to .780</td>
<td>-1 to .49</td>
<td>0 to .833</td>
<td>0 to .833</td>
<td>5 had 1</td>
<td>3 had 1</td>
<td>4 had 1</td>
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<tr>
<td>1</td>
<td>variety of GPs</td>
<td>one practice</td>
<td>23</td>
<td>20</td>
<td>.134</td>
<td>-.85</td>
<td>.130</td>
<td>.087</td>
<td>1</td>
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<tr>
<td>2</td>
<td>visit-by-visit</td>
<td>one GP</td>
<td>2-4</td>
<td>2-3</td>
<td>.048 to .268</td>
<td>-1 to -.5</td>
<td>0 to .5</td>
<td>0 to .25</td>
<td>1</td>
<td>0</td>
<td>all had 0</td>
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<tr>
<td>1</td>
<td>visit-by-visit</td>
<td>one practice</td>
<td>3</td>
<td>3</td>
<td>.033</td>
<td>-1</td>
<td>.333</td>
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<tr>
<td>1</td>
<td>one practice</td>
<td>visit-by-visit</td>
<td>2</td>
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<td>.048</td>
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<tr>
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<td>unclassified</td>
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<td>3</td>
<td>unclassified</td>
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Discussion
The examination of consumers' preferred and actual utilisation has shown how three utilisation types can result in mutually constructed forms of continuity of care. These types are visits to one GP, one practice and a variety of GPs. The pre-conditions for continuity are access, GP competence, good communication, and a mechanism for bridging one consultation and the next.

Three benefits of such continuity have been identified. Firstly there is coherence of medical care that results from ongoing coordination of the skills of the various providers. Health problems are complex and the skills of many can contribute usefully to the restoration and maintenance of health. Secondly, continuity produces a commitment to the therapeutic relationship and this becomes a resource for managing serious illness and the facilitation of personal growth. Thirdly, constructed continuity results in more appropriate care, cooperation between all those involved, and better compliance since treatment is mutually agreed, regularly reviewed and modified as needed. These three dynamics provide a useful framework for understanding the relationship between continuity and quality outcomes and this will be discussed further in the final chapter of the thesis.

This study has shown that a participant's actual utilisation may not reflect their preference for seeing a particular GP or doctors. Indeed only half of the participants had concordant preferred and actual utilisation. Rural participants were found to be less likely than their urban counterparts to achieve their preferred utilisation. This indicates that their options for general practice care are limited; the dearth of rural GPs contributes to this and has been well documented (Britt, Miles et al. 1993). The trend that indicated that less educated people and blue collar workers were less likely to achieve their preferred utilisation warrants further research.

Strong support has emerged for utilisation characterised by all visits to one GP. This was the second most frequent utilisation pattern (14/68) and the first preference of the majority of participants in this study (41/68). In addition three participants who preferred visits to one practice saw one GP during a particular illness episode, and all five consumers who changed their utilisation preference developed a new affiliation with one GP. The consumers' decisions to opt for one GP seemed to reflect their GP's preferred style of practising.
The association between consumers having chronic health problems and all visits to one GP was identified in both this and the interview study. It is interesting that, despite their serious medical problems, consumers who visited only one GP had the lowest mean number of visits of all groupings. However it would be incorrect to infer that the one GP type-in-practice is more cost-effective than the others; further studies are needed to determine whether this is probable. I would strongly recommend that such studies also examine consumer satisfaction and reasons why participants might see other GPs or change GPs.

Consumers described access and GP availability as the predominant problems with visiting one GP at the time of the sequential interviews. Twenty-three of 27 participants who clearly identified a doctor as my GP visited doctors other than their own because that GP was not available. Nineteen of these saw another doctor in the same practice. Consumers who preferred to visit one GP voiced the least dissatisfaction of the four preference groupings. This suggests that people who see one GP do so because they are not dissatisfied. However, the converse situation that consumers are satisfied because they see one GP has not been shown.

Dissatisfaction has been shown to arise from obstacles to some, but not all, consumer preferences. The vast majority of participants evaluated the quality of communication (57/59) they had with their doctor and their perception of that GP's expertise in relation to their health problems (50/59). When either of these two aspects was not satisfactory, consumers were unhappy and those who had selected a GP on a visit-by-visit basis usually did not return to that GP again. Instead of causing dissatisfaction, difficulties associated with access, cost and GP availability influenced the type of utilisation preferred by a consumer.

Thus each of the four utilisation types has been shown to suit consumers with distinctive needs arising from their particular health problems and life circumstances. Inherently, each utilisation type can only meet a consumer's needs as long as their particular mix of issues is satisfied by their (one or several) GP's skills and availability. Such matches can be more or less enduring as has been indicated by the 13 participants who changed doctors during the study.

The four types of GP use are not readily available to all consumers so they do not have equal access to them. The experience of participants whose
actual utilisation was with one practice suggests that many GPs who are co-located do not work as a team. Although collective approaches to practice care were documented in this and the interview study, six of the ten participants who preferred and actually had visits to one practice voiced dissatisfaction. Dissatisfaction arose from conflicting advice or differing management styles of the various doctors, and competitiveness between GPs in the same group was also noted. None of the consumers from practice 1 expressed a 'preference' for one practice utilisation even though that practice had ten GPs (six full-time equivalent doctors) working at the one site. It is possible that consumers there were aware that those GPs worked independently and were co-located for cost-efficiency rather than functional reasons. This indicates that if consumers are to have the choice to use either the one practice or variety of GPs approach, the availability of a number of GPs at one site is not sufficient. As I also suggested in the interview study, special commitment is required if continuity is to be developed and maintained in these two types-in-practice.

Calculation of continuity indices and assignment of trajectories to groupings both require the researcher to impose a time period of interest. The selection of a such a time period must be arbitrary and shorter periods will appear to enhance separation of utilisation types while longer ones will reveal more mixed utilisation. Continuity indices have been found to be descriptive of past utilisation only, having no predictive power. In contrast, the trajectories retain information about the temporal relationship of visits.

Actual utilisation has been found to result from a complex interplay between a consumer's preference, the types of utilisation available to them, the particular characteristics of the GP(s) and their changing needs. Each of these would need to be modelled for prediction of future utilisation.

In this study I have investigated consumer choice of GPs by documenting visits prospectively and exploring participants' preferences. In the reference group meetings presented in the next chapter, consumer and GP perspectives are developed about utilisation of general practice, while the implications of the typology for medical education and public health policy are examined in the final chapter.
CHAPTER 9

Reference groups

The studies presented in chapters 4 and 5 show the need for an understanding of both consumer and general practitioner (GP) perspectives on dissatisfaction, and, in particular, its relationship to discontinuity. While I could listen attentively during interviews with individuals and gain an understanding of each person's view of the issues, and could draw on my experience as a practising GP (and to a lesser, my own experience as a consumer) I could not presume to synthesise a unified perspective for each group.

Group discussions provide one way of synthesising views as individuals share ideas and perceptions about an issue, and influence each other by responding to the various ideas and comments of group members (Kreuger 1994). During the discussions participants share illustrative personal experiences so a wide range of relevant issues can be canvassed in a way that retains a strong connection with participants' cultural milieux. By debating the issues the group can identify areas of agreement that could be described as a collective perspective or group construction on the issues at hand (Guba and Lincoln 1989).

In addition to developing more or less coherent perspectives, group discussions can be helpful when a researcher wants to learn how people talk together about a phenomenon of interest. They allow people to be questioned further where issues remain ambiguous, and can assist with refining interpretations of study results, and generating new ideas and creative concepts (Stewart and Shamdasani 1990; Kreuger 1994).

I established two groups - one of consumers and one of GPs - to formulate a consumer and a GP perspective on discontinuity and dissatisfaction with
visits in general practice. This was done to complement the individual views obtained in the interview and longitudinal studies. I also sought the advice of these reference groups about my methods and questions in the Seeing doctors survey and interview study (chapters 6 and 7), and discussed the early results with them. Through an exchange of information between the two groups, I hoped to get a deeper understanding of the different views held by consumers and GPs. Further, I wanted to see how each group would respond to the other's understandings and whether consensus or new views could be achieved (Wadsworth 1984; Guba and Lincoln 1989; McGuiness and Wadsworth 1991; Wadsworth 1991; Summers 1993). The achievement of consensus or agreement about new ways forward would be important as changes to general practice care must be acceptable to both consumers and GPs (perhaps after a negotiation phase) for implementation to be practicable.

The reference groups were also important methodologically as discussions focussed on the whole inquiry process, not just the individual studies. The various discussions helped me engage with the stakeholders in a deeper and more prolonged discourse than would otherwise have been possible (Guba and Lincoln 1989, chap 7; Guba and Lincoln 1994, page 114). Thus the groups had a role in addressing the credibility of the constituent studies and strengthening the authenticity and quality of the entire project (Guba and Lincoln 1989).

This chapter describes the role of the consumer and GP reference groups in the research project and summarises the outcomes of a series of reference group discussions.

**Aims**

The aims of the reference groups were: to provide advice about methods for the Seeing doctors and interview studies; to examine selected findings from the six studies (described in chapters 4-8); to develop collaborative interpretations; to synthesise a consumer and a GP perspective on dissatisfaction with general practice care (particularly its role in discontinuity); to identify the differences between the two perspectives; and to formulate mutually-agreed recommendations for enhancing the quality of general practice care.
Membership of the reference groups

I was not able to find recommendations about convening reference groups for the purposes I have outlined so I drew upon recommendations about focus groups. Generally focus groups explore a research issue in a single meeting. For this reason most methodologists recommend that group members not be acquainted prior to the discussion (Morgan 1988; Hawe, Degeling et al. 1990; Morgan 1992; Kreuger 1994). These writers also make specific recommendations about size, and composition of the group (homogeny vs heterogeneity), group structure, and number of groups (Morgan 1988; Hawe, Degeling et al. 1990; Morgan 1992; Kreuger 1994).

In keeping with these recommendations, I planned to recruit 12 people for each group (Kreuger 1994). A series of meetings was planned as I had several matters I wished to explore with the groups. A key concern was to invite people with diverse interests and views, who were articulate and interested in general practice.

The consumer group of 12 represented a range of experiences and interests, included equal numbers of men and women, a spread of ages, and two people from a NES background. I asked the Consumers' Health Forum to recommend four representatives, and a HIV self-help group nominated two representatives. I invited two participants from the preliminary interview study (described in chapter 5), two people who attended a community health centre, a person from another self-help group, and a NES health interpreter.

I welcomed all nominated representatives, recognising that some individuals may have been acquainted prior to the first meeting. As the groups were to meet on several occasions, all participants would in any case become familiar during the course of the meetings. This in turn had important implications for the protection of participants' confidentiality which was discussed during the initial meeting. Confidentiality was a particularly important issue as both groups comprised people who lived and worked in and near Canberra.

The GP group of 12 included practitioners from different settings (including for example, urban and rural, solo and group practice, private and public community settings, and casualty services), with varying interests. Some were involved in teaching, research, and medical editing. Members also had a variety of foci (including those in full- and part-time practice, generalists and some with a special interest in obstetrics, procedural
medicine, women's health, and HIV-AIDS) and represented a range demographically (equal numbers of men and women, a spread of ages, and some with NES background).

Analysis
The discussions were recorded. Tapes were transcribed by people who were aware of the imperative of protecting participants' confidentiality. I edited the transcribed tapes, summarised each meeting, and analysed the documents thematically.

Reference group meetings
The groups met at the National Centre for Epidemiology and Population Health (NCEPH) which was a centrally located, neutral venue. Consumer participants were offered travel reimbursement and at meetings of both groups I provided light refreshments. The first meeting of both groups was structured. Subsequent meetings were progressively less structured so their exploratory role could be fulfilled.

Meetings in the first round
The groups first met in February 1993. The aims of the inaugural meeting were to introduce members to each other, to begin to develop an awareness of the diversity of experience among group members, and from this to develop a sense of cohesion in each group. Also both groups discussed the role that they might adopt in the research process.

The discussion centred on consumers who attend various doctors; this was the focus of the preliminary interviews too (chapter 5). The group discussion helped create common ground for the members which was helpful in itself and provided a basis for their advice on the language chosen for questions in the Seeing doctors survey and the more detailed interview study (chapters 6 and 7). The details of each group's recommendations and their implementation are described in chapter 3.

The groups explored different aspects of the discontinuity and dissatisfaction cycle. The GPs emphasised the difficulties they recognised with consumer access to consultations and the barriers that prevent doctors exercising responsibility for patient care. Rather than seeing the problems as external to the interaction, the consumer group said that their main source of dissatisfaction was with the consultation itself. The consumer group also highlighted the way that language conveys respect.
The initial meetings were broadly successful in meeting the groups' negotiated objectives. By the end of those first meetings each group had begun to coalesce as a collective enterprise. Their engagement with the issues was energising for me and their interest in each other was apparent as informal chatting continued long after the structured part of the meeting had concluded.

Meetings in the second round
The main focus of the second round of reference group discussions was the experience of uncertainty in general practice. This round occurred in August 1993 soon after the interviews (chapter 7) had been concluded. During the interviews the topic of uncertainty had provided many insights into the nature of continuity and relationships between doctors and consumers, and I wanted to explore this further with the two groups.

Six GPs attended the second GP reference group meeting and five consumers attended the consumer meeting. I began each group by summarising the fieldwork I had done in the intervening period and highlighted how and where I had implemented the suggestions made by both reference groups.

I selected two vignettes from the interviews with GPs (chapter 7) and presented them as a trigger for the GP group discussion. I also gave group members a summary from the same study of GPs' reactions when patients presented with uncertain problems. The written material presented to the GP participants in this round is in appendix 9.1.

I gave the consumer group a summary of the answers given by 15 consumers in that study to questions about 'problems where the cause was unclear', and information about the consumers' reactions to having these health problems. Appendix 9.2 contains the written material presented to the consumer group.

The two groups approached the topic of uncertainty differently. The GPs explored their own management of uncertainty and described the methods they had developed for this. The most active role they entertained for the consumer in managing uncertainty was having tests and seeing how the passage of time influenced the problem. Many of the GPs were reluctant to acknowledge their emotional responses to ambiguity in consultations. Only informal strategies (such as debriefing with a partner) were used by group
members for coping with this aspect of uncertainty. This suggests that the most common GP response to cumulative stress might be intellectualisation and detachment.

Members of the consumer reference group readily identified with medical uncertainty. They described several strategies that allowed them to participate actively in problem solving. These strategies included 'pre-diagnosis', gathering evidence that their dis-ease was 'real', encouraging open two-way communication during consultations and developing reciprocity in relationships with their GPs. They also discussed barriers to their active involvement in consultations and ways of dealing with these.

The consumers' notion of pre-diagnosis is similar to the 'patient's ideas' described by Levenstein et al. (Levenstein, Brown et al. 1989). However Levenstein discusses the GP's task as one of reconciling the patient's ideas with the doctor's, whereas in this discussion the consumers envisaged a joint task requiring more open, two-way negotiation about the problem and its management.

Although seven months separated the initial and second round of reference group meetings, participants joined in the discussions with vigour and seemed to delight in shared insights. They were enthusiastic when I suggested they meet again in six weeks to continue dialogue about communication in consultations between GPs and consumers, as both groups saw this as crucial in the management of uncertainty.

**Meetings in the third round**

Six GPs attended the meeting in October 1993 and 5 consumers attended the corresponding meeting the next evening. In this round I provided both groups with the same written material (appendix 9.3). Participants covered many issues during their discussions about communication. Again, there were differences in focus between the two groups but each group moved closer to developing within-group consensus during this round.

The GPs discussed aspects of their role and various mechanisms that have been developed to assist communication during consultations including the medical record, interpreter services, and accompanying persons. Lack of time was repeatedly mentioned as a barrier to good communication since the group was conscious of the time-money nexus inherent in fee for service remuneration.
The consumers identified many features of good consultations. They highlighted the importance of diagnosis, open communication and the role of the GP as a sounding board and interpreter-coordinator of their health care. The group said they found the discussion of options was often a difficulty in consultations and some said that they had felt that their GP was unwilling to individualise management choices.

Consumers' facilitating techniques included the use of exploratory and confirming questions, and reflections. These techniques could be thought of as complementary to the doctor's facilitating behaviours discussed by Levenstein et al. in patient-centred clinical interviewing (Levenstein, Brown et al. 1989). Doctors' facilitating behaviours include acknowledging that they have heard the consumer, and using open-ended questions, open-ended statements, reflections and confrontations. There were parallels between the joint relationship described by consumers during this discussion round and the concept of mutuality as described by Stewart and Roter (Stewart and Roter 1989).

As both groups had indicated their curiosity about the views of the other group, an exchange of summaries of the previous meetings was arranged for the fourth round.

Meetings in the fourth round
This round of meetings were held in February 1993, and the consumer meeting preceded the GP one. Each was devoted to a discussion based on reading the other group's views about uncertainty and communication. Summaries of the GPs' and consumers' views on these issues were given to all participants in this round (appendix 9.4).

Upon reading the GP's responses the consumer group identified that the GPs were uncomfortable with conflict in consultations, seemed to lack negotiating skills, and generally preferred to avoid conflict. The consumers speculated that the GPs seemed concerned to retain power in their relationships and also that they gave precedence to financial considerations over health outcomes for their patients.

The GP group discussed the consumer perspective on two levels. They agreed that, within consultations, the development of a trusting GP-patient relationship was a prerequisite for negotiation about the diagnosis and management. They agreed too that negotiating was satisfying for individual
consumers and allowed consultations to be transforming not controlling. At the structural level the GP group thought that many of the problems they faced in consultations were exacerbated by financial reward being tied to high service volume.

Each group decided that they would prefer not to meet their counterpart group face-to-face. Several members of each group had been present at a meeting in a different forum where a heated confrontation about power and money had erupted between consumers and GPs.

The consumers feared that these issues (identified by them as crucial to better consumer-GP relationships) would not be discussed constructively and the possibility of escalating conflict outweighed the potential benefits of such a meeting. Instead, the group suggested that an exchange of ideas via a paper summary might foster collaboration between the groups.

The GP group also feared a confrontation, but in addition they felt that the principal impediment to enhanced general practice was financial and the strategies for resolving this were structural. In the meantime the GPs thought the solutions to difficulties in consultations would have to be negotiated with individuals so a group meeting did not seem to be a fruitful way forward.

Meetings in the fifth round
There was an eight month interval between the fourth and final meetings of the reference groups which took place in November 1993. The aim of this round was to discuss the findings of the project. Both meetings were poorly attended; three GPs attended the meeting and two consumers came the following evening to the last consumer reference group discussion. This was understandable given the time lapse and the apparent impasse at the end of the last meeting.

The GPs highlighted the diversity of their work, their sense of isolation from both their peers and patients, and the pressure they felt to see many patients quickly that is a feature of a fee for service system. They commented that their sense of isolation was a negative feature of the traditional notion of continuity.

Particularly in this and the preceding meeting, the GPs presented as if under siege. They seemed defensive and were apt to project blame for consumer dissatisfaction with general practice onto others whether this be bureaucrats,
part-time GPs, 24-hour clinics, politicians, or consumers. Consumer 'challenges' to GPs' expert status (such as in consumer 'pre-diagnosis') were contrasted with a view of the consultation as a site for negotiation about diagnosis and management of health problems. The GPs' pleas were for remuneration that was adequate and not linked to throughput, and they were attracted to mechanisms for peer support such as divisions and Balint-style groups.

The consumers highlighted the place of respect and being listened to, and their desire to participate in their medical management and take responsibility for their health. The consumers' pleas were for adequate time in consultations and protection of their agency. Agency here refers to the consumer's right to choose the doctor on every occasion they visit a GP.

Findings
The reference group discussions are presented thematically. They elaborated GPs' and consumers' experiences of uncertainty in consultations, strategies for managing uncertainty and ways of communicating effectively within and between visits. They also briefly explored the policy implications of the study.

GP visits
During the third reference group discussion, the GPs drew out the differences between typical general practice consultations and those with specialists. They felt that less factual information was shared in general practice consultations compared with specialist visits. However they said that GPs needed to translate and explain medical terminology and explore the person's reactions and responses to their particular situation more often than specialists:

The GP offers (a) far more accessible service and can offer ... finite amounts of information and can discuss it in more of a situation that is on her (the patient's) own terms. They can go to family, they can go to the home and discuss things there. (Lillian)

This observation acknowledges the central importance of communication skills in general practice.

Health problems seen in general practice
The consumers were aware that many of the problems about which they visited GPs were related to life experiences rather than biomedical disorders.
Further, these problems were often nebulous so adequate discussion and promotion of the consumer's autonomy were important for their recovery:

> We are trying to operate on the biomedical theory that there's (this) thing that can be fixed by this known (intervention) and that the doctor holds this knowledge. ... Yet that's not most of what we deal with the GP is about. ... I mean, when we're feeling sick it's undifferentiated, it's ... vague. ... It might turn out that it's really because we've had sleepless nights with the kids or whatever so it's not a germ that gets fixed by a body of knowledge. ... They're styles of life, they're life experiences which ... impinge on our body and some of which originate in our body. We're not going to get out of this bind unless we think about ourselves and our ... illnesses in a different sort of way. (Jenny)

The complex nature of these problems and the non-specific nature of many symptoms means that there is often initial uncertainty about diagnosis and thus management.

**Consumers' experiences of uncertainty**

The consumers all agreed that finding ways forward for such problems was an enormous challenge for them. Uncertainty featured prominently in problems with nearly every bodily system. They gave many examples such as persistent sore throat, problems associated with the menopause, irregular pulse, sinusitis, skin problems, gall-bladder symptoms, detached retina, migraines, and haemorrhoids. Many consumers described feeling nervous, frightened, unhappy, frustrated, overwhelmed, desolate and apologetic when they had these kinds of health problems.

During the course of the discussions each commented on the powerlessness that they felt while their problems were unnamed and unresolved. In the absence of a diagnosis some consumers found that their GP was less likely to believe that they had a problem. Instead of assisting, some GPs did not listen, others communicated in a 'dithering' way and many ended visits abruptly. A few attacked the consumer's integrity with phrases such as *you're mad; you're a hypochondriac*, or undermined their credibility:

> You feel as ... if your observations are not taken seriously anyway. ... I guess my experience with my mother (was) that ... the doctors relied heavily on your observations about how this person was, but then when it came to the crunch they didn't believe (you) (Jaimie)
The group explored the reasons why consumers might not be believed. Some participants suggested that women were not readily listened to by GPs (especially male GPs) and this tendency was exacerbated when there was an educational differential between the consumer and doctor. Also they felt that consumers were not educated about ways of being assertive nor were they encouraged to be so.

Also some consumers said that they seemed to have greater difficulty explaining their problems when unaccompanied than when they went with an adult relative or friend. Another participant said:

*I find it easier when I'm intervening for my husband, for whom I'm a carer, than I do for myself. ... I can go in with him to a doctor and ask quite specific questions ... or at least focus the questions to get that to happen. ... (But) I'm not able to do that in the same way for myself. (Jenny)*

Broom observed that women who went to the GP obtained more information about their children's health problems than they did when they went about their own problems (Broom-Darroch 1978). It is not surprising that a mother can assist at her children's visits and gain satisfactory information about the problem, but it is noteworthy that the same skills appear to be less effective in her own consultations.

The group described how most consumers make an assessment of the likely nature of their problem prior to the visit. They then test out this 'pre-diagnosis' during the consultation. If they are not given an opportunity to voice this concern or opinion, then the consumer often feels dissatisfied with the visit:

*90% of patients come (to a GP) knowing what's wrong with them. ... (Or having) an opinion about what's wrong. (Jenny)*

But after making a pre-diagnosis, consumers had considerable difficulty with interpreting the significance of their symptoms (whether they indicated a serious or transient condition) or their meaning (why they should experience them at this time). Most felt that their GP hadn't assisted them with these tasks either. In Levenstein's terms, the GPs seemed not to have inquired about the person's expectations, feelings or fears (Levenstein, McCracken et al. 1986).
The reactions evoked by the uncertain problem could be so strong that some consumers became overwhelmed by a sense that they lacked control. One participant mentioned that part of the explanation for these strong reactions might be a culturally sanctioned link between illness and sin:

*It (illness) seems to be an admission of defeat.... loss of control. I mean ... to me there's that whole tie up in our culture between illness and sin and badness anyway so ... some of that often underlines the way we feel about these things. That we are failing and (feeling a) lack of control about having to admit it. Having to be dependent on somebody else.* (Jenny)

Since they were unable to name their problem, consumers felt powerless and often found it difficult to communicate their concerns clearly. Many reported that they felt as if they *floundered along* in the consultation. Some said they felt defeated and inarticulate even though they might otherwise be eloquent. Perhaps surprisingly, they tended to blame themselves for this situation.

One of the consumers was self-critical in this way. She said that she had not done her part, because she felt that good communication required that both parties articulate their concerns clearly. However another member of the group countered that her linguistic style mirrored her appeal for an exploratory discussion.

Consumers said that they found it was difficult to discuss management choices with GPs because many were reluctant to individualise treatment options:

*I was ... exploring this hormone replacement therapy for post menopause so I said, 'Tell me your arguments for it' and he said, 'Oh I'm not going to argue' (laugh). And I said, 'Is that all?' ... That's not what I meant. 'Tell me the case as you see it for it'. ... So he did and then I said, 'Well the way I see it, this is the response (rebuttal) to that and it doesn't convince (me). ...At that point he (said), 'OK, that's up to you'.

*It has left me ... lacking in confidence that his medical advice was advice for me. ... I got the feeling that there was ... standard advice and that he wasn't confident enough in whatever those guidelines ... were to pursue it, to apply to me in the specific. But that's what is important.*
I came away and thought that hasn't moved me anywhere and that was partly my responsibility because I played with it as a debate. ... I'm looking for something a bit more prescriptive, I still (want) to make my own decision but I (want to) make it for or against something that is very definite and I'm not feeling that I've got that. And I'm not sure whether that is realistic. (Jenny)

Despite these negative experiences and the accompanying dissatisfaction, the group recognised that many consumers continued to see their current GP. The reasons for consumers' reluctance to change doctors centred on the comfort of familiar arrangements in the face of the discomfort generated by the illness.

As a group the consumers suggested several strategies for dealing with the feeling of lack of control that was associated with uncertainty. In the reference group discussion of this issue one person made a suggestion and others added to it, so a composite strategy for regaining control began to emerge.

An important step was to gather 'evidence' that the problem was 'real' rather than imagined or 'psychiatric' in origin. The group felt that such evidence had to be seen as acceptable to both the consumer and the GP or it might be discounted. Credible evidence could be obtained from another doctor, for example:

"You actually have to get evidence to back up your observations. ... I did. ... (I got evidence from) three experts, yes that's right. ... I wouldn't have thought that evidence from a naturopath or ... an alternative practitioner would have helped. ... No-one would believe me. ... Good evidence is you dying you know (laughter), 'See I told you I was sick'. ... Or actually going into hospital is another thing ... Oh yes, 'Well I'm here. Actually getting sicker'. (Shona)"

Several consumers reported that the experience of gathering evidence for an uncertain problem had given them the confidence to do it again. So if they had another uncertain problem, other doctors were less likely to fob them off with personal attacks or evasions. A consumer's confidence could be boosted by respectful responses from GPs. One consumer described a response that had been enduringly valuable:
Well I think ... I turned the corner when a female GP wrote me a reference to
the medical superintendent saying, 'This lady is the most sane woman I
know' which opened all doors. ... I had umpteen copies made of that
reference (laughter). (Adelaide)

The group explored ways that consumers might facilitate a discussion about
their health problems and management. They said that diagnosis was a
crucial step so that a fear of cancer could be quelled (if possible) and
appropriate management commenced:

'It's nice to have names to things isn't it, I mean ... to exclude what you are
most worried about. ... Well that's very important. (Jenny)

Woodward et al. have reported that consumers with chronic fatigue
syndrome regard diagnosis as the single most helpful event in the course of
the illness (Woodward, Broom et al. 1995). In the next quotation the
consumer explained that naming the problem separated the problem from
them and opened up the possibility of researching it:

Once you have got a chronic condition or a condition that is repeating and
that's different from going to the GP with the coughs, colds and odd things
that you do want some reassurance about. ... Maybe the principles are the
same but I think you can establish patterns in longer term concerns. Where
you have got a condition ... that at least ... has ... a name ... it is yours.
...Therefore you ought to be able to learn as much about it as any
professional (and) you have got an insider experience. (Geoff)

Drawing on the experience of people with chronic health problems, the
consumers discussed techniques that facilitated negotiation with GPs. Some
people had interactions with doctors which seemed to increase their self-
confidence and assertiveness. These experienced consumers used
exploratory and confirmatory questions, and reflections. All were careful to
avoid confrontations with the GP but they said they might query the doctor
or request references that supported the doctor's views:

I've always managed to get on the right way (by) being able to say, 'Hey but
what about this or that?' or 'Do you really think so?' which is double speak
where I don't quite believe it! (laugh). ... Even if I said, 'Look, is it written
down somewhere?' they would whip out the MIMS (prescriber guide) or ...
an article and (say) 'Well look take this home and read it and bring it back'.
(Adelaide)
Some members of the consumer group felt that women doctors and particularly younger doctors were more likely to engage in these sorts of discussions. One consumer said of his GP:

_He actually ... listens to you and also he ... recommends alternatives. ... If certain things aren't working, he'll say, 'Oh well, look, we'll come off that (medication)' and he'll try something else. If that doesn't work 'Well all right, (he'll say) may be we should sit and chat and see whether there is another underlying problem'. (Geoff)_

In summary, the consumers described how gathering 'credible' evidence about problems assisted them when they had problems with associated uncertainty or ambiguity. They said that diagnosis was a valuable step in resolving problems. Some described how the presence of an accompanying person and the use of specific communication skills helped them achieve more satisfactory consultations. Others said that changing to seeing women or younger GPs was beneficial too.

**GPs' experiences of uncertainty**

All of the GPs acknowledged that there was commonly a lack of specificity in the symptoms that people brought to them. This experience was counter to the expectations cultivated during their training and promoted by medical text books. Both kinds of authoritative sources tend to present problems as 'black and white' and amenable to biomedical diagnosis. The GP group said that this simplistic view ignored the importance of the psychological and social practice dimensions of these problems.

The GPs described various personal and professional ways of dealing with uncertainty. The feelings that were aroused included being irate, annoyed and angry and a sense of being isolated from colleagues and their advice. Their responses included referral, ordering additional investigations, and rationalising that perhaps medical science could not explain the problem. Sometimes the GPs thought that having such problems was itself an indicator that the consumer had psychological problems. Others were discomforted by such explanations.

Several group members agreed with one GP who said, _I think in a sense we (GPs) are the experts on undifferentiated problems and the management of uncertainty_. However some GPs felt reluctant to ask other doctors about problems for fear of being judged ignorant. One GP summarised this concern:
As GPs we tell ourselves it's not OK for us not to know and its even less OK to display (that) to our colleagues. When you keep it to yourself ... it heightens one's anxiety and doesn't really get you anywhere. (Lillian)

Mostly the GPs didn't have any conscious strategies for dealing with their own reactions to uncertain problems. Also they said that lack of trust between them and consumers impeded their management of ambiguity:

_These days I'd say most patients are not seeing a doctor with quite a deal of experience whom they know well and they have some form of ... trust. ... I suspect if you look at what is really happening out there in GP land that most patients are not seeing doctors with whom they have a very close relationship._ (Bevin)

The GPs agreed that uncertainty was common and described what might be thought of as biomedical management strategies for them, even though this meant that the psychological and social dimensions of the problems persisted. They also were aware that uncertainty stressed them.

The GP participants shared their strategies for coping with uncertainty. The strategies included seeing how time affected the problem; saying they would investigate the problem and report back to the patient; discussing the problem with another GP in the practice or another colleague; performing investigations; trying medication; referring the patient for a GP or specialist opinion; becoming preoccupied with medicolegal issues; becoming withdrawn and cutting off from the problem; seeking solace in alcohol or other drugs. No-one explicitly mentioned the value of talking with the consumer at greater length.

Some GPs agreed with the consumers that naming the problem could aid the management:

_Let them make their own label. ... If it (the consumer's diagnosis) is exceptionally comfortable for them (and it) is in line with their probable condition and useful management then it's that part of ... developing the patient's consciousness about their condition._ (Ivan)

The GP group agreed that another useful strategy was to regard the consultation as a transforming process with an educational component. They described the elicitation of the consumer's formulation of the problem, the examination and formulation by the doctor, the discussion of
the diagnostic possibilities, and the negotiation of a management plan, and follow-up as required. Some GPs said they usually asked the consumer about their understanding of the health problem so this could be addressed and reassurance given where appropriate:

*I often do ask them what their concerns are ... I mean that's a clue. It ... lets me know where they are coming from so I can then adapt my strategies to deal with that anxiety. ... Often our differential diagnosis doesn't include the disease they're frightened of. ... So I often do ask, 'What do you think is wrong?' Then I can tailor my examination ... to reassure them.* (Ivan)

Trust was mentioned as a prerequisite for this negotiating style of communication.

Three participants described how they managed their personal reactions to uncertainty. Two women GPs in the group said that they sometimes discussed their feelings with their medical spouses and one former FMP trainee said she felt comfortable talking about her feelings with colleagues:

*With the (vocational training) program you are allowed to feel uncertainty. You are encouraged to go talk to your supervisors ... in (the) practice, so it's OK to say I don't (know). ... That extends very naturally then to go and talk to the other people in the practice about (uncertainty). May be not there and then but if I'm unsettled enough it's going to be within the next day or two. ... It's been easier to learn it's OK to go and talk to my colleagues. The bigger step was to learn it's OK to talk to the patient and say, I'm really not sure what's going on here. This is what I think is going on but I'm not sure and I'm going to get back to you about this. Can you leave this with me for 48 hours and I'd love to see you back and I hope I've got some more information about that time?' ... I have never had anybody say it's not good enough and it really helps me.* (Lillian)

The possibility that Balint groups might help GPs manage uncertainty more effectively was also mentioned. In such groups each GP describes a consultation with a particular patient and 'attempts to recognise the person's complaints, not only in terms of illnesses, but also in terms of conflicts and problems, and then to use this understanding so that it should have a therapeutic effect' (Balint 1964). In these groups doctors develop the skills of attentive listening and responding to patient's 'offers'. However no Balint groups were functioning in Canberra at that time.
Towards better management of uncertainty
The consumers acknowledged that some people sought certainty even when this was not possible. They felt that this was unhelpful and likely to be met with assertions of 'certainty' based on the GP's expert status. This in turn might undermine confidence in the therapeutic relationship if the diagnosis later proved to be incorrect.

As a group they preferred a statement of 'certainty about uncertainty' which was based on the results of an examination and tests so that reversible or life threatening conditions were excluded. Such reassurance could be accompanied by a discussion of what might be done next.

 Mostly (GPs) can give ... reassurance to a person who is uncertain without pretending a certainty that isn't there. That there is a difference between certainty and reassurance. ... The doctor's role is (to give) that reassurance. ... I had ... respect for the one doctor who said, 'I can't find anything wrong within my area and I don't know what it is but if the situation changes, come back and that may give me some cue to look further. In the meantime you need to do ... this and this or look out for (that). (Jenny)

The consumer group said that they believed that transparency led to greater satisfaction with care and litigation was less likely even if adverse outcomes occurred:

 I've had quite a bit of surgery and one of mine (operations) did go wrong. ... I was told before ... this doctor operated there was a possibility that it (might not) be good. ... It didn't work out very well and I've got the consequences but there's no way I would sue him because he informed me and I went into that operation knowing (the chances). ... I wasn't angry with him at all because I know he did his best in a difficult situation and I still go to him because I have faith in him; he did his best. ... So it's about control. ... I feel that (my views) were incorporated in the process at the time. (Liz)

The consumers described their preferred management of unexpected negative outcomes of care. They valued an expression of sympathy, an apology (where appropriate), and negotiation about follow-up until the problem resolved or stabilised.

The consumer group agreed that they were better able to cope with ambiguity when the GP acted as a sounding board. Some saw a benefit in the GP acting as a coordinator of their care when other health professionals
were involved. One consumer who had complex health problems traced the changing nature of her relationships with GPs:

A long time ago ... I took charge of my own treatment and the processes of going to specialists and I didn't use my GP much. So when things weren't going well I just organised the system to get from specialist to specialist, often by getting a referral on from one specialist to another. Or if I needed to come back to the GP simply say(ing), 'I've decided I now need to see, either the name of the specialty or the specialist' and that's the way I used the GP.

I discovered later ... that the GP had actually been quite concerned about what was wrong with me, the way things weren't ... being sorted out, that I wasn't coming to him and asking and he wasn't initiating anything. And ... with the benefit of hindsight, my sense is that ... whilst I might want to take charge it might be good to have somebody to check back with. ... Now (I) look to my GP to ... either give me the confidence not to go (to a specialist) or to help me negotiate some arrangement ... as sort of a sounding board. ... So you do need somebody to negotiate (the system) and go through it (with you). (Jenny)

She suggested that over-familiarity could be associated with GP inattention and this might necessitate changing doctors:

It may be that some people ... need a change every so often just to sort of re-evaluate ourselves. What becomes the total relationship is locked in and sometimes it is important to make a change (when) you have come to a different stage in our development. ... Sometimes the GP will get to think that he knows you so well or she thinks she knows you so well and ... this is half the trouble quite often. ... Over familiarity ... contributes to you not being heard. (Jenny)

One consumer described her search for an ideal GP and the relationship she desired:

I think ... if you are confident in your doctor, (and) he's confident in you, it's really empowering. ... In the last couple of months (I) have changed my GP. ... I searched around for him. ... He's thorough. He talks to me on my level which is good and if he's not sure of something he doesn't pretend. He says, 'I will research it'. ... I feel he respects me as a person. ... In the surgery he says, 'Hello Liz'. That's how he addresses his patients- by their
The group valued GPs who showed honesty, warmth and above that they are human beings. They also recognised that there was considerable comfort in a familiar relationship in the face of illness and the sense that the GP was there for the long haul.

Communication
The GPs pointed out that the foundation for good rapport in consultations often preceded the first meeting between the doctor and patient because many patients first chose a GP on the recommendation of others. The role of other practice staff, particularly receptionists, in establishing rapport was highlighted too. For example staff often welcomed new patients to the practice and spoke in a complimentary way about the doctor.

When consumers had problems that were confusing they felt that it was particularly important for the GP to listen carefully to their experiences. They highlighted the importance of having adequate time to explore problems. They also emphasised the desirability of the doctor being open, attentive and responsive. Balint also identified that these communication skills were crucial (Balint 1964). One consumer described this open style of communication as candid and unguarded, not needing to think of every word before you say it.

GPs and consumers agreed that open and honest communication included an acknowledgment of uncertainty whenever appropriate. A GP described his approach to uncertainty in a way that mirrored the consumers' description of 'certainty about uncertainty':

Be confident in your uncertainty! ... Be able to say, 'Look I don't know... I can't give you a straight answer to this'. ... I'd rather say, 'I don't know'. In some areas I can be fairly confident that medicine doesn't know or ... that no-one knows. ... (Or) it may be simply that I don't know, but someone else may know. Hopefully I've got enough knowledge at least to push them in the appropriate direction. But in other cases I'll say, 'I don't know but ... why don't we wait and see?' and get them to be involved in this strategy. They don't know, I don't know but I'm fairly confident waiting a bit is not going to do any harm. (Peter)
Those participants who had experienced open exploratory communication said it did not move the relationship into the sphere of unbounded personal friendship: the professional relationship between GP and consumer persisted.

The consumer group mentioned various GP actions that could facilitate communication during consultations. They valued GPs who demonstrated some emotional commitment to them and their health; explained medical terminology and treatment options; gave individualised information; made sufficient time in consultations for the consumer to feel that they could discuss their concerns; and encouraged the consumer to take responsibility for their health and treatment. Also they valued written information about the dosage and frequency for each prescribed medication which included the date of the advice so that the timing of changes was clear. Similarly those consumers who liked writing a list of issues and concerns to discuss with the GP felt this procedure should be respected by GPs:

Taking lists along ... is probably a good idea. .... I sit down and write and think about it and then do another list which ... might omit something as being not worthwhile touching (because of) time constraints. ... I reckon it's my memory and ... I can't be blamed for having a poor memory! (Shona)

The consumers also identified modifications to therapeutic relationships and practices within the consultation that increased their satisfaction with general practice care even though their physical condition might be unchanged. These included developing reciprocal relationships with their GPs, being accompanied to consultations more often, and negotiating with the GP. One consumer described this:

I was prepared to do battle and my wife came too and she was prepared to do battle on slightly different lines. ... (After) the first few words of welcome ... he told me everything we wanted to know. Quite satisfactory. Explained what's wrong and ... if you have this treatment what the result will be - pros and the cons and so on. I came out quite satisfied. (Question from a consumer in the group:) Did your feet change or did you just now feel satisfied with the information you received? I was satisfied with the information. ... (But the problems) are going to go on and on. (Ted)
Enhancing communication within consultations
Six specific means of enhancing communication were evaluated by the groups. These were list keeping, the provision of explanatory diagrams and notes, telephone interpreter services, people accompanying patients in consultations, individualising management choices and audio taping consultations.

List keeping
Consumers supported list keeping as a memory aid to help them canvass important issues and concerns during one visit. Some were reassured by being able to refer regularly to the list during the consultation while others used it to prioritise their concerns before the visit.

Several GPs encouraged the use of lists and recommended them to their patients. A few invited the consumer to share the full list and then prioritised these after discussion so there was agreement about which issues would be addressed in that visit. Some were opposed to them because the list was tangible evidence of the consultation agenda shifting in the consumer's direction: here the GP's opposition was an indicator of the effectiveness of lists in enhancing communication within consultations.

Provision of explanatory diagrams and notes
There was agreement that prepared written information or the provision of explanatory diagrams and notes made during the consultation would facilitate better information transfer. The repetition of key concepts and the provision of additional written material were suggested as aids to communicating technical information.

Telephone interpreter services
The consumer group fully supported this service while the GP group was equivocal. The anonymous nature of the service was seen as usually beneficial. Some GPs raised an objection that handing the 'phone to and fro was disruptive to the flow of ideas and the need for clarification and repetition increased the length of the consultation. Because of the additional time they took, the GP group generally did not like bilingual consultations that required interpreters. Such reservations leave NES consumers in some difficulty obtaining good care.
People accompanying patients in consultations
The consumers were appreciative of people who accompanied them on GP visits. When the additional person was there to support the patient, prompt discussion of issues, or remind the patient about information from the consultation, their presence was regarded as helpful by GPs too. However, if the extra person took centre stage in the consultation the doctors regarded this unfavourably. In these circumstances the GPs suggested that the accompanying person be asked to leave once their viewpoint had been elicited, or the patient could be examined in a separate room to allow a private conversation to occur. One GP described negotiating to divide the consultation time so they saw the patient both with the accompanying person and separately. The GP group added that such consultations took longer and rapport could be more difficult to establish when another person was present but you are only getting paid for one consultation.

Individualising management choices
Consumers were better able to discuss management options when the GP described the details in terms that were tailored for them. This strategy allowed the consumer to see the various choices from their own context and, often after deliberating with the GP, to make a decision that was seen by them as appropriate.

Audio taping the consultation
Both reference groups were unanimous that GP consultations should not be audio taped. They believed that audio taping would change their behaviour, that tapes could not capture the non-verbal aspects of the consultation, and that as a consequence it might be difficult to understand after the visit. Additional fears of potential breaches of confidentiality and concerns about medicolegal implications were raised too.

Enhancing communication between consultations
The main method for facilitating communication between different doctors treating one patient is detailed medical records.

The GP group was sceptical about the effectiveness of medical records in enhancing information-sharing or the coordination of patient care. It was agreed that the content of medical records varied between doctors and practices along a continuum from an aide memoir to a comprehensive record of biomedical symptoms, observations, investigations and
management plans. An important factor which influenced the amount of recorded information was knowing the intended audience for the notes:

*It will change the whole nature of what you will write whether you are writing it for yourself or your colleagues; (and that) isn’t the same as what you write for the patient.* (Ivan)

However all the GPs agreed that psychological and family related information was recorded less often than technical data and yet these were areas in which accumulated knowledge gained from an ongoing relationship was particularly helpful.

Experiences with shared obstetric care led some to say that information on the combined record was not complete. Others were sceptical about the role of medical records in continuity. One doctor said:

*Some patients have an extremely emotional attachment to their medical reports. ... I’ve got three filing cabinets draws full of peoples old records from previous GPs and I refer to that extremely rarely. I mean it’s just not relevant to me.* (Ivan)

These observations highlighted the importance of stating the purpose and intended audience for medical records. It is unlikely that one form of record will satisfy every use.

**Typology of GP utilisation**

All five people who attended the final reference group meetings said that the typology of GP utilisation made sense in terms of their personal experience and the previous reference group discussions.

The GPs wondered whether the differences between the four types were widely known or appreciated. They commented that the doctor's responsibility for prescribing and monitoring drug interactions and side-effects was unclear for all patterns except the one GP type:

*There are all sort of things that we don't write down ... ('One practice' continuity) is not the equivalent of another one of me working at all ('One GP'). ... There are things that you don't know (even though) you work in the same practice. You know that, for example, if there are marital problems but you're very unlikely to document those and yet they might be impacting on people's reactions to their health or their illnesses.* (Kate)
Also they thought that the doctor's total consulting hours per week and the interval between consulting sessions would be likely to affect the patterns. With restricted consulting hours, the group felt that part-time GPs would be restricted to patients using one practice, a variety of GPs and visit-by-visit types of care. They noted that there was no evidence about the minimum time a GP would need to be available in order that they could facilitate care in the one GP model. They predicted that compared with GPs who were consciously participating in the one practice mode, GPs who felt solely responsible for a consumer's medical care would be more likely to write aide memoir records.

In the final consumer meeting the two consumers emphasised that the four utilisation patterns reflected different consumer choices, not disloyalty. The importance of choice had been emphasised by the consumer group at their other meetings too:

*We acknowledge that it is a right to choose (which GP we visit) ... you don't want to have to be pretending all the time that you are not going to someone else. ... If there is no choice then we can't necessarily have quality with continuity of care because people just might not go. ... I think it should not be seen as a sort of an insult or personal loyalty problem. (Shona)*

Generally the different utilisation patterns and their implications were not appreciated hitherto by either GPs or consumers and they were intrigued by the possibilities that were raised during discussion of the typology.

**Differences between the groups' views**

With the exchange of information between the two groups in the fourth round, their different views became apparent. The GPs felt that the consumer perspective did not take account of the variety of problems and different personalities doctors encountered in general practice. They felt that no single approach would improve the quality of general practice care and this led some to lament:

*I suppose it is the other side of what Lillian and Bevin are saying, 'You can't be everything to all people'. I've got the feeling reading through those (summaries), 'You can't win'. (Rick)*

The group discussed the notion of consumer 'pre-diagnosis'. Some GPs expressed frustration and resentment about consumers stating a diagnosis,
particularly when this was linked with a request for a specific treatment. One GP caricatured consumer pre-diagnosis in the visit-by-visit model:

_They get the service they want; they don’t necessarily get the service they need. That’s my dilemma. ... I could easily go through my days in the practice and make follow-up really easy. ... ‘OK what are you here for?’ ‘Do you want the Amoxil for your middle ear - don’t mind if I have a look at the ear do you? Which ear would you like it for?’_ (Peter)

Other GPs in the group were quick to challenge this opinion. They discussed the notion of consultations as transforming for both the GP and consumer, and said that management of health problems was a joint task requiring open, two-way negotiation.

The GP group held to the one GP model as their preferred type but did not discuss the other models in detail so they were not able to develop a collective view about all four types of care. In turn, their focus on the one GP type hampered a thorough discussion of the problems that consumers had experienced with the other three types, so consumer strategies for dealing with dissatisfaction were dismissed lightly.

The consumers summarised their reactions to the GPs’ views and described them as concerned with retaining power; giving precedence to the time-money nexus over outcomes for consumers; and avoiding conflict because of an inability to negotiate mutually acceptable solutions. In relation to this, one consumer said of GPs:

_My feeling was that they have got ‘expertise’ and ‘being an expert’ confused. Their concern is aroused (by uncertainty and feeling) unsure. Yet (GPs feel they) have to cover up because otherwise they’re not experts. But you can have a lot of expertise and still be unsure. What I think we’ve been saying is we (consumers) get confidence out of the expertise that they share._ (Jenny)

The differences that persisted were that the GPs seemed frustrated and intent upon practising in the way they were most familiar while the consumers were seeking change and suggesting strategies to accomplish it. The various policy implications of the changes needed to facilitate better management of uncertainty were discussed by both groups.
Policy implications

Enrolment
Based upon their understanding that consumers make informed decisions about the GP they will see and make the best choice they can in a complex environment, the consumer group rejected the idea of compulsory allocation of a consumer to a particular doctor (enrolment). They were in favour of retaining the existing policy that allows consumers the freedom to choose which GP they visit:

'I'm sure that there are people (at) a particular stage of their life or particular set of circumstances or particular personality types who would actually prefer and see a doctor as you know the quick fix. ... But ... they have to be free to choose, to change, to move, to find a doctor that suits them. I'd hate to be just assigned an area and a particular doctor. (If someone) said, 'OK you are on this list and there you will stay' ... that would be awful. (Shona)

We want to emphasise the importance of recognising and supporting consumers making choices. So that's choices in relation to their health but also choices in relation to which practice they go to. (Adelaide)

The GP group did not express an explicit view about enrolment. This policy option is addressed in more detail in chapter 10.

Fee for service and competition
The GP group was more interested in discussing the effect of working in a competitive environment with fee for service remuneration. The negative consequences for continuity of intense GP competition were illustrated with the example of a GP (other than the usual one) ordering a blood lipid profile and asking the consumer to return for the result. At that second consultation the GP offered interventions such as dietary counselling to attract the consumer to the practice. Such behaviour was regarded as poor practice. The group returned several times to the problems associated with the link between time and financial reward for the GP:

(Time) is the most costly thing in medical practice. ... You only have to add two minutes to ... say a ten minute consultation and that reduces your profit by 40%. ... I very much feel that while we're under-remunerated for the services provided, I really doubt there'll be a huge change in behaviour (unless) people pay more for ... the time they require. (Ivan)
Under the pressures of competition or lack of time, the GPs felt that fee for service remuneration was not conducive to continuity or quality of care. The consumer group agreed that time was an important dimension and discussed various funding alternatives which might alleviate this problem.

**Salaried practice**
Both the GPs and the consumers suggested salaried practice as one mechanism to overcome the nexus between volume of services and income for GPs. One GP spoke positively of her experiences as a salaried worker and said:

*I've no doubt I enjoyed practising medicine more when I was purely on a salary and didn't have to bother so much about bringing in an income. ... Certainly now the pressure (is) I must see so many people per day. (Joy)*

This experience was not explored by other GPs in the group. The majority were committed to private medicine which they saw as synonymous with fee-for-service funding.

**Revision of the fee schedule**
The consumers supported adequate remuneration for those GPs who spent time to communicate with them and suggested that the Medicare schedule could be reviewed with this aim:

*We're saying we want communication and acknowledge that (it) takes more time. ... What if we could turn that (the Medicare schedule) upside down so that specialists ... didn't get as much money ... and paying GPs say four times as much per consultation and reducing specialists equivalently. ... I mean 80% of us had contact at the GP's. ... It is this contact that's really important - that is about health, and not just about fixing up bits of us. (Shona)*

While the GPs supported such a revision, they were sceptical that it would occur. This scepticism impeded further discussion of this strategy.

**Credibility, authenticity and quality of the research**
The work of the reference groups has contributed to the overall quality of the research both at the level of the groups themselves and in the relationship between the groups and the other studies in this research program.
The consumer group's experience of ambiguous problems being equated with psychiatric or psychological problems reinforced a similar finding in the preliminary interviews (chapter 5). Also, in the second round meetings, both the GPs and consumers identified with the situations portrayed in the vignettes that were derived from the more detailed interviews (chapter 7). They indicated this identification in statements such as, *That one really clicks with me*. Both groups reported experiencing similar emotional reactions to those described by individuals in both interview studies too.

The occasions when the group views accorded with those of individuals reported in the preliminary interviews (chapter 5) and more detailed interviews (chapter 7) attest to the trustworthiness of the data (Guba and Lincoln 1989; Guba and Lincoln 1994).

In their third meeting several of the consumers reported that they had reflected on some difficult issues in their own relationships with GPs and could see benefits from changing doctors. Previously only the disadvantages of changing GPs had been canvassed by the group. This is an example of the value of critical reflection and of re-visiting and, where appropriate, reconsidering views in subsequent discussions.

Five consumers said that the process of their involvement in the reference group had changed them too. Four consumers at that meeting indicated that they had changed GPs during the year and the other one said, *I've changed my thoughts about my GP!* Their testimonies are evidence of the ontological, educative and catalytic authenticity of the research.

Similar testimonies were not evident among the GP participants, however. In the future such testimonies and other indicators of authenticity will be essential if enduring change is to occur in Australian general practice.

**Summary and conclusions**

The principal successes of the reference group discussions were in the development of collaborative interpretations of data and the synthesis of collective views on dissatisfaction with general practice care, and, in particular, its role in discontinuity of care. These perspectives include a rich and detailed description of consumers' and GPs' experiences as well as strategies for change based on their experiences. The discussions were also helpful in assisting me to refine the design for the survey and interview studies.
I had hoped that the reference groups would agree on changes to general practice care that were likely to assist in the resolution of dissatisfaction and discontinuity. This aim was not achieved as the two groups' had different foci. This difference became clear during the meetings of the fourth round and the discussions ended with an impasse that I could not resolve at the time.

I think that groups of interested and articulate consumers and GPs could continue to discuss these issues fruitfully. Such differences are important because, without resolution, consumers' health needs will not be met fully or effectively, and consumer and GP disquiet will persist.

One strategy to overcome the impasse might be to gain agreement on the nature of the differences between the two groups' views using the descriptive and identifying phases of critical reflection (Schoen 1987; Smyth 1989). Such a process would help individuals to separate the issues from their personal practice and examine them dispassionately. A next step might be to confront these notions using questions designed to identify each groups' ideals and values in relation to their different views (Peavey 1992). Then the groups could enter a reconstruction phase and develop detailed strategies for change.

The strategic use of ongoing, facilitated dialogue between GPs and consumers could play a useful role in fora such as divisions of general practice. In discussions based on fourth generation evaluation principles (Guba and Lincoln 1989; Guba and Lincoln 1994), some of the more challenging matters and ongoing tensions in general practice could be discussed and reflected upon until more common ground is identified.
CHAPTER 10

Summary and conclusions

I began this work because it seemed paradoxical that nearly half the Australian population were visiting two or more GPs a year (Health Insurance Commission 1992) while many consumers, GPs, and their professional organisations were recommending a stable, ongoing therapeutic relationship between a consumer and a single GP. This observation raised many questions about how we might understand continuity, its value and relevance, and the circumstances in which people see various doctors or change doctors.

From my clinical practice I was aware that some people were seeing many GPs and expressing considerable dissatisfaction with their care. Their experience seemed to echo the prevailing GP view that consumer dissatisfaction was linked to discontinuity. The two case histories presented in chapter one, show that the sources of dissatisfaction are multiple, often involve complex interpersonal dynamics, and are difficult to understand if only one viewpoint is considered.

I devised a multi-method, sequenced research project to examine the issues that impact on consumer and GP dissatisfaction and provider discontinuity in Australian general practice. I examined these issues with GPs and consumers who had personal experience of the problems and with two reference groups. My aim was to understand and later, to contrast, the views of consumers and GPs.

The issues that participants raised about their general practice care during the interviews and reference group discussions were found to be strikingly similar to those identified in the questionnaire-based epidemiological studies. This strengthened the validity of the qualitative results, but the
sampling process for those studies was not random, so the proportions of participants in each utilisation type cannot be generalised to the Australian population.

The typology of general practice utilisation
A key outcome has been the recognition of four types of general practice utilisation. These are visits to one GP, visits to one practice, visits to a variety of GPs in different practices, and visit-by-visit use.

Hitherto, discontinuity has been conceptualised as resulting from interruptions to having all visits with one GP. However, I found that all 'discontinuity' was not the same. When the doctors and consumer were working co-operatively in the visits to one practice model or in the visits to a variety of GPs model, discontinuity was not an inevitable result of the fact that more than one GP was seen.

Consumers' actual utilisation did not always reflect their stated preferences. In the relatively short period of nine months of the longitudinal study, half of the consumers did not achieve their preferred GP utilisation. Difficulties with access, cost and GP availability influenced the type of utilisation whereas problems with communication or feeling that the GP lacked relevant expertise were associated with consumer dissatisfaction.

Consumers who preferred and usually had all their visits to one GP also saw other doctors when their usual GP was not available. The interview and Health diary studies showed that those who wanted ready access to GPs generally were unable to achieve this when they had all their visits to the same GP. Some found their needs were better met by visits to one practice, or to a variety of GPs or a mixed type of utilisation. Others persisted with the visits to one GP model but had visits to other doctors (generally from the same practice) if their GP were unavailable.

There was a tendency for young and healthy people to prefer a visit-by-visit approach, for people at the 'families stage' to have continuity with a practice, for those experiencing several distinct problems to choose care from a variety of GPs, and for the elderly and people with life threatening problems to prefer continuity with one GP. The advent of illness or changes in life circumstances may prompt a change to a different utilisation pattern. This suggests that the four utilisation types may suit people for specific
periods or at different stages, rather than being a lifetime-defining characteristic of consumers themselves.

For some consumers, visiting several GPs provided them with an opportunity to experience different medical and personal styles. These visits provided evaluative information which was used when decisions were made about changing doctors.

Consumers changed GPs when the needs associated with their particular health problems and life circumstances were not satisfied by their (one or several) GP's availability and skills. A change of GP often occurred after either the consumer or GP moved and in that circumstance did not indicate poor quality care or dissatisfaction. However consumer dissatisfaction associated with communication difficulties was found to be a potent stimulus for changing GPs. So the match between a consumer and a GP was more or less enduring, and changing doctors was a rational and understandable step that most people took several times in their lifetime.

Relationship between continuity and quality
In all of the six studies there was strong support from consumers and GPs for utilisation in which all visits were to the same GP. In the epidemiological survey (chapter 4) 83% of people said that they saw their usual GP on their last visit and the Seeing doctors survey (chapter 6) at the nine general practices found that 55% of patients were seeing their usual doctor on the study day/s. Similarly in the Health diary study (chapter 8), this type of utilisation was preferred by the majority of participants.

Three benefits were associated with visits to one GP and they are believed to contribute to the achievement of good outcomes. These were coordination, familiarity and openness in the therapeutic relationship, and a capacity for review of progress and treatment.

The first benefit of visits to one GP was that care could be coordinated and thereby experienced by the consumer as coherent. Coordination allowed the GP and consumer to integrate relevant information and gain an overview of the consumer's health problem since the skills of many (both health professionals and others) might influence the consumer's health experience. In this way the complex interplay between the medical problem and the personal and social aspects of their life was acknowledged.
Secondly, visits to one GP built familiarity between the consumer and GP, and over time, this enhanced the commitment each felt to the therapeutic relationship. The relationship itself became a resource and forum in which the consumer was encouraged to discuss intimate feelings and concerns. According to their testimonies in the reference group meetings, such relationships facilitated the consumer's personal growth and were of particular benefit to consumers who had serious and chronic illnesses. GPs also benefited from therapeutic relationships which added to the store of experience on which they could call for other patients and their own personal development.

Thirdly, successive visits to one GP allowed feedback about previous visits. This was important so that appropriate care incorporating mutually agreed treatment and monitoring could be designed by the GP and consumer.

These three dynamics provide a useful framework for thinking about continuity of care generally, and the relation between continuity, satisfaction and quality outcomes.

It follows that if coordination, familiarity and openness in therapeutic relationships, and review can be achieved in types of utilisation other than when visits are to one GP, those other utilisation types can support continuity of care. Examples of such continuity of care were related by consumers who had visited one practice and others who had visits to a variety of GPs (chapters 7 and 8). However the inherent lack of feedback in a visit-by-visit approach to utilisation would seem to be an impediment to this type of constructed continuity.

There were also instances when consumers had all their visits to one GP but appeared not to reap the benefits of continuity (chapter 9). So continuity can not be equated with seeing only one GP, nor did the visits to one GP pattern of service use guarantee continuity. Further, visits to one practice or a variety of GPs did not preclude continuity.

Continuity of care results from the efforts of both the consumer and the GP within a particular consultation and over time. Meaningful assessments of continuity must include appropriate information from consumers and GPs. My claim is that continuity must be constructed by the consumer and GP(s) together; it cannot be delivered to a passive recipient by the GP, however skilful.
The majority of consumers preferred, and by and large achieved, continuity with one GP, at least for periods of time. During the longitudinal study, practice continuity and continuity with a variety of GPs were preferred and enacted by 22% and 5% of consumers respectively.

Four essential pre-conditions for continuity of care have been identified in the studies and described in this thesis. They are access, GP competence, communication, and a mechanism for bridging from one consultation to the next. The first three have been emphasised in consumer-based research (Consumers' Health Forum of Australia 1993; Albany Consulting Group 1995).

Access resulted from a match between the consumer's ability to get care (which was affected by physical matters such as location, proximity to transport, for some, whether lifts or ramps were provided, financial considerations and cultural appropriateness) and the GP's availability.

The GP's competence included knowledge, skills and attitudes about the full array of illnesses, their natural history, and the effects of interactions between the illness and various other personal and social factors. The potential complexity of many health problems plus the non-specific nature of many symptoms meant that there was often uncertainty about the significance of consumer's problems, at least at the outset. Consumers believed that good GPs recognised, acknowledged and jointly managed this uncertainty with them.

Good communication was valued so highly by consumers that nearly all participants (57/59) in the longitudinal study said that it affected their choice of GP (chapter 8). Its importance was emphasised by the consumer reference group too. The features of good communication emphasised by consumers included feeling that they were listened to, and accorded respect, were given the opportunity to participate in their medical management, and were given adequate time for this during consultations.

A mechanism for bridging from one consultation to the next was essential for providing feedback to both the consumer and the GP. Without this it was not possible for the GP or consumer to develop individualised, informed management plans.

Medical records sometimes assisted coordination of care, particularly within one practice. However 'the notes' were unlikely to be the whole answer to
coordination since different GPs recorded varying amounts of information. Even those GPs who wrote detailed records rarely documented the interpersonal and social aspects of health problems. Innovations such as consumer 'smart cards', which contain coded medical information, may help with the coordination task between doctors at different locations. However they too will be restricted in content and by confidentiality provisos and cannot replace the role of either the GP or the consumer in coordination.

The consultation
The consultation was seen as an arena where both the consumer and GP were acting on the basis of, and were subjected to, many contradictory influences and tendencies. The nature of the presenting problem, dealing with uncertainty, and tensions about control and trust were elements of, and dynamics within, the consultation that help us make sense of the inter-relations between continuity, satisfaction and quality outcomes.

Nature of the problem
It seemed that the health problems presented by consumers in consultations had three distinct components. The first could be described in biomedical terms: symptoms, diseases and disabilities. Social problems, the second component, affected and were affected by the biomedical component. Thirdly, existential fears were aroused by illness, such as those associated with the meaning of illness and its timing. In addition, health problems change with time, and sometimes became more amenable to categorisation (diagnosis) or resolution with chronicity.

Uncertainty
Consumers reported that the way a GP acknowledged and dealt with uncertainty was vital to their satisfaction with visits and their overall confidence in the doctor. Ultimately the GP's management of uncertainty also influenced consumers when they considered changing doctors.

Consumers were especially critical of GPs who offered reassurance without explaining why their symptoms could be ignored safely. Competent GPs (as judged by consumers) provided reassurance or 'certainty about uncertainty' that was based on evidence not assertion, and demonstrated their 'expertise' by devising a management strategy with the consumer that was based on their joint knowledge, skill and experience, rather than adopting the role of 'expert'.
The preferred process for investigating a problem with an uncertain component appeared to have two steps and required at least two consultations. Initially consumers wanted the GP to respect and listen to their account of their problems and concerns and then to recommend tests or referral in a discriminating way, so reversible and life threatening conditions could be identified or excluded. Then, consumers were content to see how the passage of time, and therapeutic and health-promoting activities affected the health problem. At a subsequent consultation progress could be reviewed jointly. Even when adverse health outcomes occurred, consumers said that when they played an active part in the consultation and shared in the decision-making, they were not dissatisfied. GPs who felt confident managing uncertainty agreed that this approach to dealing with uncertainty was satisfying and effective.

The importance of review in the management of uncertainty was highlighted by its absence in the visit-by-visit approach to health care. The lack of a feedback mechanism discouraged negotiation about diagnosis or collaborative development of management strategies within visits. Thus a superficial approach to problem definition and management resulted and contributed to consumer and GP dissatisfaction with the visit-by-visit approach.

All GPs discussed uncertainty during the interviews and reference group meetings. They acknowledged that such problems were a potent cause of occupational dissatisfaction. Many felt hampered in their attempts to manage uncertainty by their biomedical training, a lack of appropriate skills to manage such problems, time pressure in consultations and a fear of being judged incompetent by consumers, peers and competitors. While consumers and GPs agreed that the process and conduct of the consultation and subsequent review of progress were critical to good care, few GPs appeared to have been educated about this and they could not identify any mechanisms to assist.

**Control and trust**

Many consumers discussed the tension produced by wishing to stay in control during a consultation and in life in general. Some said they wanted a focus (which was sometimes the GP) to blame for their pain and uncertainty. Even though they recognised that exploratory discussions were necessary for managing uncertainty, these carried a risk that insecurities would be identified. On the other hand, some concluded that naming their
insecurities and seeking causes were important in the resolution of the social and existential aspects of their health problems.

GPs also experienced tension about controlling consultations at times. For some, an awareness of the inherent vulnerability of the human condition seemed to be associated with a paradoxical urge to control the consultation which in turn, seemed to have emphasised the inadequacy of their knowledge and skills.

During the reference group discussions consumers highlighted the importance of the GP's recognition of their autonomy. This required the GP and consumer to find a balance between being in control and trusting the other. The balance also facilitated consumer participation in their medical management and signalled that it was ultimately the consumer who had prime responsibility for their health. This contrasts sharply with the traditional understanding of continuity of care being delivered by the solely-responsible GP who makes decisions for patients and issues 'doctor's orders' for them to implement.

Influence of external factors on the clinical consultation
Public and community opinion, professional, institutional, and economic factors can have various, even opposing, effects on consumer dissatisfaction and discontinuity.

Public and community opinion
Both consumers and GPs believed that public opinion about GP care has changed over the last ten years. Increasingly individuals have visited different doctors and changed GPs if they were dissatisfied. The high proportion of people seeing more than one GP during 1992 compared with annual utilisation a decade earlier is evidence of such a shift (Andersen, Bridges-Webb et al. 1986; Health Insurance Commission 1992).

The interaction between public opinion and decisions about choosing GPs was described by the five participants in the diary study and those consumers in the reference group who changed GPs. They said that an awareness that changing GPs was almost commonplace and had been beneficial for others could 'tip the scales' in favour of them changing GPs too.

Many consumers described visits to GPs in which they mentioned their interest in alternative health therapies and self-care practices but these
avenues for health improvement were often rejected or trivialised by the GP. Such experiences were often retold within family and friendship groups, giving impetus to the perception that GPs were biomedical technicians with less to contribute to the resolution of social and existential problems. In turn these perceptions diminished the likelihood that consumers saw the GP as the professional who was best equipped to assist them with these problems so the community view was reinforced.

Professional and institutional factors
Professional demoralisation can have direct effects on the way GPs practise. Individual GPs and members of the GP reference group described feeling professionally isolated and dejected. A recent NCEPH survey found that 35% of GPs were so dissatisfied with general practice that they would leave if 'they thought there was anywhere else to go' (Bailie and Douglas 1995). These findings suggest that a proportion of GPs might be disinclined to maintain their skills and commitment to their vocation. Rather, they might be more likely to provide visit-by-visit type care, as Jason had (chapter 7), because he saw the task as straightforward and not intellectually demanding. He acknowledged that he did not find this type of practice satisfying and that his detachment reduced the chances of his building trusting and rewarding relationships with consumers.

In addition many urban GPs were concerned about intense competition for patients due to high numbers of GPs in their locality. They said the feeling that they had to fight for their livelihood and protect their practices inhibited collaboration between GPs and was one reason that GP-to-GP referrals (for special services such as sports medicine) were uncommon in urban settings. Competition was frequently cited as the reason why GPs were not motivated to join Balint-style groups despite evidence that such groups enhance GPs' skills to manage psychosocial and existential health problems.

Economic factors
Professional alienation has been associated with high volume, brief visits in general practice where consumer's problems were handled superficially, causing dissatisfaction and discontinuity.

Health economists and policy makers have become concerned about these and also about the escalating number and cost of GP services. The policy response to the high and increasing government outlay on general practice
services has been to reduce rebates for GP services relative to the consumer price index. However GPs have been shown to be working harder for longer hours to maintain personal income targets (Hawkins 1995) and it is probable that resulting fatigue could impair GPs' performance in clinical encounters and contribute directly to consumer dissatisfaction.

Implications for general practice
Most consumers obtain most of their general practice care from one practice. Access, cost and GP availability influence the type of care obtained by consumers so these matters should be discussed within practice groups and decisions about each made with an understanding of their likely effect on utilisation. For example, GPs and consumers report that a practice decision to increase fees above the level of the bulkbill rebate reduces the proportion of consumers who see them for all their visits. Faced with a financial obstacle to access, consumers become more likely to visit a variety of GPs or to visit one GP who bulkbills.

GPs would benefit from discussing the types of care they want to provide at the practice so that their staff support them and the options are clear to consumers. Many GPs prefer working in the visits to one GP mode. For this type of care to function effectively there must be explicit arrangements for occasions when they are not available and mechanisms for ensuring that important information related to those occasions is brought to their attention.

GPs in practices that want to offer continuity of care within the visits to one practice model must develop a shared philosophical understanding (and hence familiarity between the GPs). Also, opportunities for consumer familiarity with the practice GPs, and clear mechanisms for coordination and review are necessary. Based on these shared understandings, medical record keeping and the use of clinical guidelines should be discussed and modified as required. Consumers who visit a variety of GPs would benefit from a discussion with each of their doctors about coordination and review, and familiarity within each of those therapeutic relationships.

Since some consumers change the type of care they prefer with the advent of illness or when their life circumstances alter, GPs should update their understanding of the consumer's utilisation preferences regularly.
Similarly, practice meetings will have different contributions to make in each utilisation model. If the GPs at one practice work reasonably independently using the visits to one GP mode, their interests in practice meetings may focus more on the effectiveness of appointment systems, and occasional backup when the usual GP is not available. Practice meetings are particularly important for mediating continuity for visits to one practice as staff must have opportunities to discuss the practice philosophy, and to develop strategies for enhancing consumer familiarity with the GPs in the practice and mechanisms for coordination and review.

This work adds impetus to the growing recognition that medical education needs to be reoriented both to reflect a more holistic view of health and illness and an understanding of partnership between doctors and consumers. When doctors learn about a particular disease they should also consider the impact of other diseases, therapies and self-care practices, uncertainty, and the social and existential influences on the problem. Such wide ranging education is best undertaken interactively in small groups (like Balint groups) where trust can develop. In such settings doctors can examine their communication skills too so they are better able to work together and with consumers. These skills and attitudes include listening, showing respect for others, creating opportunities for consumers to participate in decision making, and allowing adequate time in consultations. Such changes would shift the role of doctors from 'expert' to one of using their expertise in working with consumers.

**Implications for policy**

Policy choices about funding general practices are influential in shaping the environment in which satisfaction, continuity and quality outcomes are produced. Within the consultation environment, consumers and GPs agree that time is an important resource because it is necessary for the establishment of rapport, considered investigation of health problems (particularly when problems are multiple and inter-related) and discussion and negotiation about management.

Three main policy options are examined next for their effect on satisfaction, continuity and quality outcomes. These are enrolment, general practice as a free market, and grants as part of pluralistic remuneration (Veale and Douglas 1992).
Enrolment
Under enrolment a consumer nominates a GP who would thereafter be responsible for delivering or brokering their medical care. Enrolment has health promotion and program evaluation benefits and is viewed by its GP proponents as a mechanism to re-establish continuity.

However in itself enrolment does not promote spending adequate time in consultations, nor does it affect communication or guarantee good therapeutic relationships, so quality of care is not assured. In Australian general practice in the nineties, consumers valued their right to exit from an unsatisfactory relationship with a GP because in many instances leaving was deemed to be the healthiest option in the face of problems with the GP and system that were beyond the consumer's sphere of influence. Consumers in the reference group urged that their right to choose to visit any GP be protected in any reforms to the present health system.

Free market
A different response to dissatisfaction and discontinuity is proposed by those favouring a free market approach to medical care. These people hold that medical services are like other commodities and that selling and purchasing services in a free market enhances quality and efficiency through competition. Consumers, they suggest, will choose the best service at the best price and will be more likely to be satisfied. The policy changes that are consistent with this perspective include unlimited university places for those wanting a medical education, unlimited access to vocational training, removal of public subsidies for health services and removal of the community rating for health insurance premiums.

However the tenets of the free market do not apply to general practice care since it is not a commodity like other consumer goods. Quality care requires coordination, familiarity within the therapeutic relationship, and review, and these extend care beyond the confines of one consultation. In addition, a recognition of the importance and ubiquity of uncertainty about health problems means that consumers cannot be fully informed about the nature of their health problems and management choices prior to an initial visit. Further, there is evidence that competition between GPs for customers undermines coordination yet this is important for achieving quality outcomes of general practice care.
Grants as part of pluralistic health funding

A third solution favoured by some GPs and policy makers is pluralistic health service funding. As part of pluralistic funding, the Better Practice Program (BPP) offers grants for non-clinical work that are intended to reward continuity of care within one practice with additional income that is independent of service volume (Department of Human Services and Health 1994). Grants are calculated using an HIC algorithm which includes terms for standardised whole patient equivalents, an adjusted patient continuity index for the practice (not individual GPs), and a rural loading (McCallum and Raymond 1996(b)).

Two findings from this research lend support to the rationale for the Better Practice Program grants. Firstly, I have shown that continuity of care in its constructed form is associated with consumer satisfaction, and secondly, that constructed continuity can contribute to quality general practice outcomes.

However the Better Practice Program grants, as presently defined, do not recognise the different kinds of continuity, its constructed nature, nor the extrinsic factors that contribute to discontinuity (which are beyond the control of either consumers or GPs). Also the HIC continuity index used in the calculation of the size of the grant inevitably describes past utilisation only (as do all continuity indices). It is likely that the HIC continuity index does not predict future utilisation (as none of the seven continuity indices evaluated in chapter 8 did). Further, the HIC index does not measure quality because it mistakenly assumes that all visits to one practice are functional and that visits to other practices represent poor quality care.

Analysis of the seven continuity indices (chapter 8) showed they were poor indicators of quality in the absence of additional information about both a consumer’s preferences and choices and the extent of a consumer’s and GP’s efforts to construct care collaboratively. In addition, because quantitative indices were only descriptive of past utilisation, they could not predict intention, preferences or patterns of future use. For these reasons the quantitative indices should not be used either to monitor or to encourage continuity of care as understood here. This strongly suggests that the HIC continuity index is unsuitable for use as an incentive for GPs to provide quality care.
Concluding remark
The work on consumer dissatisfaction and discontinuity has taken me from dichotomising patients into those who were 'loyal' and others who were 'doctor shoppers' to a broader understanding of them as people who prefer and enact differing forms of general practice utilisation to suit their circumstances. Constructed continuity of care results from the efforts of consumers and their GP(s) in three utilisation types: visits to one GP, one practice and a variety of GPs. I have shown that continuity is associated with high quality care, and with satisfaction for both consumers and GPs. This research has assisted me to think more explicitly about many of the issues associated with the production of quality of care. In turn, this has increased my awareness of and respect for my patients' choices and enhanced my own clinical satisfaction. I hope these insights will assist consumers and other GPs in their deliberations about continuity and quality of care.
Appendices
Appendix 2.1 Individual Characteristics Associated With Sequential Continuity of General Practice Care

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INDIVIDUAL CHARACTERISTICS ASSOCIATED WITH SEQUENTIAL CONTINUITY OF GENERAL PRACTICE CARE

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ABSTRACT

Aim: To identify individual and social characteristics associated with sequential visits to general practitioners in 1991-92.

Methods: Data for this study were extracted from the National Centre for Epidemiology and Population Health "Record Linkage Pilot Study", that linked personal interview and Health Insurance Commission information and Australian National Heart Foundation Risk Factor Survey data for 521 subjects aged between 23 and 72 years. Each sequence of visits for each participant, to the same or a different general practitioner, was treated as an event, and these sequences provided the main outcome variable.

Results: Using logistic regression, younger age, good physical functioning and self-rated health, normal body mass index, shiftwork and the longer time interval between visits were significantly associated with less continuity of care.

Conclusion: This study provides an innovative method for examining sequential visits, and raises questions about the relationship between chronological continuity and quality of care.
INTRODUCTION

The Royal Australian College of General Practitioners defines general practice activity as "The provision of primary, continuing, comprehensive, whole patient care to individuals, families and their community." Continuity of care is explicitly included in this definition, and is considered to be an important contributor to quality of care in general practice. Its importance stems from its presumed positive effects on health outcomes, which have been said to include improved doctor-patient relationships, increased knowledge of and interest in the patient, promotion of confidence and rapport, increased compliance with treatment, reduced hospitalisation rates and reduced levels of disability and discomfort in chronic disease.

Continuity of care being defined as "the uninterrupted responsibility of one doctor for a patient's care" has been used internationally to assess the benefits of continuity in general practice. However, there is no universal agreement about the definition of continuity of care. Continuity of care can be viewed as an attitude of doctor or patient, as well as an activity involving encounters between doctors and patients. Rogers and Curtis have conceptualised encounters as occurring in what they termed a 'continuity environment'. They postulated this environment to be comprised of a range of environmental factors that affect continuity, and divided the environment up into a number of dimensions. These dimensions are chronology, geography, interdisciplines, relationships, information, accessibility and stability. The chronological dimension includes providing health services to patients and families over time.

Quantitative-based measures of continuity can be individually or visit-based. Eriksson suggests the visit-based approach, which assigns continuity values to each single visit, is easy to use conceptually and technically, and is more flexible than the individual-based approach. Quantitative visit-based measures of continuity of care stress different dimensions of continuity such as the numbers of visits to different doctors, the distribution of visits between available doctors, the share of visits of the dominant
provider, and the sequencing of visits. Steinwachs designed a sequential continuity index to measure the average number of doctor visits in sequence over time. A series of Swedish studies focused on sequencing by arbitrarily relating their measure to the last visit. A review of seven continuity indices from other studies, using the same data set reported in this paper, showed poor correlation between measures of continuity depending upon which aspect of continuity is emphasised in the measure.

While having a focus on sequencing, this paper takes a new approach to those already in the literature. Rather than using a summary index or arbitrarily choosing the last visit, we treat each available sequence of visits as an event. It is patient continuity between consecutive visits over time that forms the basis of this study, which aims to link such visits with known individual and social characteristics of participants. The availability of high quality event history data allows this more direct approach to sequential continuity.

**METHOD**

This study is based on data collected in the 1992 National Centre for Epidemiology and Population Health (NCEPH) "Record Linkage Pilot Study", that aimed to investigate the predictors and outcomes of health service usage. Canberra participants in the 1989 National Heart Foundation (NHF) Risk Factor Survey were interviewed during April and May 1992. At the time of that interview, participants were requested to give consent to the linking of this information with data from the Medicare records of the Health Insurance Commission (HIC), the Australian Capital Territory's (ACT) hospital records; and the records of the cancer registry.

The interview schedule contained the RAND Corporation Medical Outcomes Survey schedule, that provided a rating on dimensions of health, including physical functioning, depression, social functioning, physical and emotional roles, vitality, mental health, bodily pain and self-rated health. Other questions provided personal information about home duties, retirement, shift work, employment status, car ownership, number of
children, social contacts, country of birth, change of address, marital status, income and private medical insurance.

To satisfy requirements of ethics and privacy for record linkage to Medicare records, in addition to consent by the person whose records were being sought, prior approval was gained from the Australian National University Ethics in Human Experimentation Committee, the Commonwealth Minister of Health, the Commonwealth Privacy Commissioner, the Health Insurance Commission and the Health Care Access Division, Department of Human Services and Health.

The information gathered at the NCEPH interview provided all the predictor variables for study, apart from income and body mass index that were derived from the NHF 1989 survey. The HIC data were used to identify visits to general practitioners, particularly the number of visits and number of general practitioners visited for each individual. Individual general practitioners were coded by the HIC and were not identifiable by name. As well, the continuity of general practitioner for any visit in relation to the general practitioner seen at the previous visit was ascertained. This provided the main outcome variable for the study. The time period covered in relation to general practitioner visits was 24 months from January 1991 to December 1992.

**Statistical Analysis**

Firstly the numbers of visits to general practitioners by participants were recorded and analysed by age group and gender. Three groups, each containing as close to a third of subjects as possible, formed age group intervals of less than 40 years, 40 to 49 years, and 50 years and above. For each age group/gender category, the distribution of the number of visits was graphed.

Remaining analyses used only those participants with two or more doctor visits. Each visit, after the first, was classified as $0 = \text{the same general practitioner seen as the}$
aged less than 30 years in the NCEPH study. As a requirement of the 1989 NHF survey, participants were aged between 20 and 69 years inclusive. Thus participants were aged between 23 and 72 years inclusive at the time of the NCEPH interviews. Of the 521 participants, 269 were males and 252 were females. One hundred and eighty were less than 40 years of age, while 184 were aged fifty and above.

**Number of visits to general practitioners**

The number of visits to general practitioners by study participants in 1991-92 was positively skewed (Figure 1). The four people excluded from Figure 1 had 59, 62, 90 and 213 visits respectively. The numbers of visits to general practitioners were analysed by age group and gender. For this analysis, participants with more than one visit were divided into those who had 2-5, 6-11, and 12 or more visits, to maximise the membership of each group (Figure 2). The proportion of participants who had 12 or more visits was highest in the oldest age group. In all age groupings, females tended to visit general practitioners more frequently than males. Seventy-three percent of females attended the doctor 6 or more times compared with 47% of males. Eighty percent of the 73 people who did not visit the general practitioner or visited only once during the study period were male.

**Subset analysis**

This section of this paper is concerned with sequential changes in general practitioner visits from one visit to the next. The 73 people who did not attend the doctor or attended only once during the study period are therefore excluded from further analysis. There was a strong correlation \( r = 0.84 \) between the number of general practitioner visits by individuals and the number of changes of general practitioners from one visit to the next. Figure 3 shows the mean number of visits for males and females, by age group, in which a different general practitioner was seen from the one seen in the previous visit. Though there was a trend for females to have a higher mean number of
changes than males across all age groups, these differences were not statistically significant. The highest rate of change occurred in females aged less than 40 years.

The predictor variables described in the methods section were then included in the individual based logistic regression model. Statistically significant predictor variables were then included in the visit-based logistic regression, with the dependent variable defined as a visit to a general practitioner who was different or not from the one seen at the previous visit. Younger age, good physical functioning and self-rated health at the time of the interview, normal body mass index in 1989, shift work and more days between visits were significantly associated with less continuity (Table 1). The magnitude of the associations were similar for common variables between the individual and visit-based models.

DISCUSSION

The approach to sequential visits employed in this study has a number of advantages. Since all visits over the study period are included for analysis, there is no loss of information as occurred in the Swedish studies that related continuity only to the last visit. Also, this method overcomes the averaging of effects as in the Steinwachs' model, and allows the time interval between visits to be considered. The main barriers, however, relate to the need to link databases containing highly sensitive information, and the need to address complex ethical and confidential considerations that arise as a result. Where it is possible, such record linkage does provide a rich database for quantitative exploration of continuity of care.

The time period under study was two years, resulting in 73 participants with less than two visits being excluded from the analysis. The number excluded would vary depending on the time period chosen, which may affect the level of the association between the time interval between visits and continuity. However the finding that a longer interval between visits was associated with less continuity raises an important
previous twelve months. Further research is needed to explore the effect of socioeconomic status on multiple general practitioner use.

The population used in this study was highly selected, being from Canberra, having participated in the 1989 National Heart Foundation survey and having agreed to the NCEPH follow-up. To address the issue of generalisability, similar studies in different populations are needed, especially since these results, if replicated, have definite implications for policy direction and decisions. For example, any rewards based on continuity may disadvantage doctors in communities with a large proportion of young healthy people, especially where there is a large proportion of shift workers.

The results of this study pose a number of issues for consideration for policy makers at both government and professional levels. If young health people are less likely to be exposed to health promotion activities through continuity with general practitioners, should consideration be given to the provision of such services through non-general practitioner sources? Or could general practitioners be involved in the provision of health promotion services outside their usual clinical settings? Also, for such a healthy group, discontinuity may have little bearing on quality of care. This is an important consideration if practices are to receive incentive remuneration based on measures of continuity of care, as is presently available under the Better Practice Program of the Commonwealth Department of Human Services and Health.

Further research is needed to explore the reasons why people see multiple general practitioners. A prospective longitudinal study would be an important next step in further elucidating the complex interplay between the sociodemographic and interactional factors that result in the utilisation of multiple general practitioners by Australians.
REFERENCES


Table 1: Adjusted odds ratios, 95% confidence intervals and p values for predictor variables significantly associated with visits to a different general practitioner from the one seen at the previous visit (n = 4513: the number of sequences of visits by participants).

<table>
<thead>
<tr>
<th>Predictor Variable</th>
<th>Adjusted Odds Ratio</th>
<th>95% Confidence Interval</th>
<th>p value</th>
</tr>
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<tbody>
<tr>
<td>Age (23 - 72 yrs)</td>
<td>0.962</td>
<td>0.953, 0.971</td>
<td>&lt; 0.001</td>
</tr>
<tr>
<td>Gender (Males = 1; Females = 2)</td>
<td>1.027</td>
<td>0.779, 1.354</td>
<td>0.849</td>
</tr>
<tr>
<td>Physical functioning (0 - 100; best = 100)</td>
<td>1.008</td>
<td>1.002, 1.015</td>
<td>0.012</td>
</tr>
<tr>
<td>Self-rated health (0 - 100; best = 100)</td>
<td>1.007</td>
<td>1.000, 1.013</td>
<td>0.04</td>
</tr>
<tr>
<td>Body mass index (Min = 14.69; Max = 43.48)</td>
<td>0.959</td>
<td>0.930, 0.988</td>
<td>0.007</td>
</tr>
<tr>
<td>Shift work (No = 1; Yes = 2)</td>
<td>1.889</td>
<td>1.000, 3.572</td>
<td>0.05</td>
</tr>
<tr>
<td>Number of days between visits</td>
<td>1.003</td>
<td>1.002, 1.004</td>
<td>&lt; 0.001</td>
</tr>
</tbody>
</table>
Figure 1: Frequency of general practitioner visits by each participant, excluding 4 participants who each had more than 48 visits ($n = 517$).
Figure 2: Distribution of visit groups for each gender within each of three age groupings.
Figure 3 Means and 95% confidence intervals for the number of visits involving a different GP from the GP seen at the previous visit by males and females in different age groupings
Appendix 4.1    Consumer Use Of Multiple General Practitioners


This paper was published in Family Practice in September 1995 and is reproduced with permission.
Consumer use of multiple general practitioners: an Australian epidemiological study

Bronwyn M Veale, John McCallum,* Deborah C Saltman,** Joan Lonergan,† Yolanda J Wadsworth‡ and Robert M Douglas* 


The aim of this Australian study was to explore the reasons for peoples' choice of general practitioner (GP) in an environment where they have freedom of choice of doctor on every occasion of attendance. A questionnaire was administered by trained research assistants to 555 people during an hour-long interview. Utilization of more than one general practitioner was examined in terms of sociodemographic factors, health status and satisfaction with the last general practice visit. Respondents were more likely to see more than one general practitioner if they had more visits; were dissatisfied with their last consultation with a general practitioner; were younger; were female; and were highly qualified. Further, respondents who described good communication as the rationale for their satisfaction rating for their last general practitioner visit were less likely to have seen more than one general practitioner.

Introduction

Texts about general (and family) practice consistently stress the importance of the provision of 'primary, continuing, comprehensive whole patient care to individuals, families and their communities'. In Denmark, the Netherlands and the United Kingdom the health systems are based on enrolment where a patient must register with a general practitioner (GP) who becomes responsible for the provision of this type of care. In other countries the doctor-patient relationship is not formalized, so the extent to which one doctor provides or coordinates the patient's care is variable.

In Australia there is freedom of choice of GP for each general practice consultation. Medicare, the Australian health care insurance system, provides publicly funded universal health insurance, so access to primary medical care is not restricted. The Health Insurance Commission annual report for 1992 showed that 82% of the Australian population attended a GP at least once in the preceding year, and that 56% of patients saw two or more different GPs. What does this utilization pattern mean? If the majority of patients are not seeing the same GP for each consultation in one year, is an individual's primary care coordinated by doctors in one practice? The Health Insurance Commission data identifies individual practitioners but does not yet identify practices, so the service utilization data cannot answer this question. Ward et al. have shown that 69% of patients attending three general practices in Western Australia did not attend elsewhere during a six-month period (July 1986–January 1987).

General practitioners are free to choose where and with whom they practice in Australia. A national study by Bridges-Webb et al. showed that 26% of the GPs were in solo practice in 1991–1992, while 40% were in groups of two or three and 34% were in practices comprising four or more GPs. So it is possible that some of the visits to different GPs recorded in the Health Insurance Commission utilization data are visits to one practice.

Some of these visits to different doctors may reflect dissatisfaction with previous consultations. In a convenience sample of 333 patients from four urban general practices, Lupton et al. found that 24% of respondents had ever changed doctors. A minority gave a reason for the change of doctors; 10% of the sample citing factors relating to problems with access to consultations, 10% stating problems with the doctor's competence, and 8% for problems associated with the doctor-patient relationship. Lupton et al. developed a classification based on the features of respondents' explanations for initial choice of doctor, reasons for continuing to attend a doc...
tor, and rationale for changing doctors. These were accessibility, instrumental, and affective features, features of continuity of care, recommendation, and other features.

Similarly in the United States, the relationship between patient satisfaction with medical care and subsequent change of doctor has been demonstrated. Marquis et al. have shown a linear relationship between dissatisfaction and provider change. However in the United Kingdom the situation is different. Salisbury surveyed new registrants with five general practices and found that the majority changed doctors because they had moved to a new area, while 10% of people who changed GPs did so for convenience or because of dissatisfaction with the last doctor.

Clearly, satisfaction is a major issue when people choose a doctor. Empirical research on satisfaction in general practice shows that patients distinguish many components of satisfaction. Zastrowny et al. have demonstrated that satisfaction related to patient–doctor contact can be distinguished from global satisfaction. They showed that it is this specific satisfaction that is causally related to use of health services and that it is context specific. Salisbury found in the UK that predictors of GP satisfaction were “the giving of information by the general practitioner, the general practitioner’s medical skills, the general practitioner’s interpersonal skills, and faith in doctors”. He found that older people were more satisfied with most aspects of their primary health care; a finding that is consistent with Australian research on satisfaction with general practice. Salisbury also found that women tended to be slightly less satisfied overall with their primary care and that social class, educational and health status were not significantly related to satisfaction. Penchansky et al., in the United States, have shown that those with less education were more satisfied with access to services and in Australia Lloyd et al. found that high and low-status respondents did not differ significantly on matters relating to changing GPs.

The highly context-specific nature of general practice suggests that patient satisfaction with general practice may vary according to the health system and other contextual factors. National studies are important to understand the factors which are pertinent to general practice care. International evidence offers the guidance of the sociodemographic factors including age, gender, educational and social status, and interactional factors including satisfaction with general practice care may be important in determining a person’s likelihood of changing doctor.

**Aims of the study**

The aim of this study was to explore the reasons for peoples’ choice of general practitioner in an environment where they have freedom of choice of doctor on every occasion of attendance. We wanted to examine the sociodemographic and interactional factors that predicted multiple general practitioner usage. This study was the general practice component of a larger project based in Canberra, Australia, “The NCEPH Record Linkage Pilot Study” which has been reported elsewhere.

For the present study, multiple general practitioner use was defined as the service utilization pattern where more than one GP was seen during the preceding 12 months.

**Method**

**Sample**

In 1992 we performed a follow-up survey of residents who had participated in the 1989 National Heart Foundation Cardiovascular Risk Factor Screening Survey in Canberra. Subjects for that survey were selected from the electoral roll (n = 981 of 1500 identified on the roll). National Heart Foundation staff gained informed consent from the original participants who were willing to be contacted about the follow-up study. Five hundred and eighty people (59%) were contacted and agreed to participate, 183 (19%) were contacted and refused, and 218 (22%) were untraceable. Subsequently, at the time of the interview, 25 people either refused to complete the interviews or could not be contacted. For the present study, a questionnaire was administered by trained research assistants to 555 people during an hour-long interview.

The questionnaire sought information about health service use, health conditions, women’s and men’s health, satisfaction with services, health behaviours, private health insurance and detailed demographic information.

Utilization of more than one GP was examined in terms of sociodemographic factors, health status and satisfaction with the last general practice visit.

The respondents’ sociodemographic characteristics were examined: age, grouped by decade; gender, male or female; and ethnicity, respondents designated their country of birth. The responses were grouped as those who were Australian born, those born in another English-speaking country (UK, Ireland, North America and New Zealand) and “Other”. Socioeconomic status was assessed using educational achievement (at primary, secondary and tertiary levels) and occupation.

General self-rated health for each respondent was appraised by self-report (ranging from excellent to poor). In addition, respondents reported the number of GP visits in the preceding year, whether they had experienced depression during that year, and the nature of current health problems.

To investigate satisfaction with the last GP visit, respondents were asked, “With regard to the last time you consulted a general practitioner, how would you describe the service you received?” The reasons for the
Consumer use of multiple general practitioners

A satisfaction rating were sought in an open-ended question, "Why do you say that?" Responses were grouped according to an expanded range of Lupton's categories. Accessibility features included proximity to a GP, patient's convenience, availability of bulk billing, and locational change by either the patient or GP. Instrumental features included the patient's assessment of the attending GP's competence, preventive activity, practice organization and availability of special services in the practice. Affective features included communication between the patient and GP, patient expressed gender preference of GP, and GP speaking a language other than English. Similarly, the reasons given for and locational change by either the patient or gender preference of categories.

Analysis

Univariate analysis using the Chi-square test and the Mantel-Haenszel test for trend was performed to determine whether there was an association between respondents attending more than one GP and the socio-demographic and health-related variables described above. Significance was assessed at both the 0.05 and 0.01 levels, and both are reported.

Multiple logistic regression was performed using SPSS 4.0 to generate multivariate models to examine the factors that were associated with respondents attending more than one general practitioner. Respondents who had two or more consultations in the preceding year were divided into those who had seen one GP and those who had seen two or more GPs. The models used multiple GP use as the dependent variable (coded 0/1: 0 = those who had seen one GP, 1 = those who had seen two or more GPs). The variables found to be significant at the 0.05 level on Chi-square testing were included in the original-model and the least significant variable was removed sequentially. The final model was chosen for its parsimony.

Results

Of the 555 people surveyed, 49.7% were female. Ninety-one per cent of the sample had visited a GP during the preceding 12 months. Seventy-three per cent (404 individuals) had two or more visits to GPs in that time, and of these, 32% (129/404) had seen more than one GP. There was a high level of satisfaction with the most recent visit to a GP. This visit was rated as excellent by 184 (33%), as very good by 207 (37%), as good by 81 (15%), as fair by 22 (4%), as poor by 2 (0.4%) and the question was not answered by 59 (10.6%).

Univariate analysis showed that age and gender were significant predisposing characteristics for multiple GP use. Age was grouped by decade, and those aged 20-29 were significantly more likely to have consulted multiple GPs (Mantel-Haenszel test, P < 0.05). Gender was significant, with women being more likely than men to have seen more than one GP in the preceding year (P < 0.01). When age groups were examined for men and women separately, there was a statistically significant tendency for younger men to have seen more than one GP compared with older men (Mantel-Haenszel test, P < 0.01). There was no significant relationship for women across age groups. Figure 1 shows the distribution of respondents seeing one GP or two or more GPs by age group and gender.

There was no significant effect of ethnicity on the likelihood of people seeing multiple general practitioners. None of the indicators of socioeconomic status (educational achievement and occupation) had a statistically significant effect on the tendency to visit more than one GP in the univariate analysis.

Univariate analysis of the respondents' health status showed a significant relationship between the number of GP visits an individual had in the previous year and the tendency to see more than one GP (P < 0.01). Women were more likely than men to have five or more visits during the preceding 12 months (P < 0.01) and for both groups an increasing number of visits was associated significantly with seeing more than one GP (males: P < 0.01; females: P < 0.01).

Figure 2 shows the distribution of respondents seeing one GP or two or more GPs by the number of visits and gender. There was no significant effect on the likelihood of seeing more than one GP of self-assessed health status, self-reported depression during the preceding year, or of self-reported current health problems.

Satisfaction with the last GP visit was found to be related significantly to seeing multiple GPs. Less satisfied persons were more likely to have consulted another GP (P < 0.01). There was a significant association for those who explained their satisfaction with the last GP visit in instrumental terms, but accessibility or
affective explanations were not statistically significant predictors. If competence were mentioned as a reason for a respondent’s satisfaction assessment of their last visit to a GP, they were less likely to see multiple GPs ($P < 0.05$).

Some respondents gave two or more reasons for seeing more than one GP in the previous year. Accessibility reasons were given by 58%, instrumental factors were cited by 42% and affective features by 25% of the respondents.

In the multivariate model for multiple GP use, the following explanatory variables were significant: number of GP visits ($P = 0.0004$), satisfaction with the last GP visit ($P = 0.002$), age group ($P = 0.05$), gender ($P = 0.05$), respondent’s qualifications ($P = 0.02$), and communication as an explanatory factor for the satisfaction rating for the last GP visit ($P = 0.003$) (Table I). These mean that the likelihood of seeing multiple GPs increased with the number of visits (odds ratio of 1.4 per visit; this is multiplicative with the number of visits); poorer levels of satisfaction with the last GP visit (odds ratio of 2.3); younger age group so the 20–29 year olds were most likely to see multiple GPs and the age group 50–59 were least likely (odds ratio of 0.3); female gender thus women were more likely than men (odds ratio of 1.8); those respondents who had tertiary qualifications—degree or diploma (odds ratio of 1.8); and decreased with mentioning communication issues as the reason for their satisfaction rating for the previous GP visit (odds ratio of 0.4).

Discussion

The sample for the present study was gained by contacting the original 981 participants in the National Heart Foundation Screening Survey undertaken in Canberra in 1992. Because the original sample was derived from the electoral roll it included adults only; further, the sample was truncated at 70 years of age. Thus, the present sample does not represent the complete age range in the Australian population. Respondents in younger age groups and people of non-English speaking background were under-represented in the original sample due to lower response rates. However, no other differential loss was noted in the present sample and a comparison of demographic and coronary risk factor variables for responders and non-responders between the present and the 1989 sample did not show any other significant difference. Age was controlled in the multivariate model to account for the structure of the sample.

Respondents were more likely than the Australian population to have visited a GP in the previous 12 months. Ninety-one per cent of the sample had at least one GP visit in that period while 82% of the general population did so. However, respondents were less likely to have seen two or more GPs (32%) compared with 56% of the general population. These findings may reflect the relative stability of the study population as the mobile subgroup within a population is likely to be healthier than those who are less mobile. Also the present sample excluded children, adolescents and people aged over 70 years and all these groups (except children under the age of 4 years) are less likely than the average to have consulted a GP in the preceding year. Thus, generalizations from this data need to be made cautiously and should be restricted to the adult population.

This research relied on each participant recalling all their GP visits over the preceding 12 months. As with other retrospective techniques for data collection, the information may be affected by recall difficulty or bias; the demand for focus; the uncertainty inherent in retrospective delineation of episodes; and difficulty in recapping decision-making processes. Considerable effort was made to facilitate accurate recall of utilization including asking respondents to review personal records of general practice visits. Comparison with the Health

### Table I. The independent variables and corresponding adjusted odds ratios and 95% confidence intervals for the multivariate model for predicting multiple general practitioner use (n = 404)

<table>
<thead>
<tr>
<th>Independent variables</th>
<th>Adjusted odds ratio</th>
<th>95% confidence interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of GP visits</td>
<td>1.4</td>
<td>1.2-1.8</td>
</tr>
<tr>
<td>Dissatisfaction vs satisfaction with last GP visit</td>
<td>2.3</td>
<td>1.3-3.9</td>
</tr>
<tr>
<td>Age group (years)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>30-39 vs 20-29 (n = 88)</td>
<td>0.6</td>
<td>0.2-1.3</td>
</tr>
<tr>
<td>40-49 vs 20-29 (n = 118)</td>
<td>0.6</td>
<td>0.3-1.1</td>
</tr>
<tr>
<td>50-59 vs 20-29 (n = 96)</td>
<td>0.3</td>
<td>0.1-0.7</td>
</tr>
<tr>
<td>&gt;60 vs 20-29 (n = 66)</td>
<td>0.5</td>
<td>0.2-1.2</td>
</tr>
<tr>
<td>Gender: male vs female</td>
<td>1.8</td>
<td>1.1-2.8</td>
</tr>
<tr>
<td>Respondent’s qualifications: tertiary vs other</td>
<td>1.8</td>
<td>1.1-2.8</td>
</tr>
<tr>
<td>Communication as a criterion for respondent’s satisfaction rating for the previous GP visit</td>
<td>0.4</td>
<td>0.2-0.7</td>
</tr>
</tbody>
</table>
Insurance Commission (HIC) record showed that respondents tended to under-report use of general practice services. A prospect data collection technique such as the use of health diaries in which participants record utilization details would improve the accuracy of information about utilization. In turn, this information could be compared with the HIC data to test the validity of that utilization data source.

We found that respondents were more likely to see multiple GPs if they had more GP visits; were dissatisfied with their last GP consultation; were younger; were female; and were highly qualified. Further, respondents who described good communication as the rationale for their satisfaction rating for their last GP visit were less likely to have seen multiple GPs.

The finding that those who had more GP visits were more likely to see multiple GPs is not surprising. The match between consumer and GP availability will be tested with greater utilization. Béland in Canada has shown that seeing the same doctor is more likely when utilization is regular and of low volume. The present study did not seek information about the problems managed during the visits to other GPs, whether the other GPs visited were in the same or different practices, or whether medical records were available to these multiple GPs. Such information would be important in a more detailed evaluation of multiple general practitioner utilization.

The finding that dissatisfaction with the last GP visit is predictive of seeing multiple GPs is interesting. It suggests that respondents are indicating both a broad sense of dissatisfaction and more specific dissatisfaction. In the United States, where patients can choose their general or specialist physician at each encounter, general dissatisfaction has been shown to increase the likelihood of provider change. Similar findings have been reported in the United Kingdom where changing GP involves changing administrative arrangements as patients are required to enrol with a nominated GP there.

In Australia, it has not been possible to say whether seeing multiple GPs is ‘good’, ‘bad’ or ‘neutral’ from a consumer’s viewpoint. However, in so far as dissatisfaction with the last GP visit is predictive of multiple GP use, we can say that the contribution of dissatisfaction to this utilization pattern is indicative of less than optimal general practice care. It is informative that good communication contributed to satisfaction with GP visits and this highlights the importance of communication skills training for general practice.

Younger patients were also more likely to have visited multiple GPs. Sloane et al. in the USA found that adults over 55 years were more likely to have visited one health practitioner only. Again, more information about the reasons for this utilization pattern is needed.

Women were more likely to see multiple GPs and this was independent of dissatisfaction. Salisbury found that women were more likely to be dissatisfied with their primary care. In Australia it has been shown that women were more likely to seek health promotion and preventive health care from female rather than male GPs. Many women respondents in this study commented that they saw different doctors for their general and women’s health needs. In the Australian setting, the tendency for women to see multiple GPs is more likely to be related to them seeing doctors for particular health needs. An evaluation of the effect of this specificity of utilization is beyond the scope of this study, but it is likely that this aspect of multiple doctor use is beneficial as women gain better access to health promotion and preventive services. However the role of the GP as coordinator of care and sole deliverer of comprehensive health care may need to be re-examined in the light of this finding.

Highly qualified respondents were more likely to have seen more than one GP. Previous research in Australia has shown that people of low and high socioeconomic status hold different views about health-related matters. This finding builds on the earlier work of Lloyd et al. who found that people from more affluent suburbs were more likely to have a pluralist use of health services. Further research is needed to explore this aspect of multiple GP use.

Indeed further research is needed to explore the reasons for people seeing multiple GPs as this study raises the possibility that some aspects of the utilization result in health benefits for consumers and other aspects may be detrimental. The importance of good communication and satisfaction with general practice visits have been reinforced in this retrospective study of the reasons for multiple GP use. A prospective longitudinal study would be an important next step in further elucidating the complex interplay between the sociodemographic and interactional factors that result in the utilization of multiple GPs by Australians.

In summary, we found that the utilization of multiple GPs was more likely when the consumer expressed dissatisfaction with the last GP visit and when they had more GPs visits during the previous 12 months. Also, consumers who were younger, female, and more highly qualified were more likely to have had multiple GP visits. Multiple GP visits were less likely when good communication was cited as the reason for satisfaction with the last GP visit.
Acknowledgments

We would like to thank Ms R Attewell for her statistical advice during this study and Dr A Veale for constructive criticism of early drafts of this manuscript.

References

Appendix 5.1  Interview schedule for the Consulting Colleagues study

CONSULTING WITH COLLEAGUES

VIA AN OPEN-ENDED TELEPHONE DISCUSSION

1. DOCTOR SHOPPING

If you think back to the last session of consulting that you did, can you recall any patients who you would describe as a doctor shopper?

Why does that description fit in your mind?

Were there any patients who you believe have chosen actively to consult at least one other GP during the last 12 months?

Towards a definition

Estimate of prevalence

Identifiable characteristics of shoppers

Effects / outcomes for shoppers

Effects on the GP (eg attitude; behaviour; self esteem; sense of responsibility; communication; investigations; altered management; prescribing; record keeping; followup; prevention)

Economics

Sharing patients with partners, assistants, locums, after hours services

Factors which may promote or diminish doctor shopping

2. CONTINUITY OF CARE

What matters? (Accessibility, Instrumental features, Affective features, Continuity of care, Recommendation)
DEMOGRAPHIC INFORMATION AND DETAILS OF CURRENT PRACTICE

1. Age 2. Sex
3. Year of graduation 4. University of graduation
5. Years of hospital training prior to entry into general practice 6. Years (full-time equivalent) of experience in general practice
7. State of current practice 8. Postcode from which you currently practice
9. Hours per week spent seeing general practice patients on average 10. Number of patients seen in an average week consulting
11. Nature of practice (solo, formal private arrangement with other GPs—indicate number of full-time equivalent partners or associates, other)
12. Are you vocationally registered
13. Are you eligible for vocational registration
14. Do you belong to RACGP (Fellow, member, associate)?
15. Member of the AMA (or the GP subgroup)
16. Member of DRS  17. Member of A2GP (Australian Association of GPs)
18. Member of Private Doctors Assoc of Australia
19. Is all your GP at one address (number of practice sites)
20. Content of your practice (typical Australian, GP modified by specific ethnic characteristics of pts., special skills, specific circumstances)
21. Do you undertake obstetric care (antenatal, management of labour, hold Dip. Obs)
22. Percentage of weekly patient contacts which are
   house calls nursing home visits
   hospital visits
   after-hours (6pm-8am weekdays, after 12noon Sat.)
23. For after-hours consultations, do you
   engage a locum service cover yourself
   roster with other practice members roster with other GPs
   work at local after-hours service
24. Current billing practice
   bulk bill all patients bulk bill health care card holders only
   b/b limited numbers of patients no bulk billing
25. Do you have experience working as a general practitioner outside Australia? (Record details)
26. Do you have experience working as a general practitioner with aborigines? (Record details)
Appendix 5.2  

Interview schedule for the *Consulting Consumers* study

CONSULTING WITH PATIENTS

VIA AN OPEN-ENDED DISCUSSION

1. Would you please think back about all the doctors you’ve seen. It might be quite a lot over your life........

Would you say that you have ever ‘shopped around’ or that you ‘shop’ now for a GP? *(Prompt: Look for the rationale - the good things)*

2. What does the term ‘doctor shopping’ mean for you?  
*(Prompt: Identifiable characteristics or preferred term)*

3. How often would you or have you ‘doctor shopped’?

4. Do you think its a common thing for people? How common?

5. What are the effects on you? On others? *(pros & cons)*
   - You: 
   - Others:
   - Pros
   - Cons

6. Does ‘doctor shopping’ have any extra costs (not only $) for you? The health system?

7. Would you prefer not to have to have to ‘doctor shop’?

For the aspects that aren’t so good about ‘doctor shopping’, what would need to be different for things to change? What kinds of change? What could be done about them - by you? by doctors? by others?
A few questions about you....

1. In which country were you born?______________________

2. If you were not born in Australia, when did you arrive in Australia? 19_____

3. In which country was your mother born?______________

4. If she was not born in Australia, when did she arrive in Australia? 19_____

5. In which country was your father born?______________

6. If he was not born in Australia, when did he arrive in Australia? 19_____

7. Is English your first language?   Yes  No

8. What language do you speak at home?__________________

9. What is your home postcode or suburb?________________

10. What was your age at your last birthday?______________

11. When did you leave school?
   • attended primary school only
   • attended secondary school but did not complete final year
   • completed secondary school to year 12

12. Have you undertaken any of the following since leaving school?
   • apprenticeship/traineeship
   • diploma
   • degree

13. How many visits to a GP did you have in the last year?__________

14. How many different GPs did you see/consult in the last year?_______
SEEING DOCTORS:

A STUDY OF GENERAL PRACTICE CARE

This project, designed by Dr Bronwyn Veale from the Australian National University, will find out from patients how they choose the general practitioner (GP) they visit.

All information will be confidential and will be kept securely according to the University's strict ethical guidelines. In particular, your general practitioner/s (GP) will not see any of your answers. You will not be identified personally in any of the written reports.

Thank you for agreeing to take part.

Dr Bronwyn Veale
National Centre for Epidemiology and Population Health
Australian National University
Canberra, ACT, 0200
ph (06) 249 5541
WHO IS SEEING THE DOCTOR?

1. **Who** is seeing the doctor today? (Please tick one box)
   - [ ] I am
   - [ ] my child
   - [ ] other (please describe)

Please answer all the following questions on their behalf.

WHY YOU ARE CHOOSING THIS DOCTOR TODAY?

2. Please think about why you are seeing this doctor (rather than anyone else).
   a) Is this your usual doctor? (Please tick one box)
      - [ ] yes, I am seeing my GP/ usual doctor
      - [ ] no, but this is the practice that I usually come to
      - [ ] no

   b) What is your **main reason** for seeing this **doctor** (rather than anyone else)?

   c) If there are **other reasons**, please list them in order of importance.

WHAT HEALTH PROBLEMS DO YOU HAVE?

3. What **problem(s)** are you seeing the doctor about **today**? (list all the problems)

4. What health problems do you have?
   (Please list all **health problems** that have affected you or are affecting you now.) eg. asthma, high blood pressure, rash, arthritis, diarrhea, anxiety, diabetes, menopausal problems, earache, family planning, headache, eye pain, urinary tract infection, cancer etc.
Please answer all these questions for the person seeing the doctor today.

THESE QUESTIONS ARE ABOUT THE PERSON SEEING THE DOCTOR TODAY

8. In which country were you born?

9. If you were not born in Australia, in what year did you arrive in Australia to live?

10. In which country was your mother born?

11. In which country was your father born?

12. What is the main language that you speak at home?

13. What was your age at your last birthday? (If you are completing this on behalf of a baby, please write the baby's present age in months).

14. Are you (Please tick one box)
   [ ] male
   [ ] female

15. Which of the following best describes your current housing situation? (Please tick one box)
   [ ] renting public housing
   [ ] renting on the private market
   [ ] own home, paying off a mortgage
   [ ] own home outright, not paying a mortgage
   [ ] staying with family members
   [ ] other (please describe)
Please answer all these questions for the person seeing the doctor today.

16. What is your home suburb or postcode?

..............................................................................

17. How many times have you changed address since January 1988?

..................................................................................

□ times

18. What was the highest level you reached in school? (please tick one box)

□ primary school

□ some secondary school

□ completed year 12 or equivalent

□ other (please describe)

19. Since leaving school have you obtained a trade qualification, certificate, diploma, degree or any other qualification? (Please tick one box)

□ yes

□ no

20. Which of these groups best describes the highest qualification that you have obtained? (Please tick one box)

□ trade/apprenticeship

□ certificate/diploma

□ Bachelor degree or higher

21. What is your current occupation for your main job? Please describe fully. (If you are retired or unemployed, please indicate this and what your last job was.)

..............................................................................

And finally, an important request......
I am interested to learn more from people who have had five (5) or more visits to GPs in the past year.

There are two things I’d like to do with interested people - an interview and a list - and you might like to do one, or the other, or both.

Your participation would be very valuable and I hope that you will want to be involved. If you would like to take part, please tick the boxes below and write your name and contact telephone number(s), or speak to me.

Bronwyn Veale.

1. The Interview

The interview • would be strictly confidential and • can be arranged to suit your convenience (morning, afternoon or evening over the next two days.)

☐ Yes, I would be happy to be interviewed.

2. A List of Visits to the Doctors in a Year

The list • would be kept by you on a card in a photo frame (a gift to keep afterwards!) in a handy spot like on the ‘fridge. • You would be contacted monthly to collect the information.

☐ Yes, I would be happy to keep a list.

My name is

........................................................................................................................................

My contact telephone numbers are

  home........................................................................

  work/other................................................................

Thank you for completing this questionnaire.
Please hand this back now to the receptionist or to Bronwyn Veale
THIS PRACTICE IS TAKING PART IN A STUDY DESIGNED BY DR. BRONWYN VEALE FROM THE AUSTRALIAN NATIONAL UNIVERSITY.

EVERYONE ATTENDING TODAY WILL BE ASKED TO FILL IN A SHORT WRITTEN QUESTIONNAIRE ABOUT SEEING DOCTORS.

YOUR HELP WITH THE RESEARCH WILL BE VERY VALUABLE - IT WILL HELP SHAPE THE FUTURE OF GENERAL PRACTICE.

TAKING PART IS VOLUNTARY - PLEASE TELL THE RECEPTIONIST IF YOU DO NOT WANT TO BE INVOLVED.

DR. BRONWYN VEALE IS HERE TO ANSWER ANY QUESTIONS ABOUT HER RESEARCH.

THANK YOU FOR YOUR HELP TODAY.
Appendix 7.1 Consumer interview schedule

1. LAST VISIT

Can you think back to your last GP visit?
What was the reason(s) for your visit that day?
Why did you see that particular GP rather than anyone else?
Have you consulted that doctor/that practice before?
What did you appreciate about the visit -Why?
What didn’t you like about the visit -Why?
Would you keep coming to that doctor/that practice - Why?
Would you recommend that doctor to a friend - Why?

2. SPLEEN

In your experience of going to doctors
- have you ever felt that the real cause of a problem has not been identified?
or
- have you ever suspected that a doctor thought your concern about your health was unnecessary?

Can you tell me about that?
How did you feel?
What did you do?
Does uncertainty play a part - if yes, how do you cope with it?
In retrospect, is there anything that could have improved the situation
- that you could have done? - that the doctor could have done? - anyone else?

3. LIFE MAP

I’d like to get a picture over time of doctors you’ve gone to and the various reasons for changing from one to another or continuing to go to one or more.

(Explore - with the aid of a diagram:
• the nature of the health problems and
• whether they go to one doctor a lot or
• various different doctors
• over a lifetime continuum
• what they were looking for
the reasons for changing
the reasons for sticking
who they sought advice from about potential doctors)

4. ALTERNATIVES

I'd like to get an idea of who else you see for health problems and why.
How do you decide when to go to the doctors rather than to these alternative health care people?

5. IDEALS

What is your idea of the ideal GP?
What is your idea of the ideal GP visit? (what you are looking for and what you don't want)
What is your idea of the ideal patient? (your version of good patient practice)
What is your idea of the ideal general practice?
Do you think you have enough time at the doctors?
What is your idea of the ideal doctor - patient relationship? May be hard
What is your idea of the GP's role in Australia? to answer

How do these ideals measure up to the realities? (satisfaction/dissatisfaction)
What do you get from your current doctor(s)/general practice?
Why do you stay/what would prompt you to leave?

FREE EXPRESSION ABOUT THE INTERVIEW - CONTENT, PROCESS, EMOTIONS......anything at all.
Appendix 7.2 GP interview schedule

1. LAST VISIT

Can you think back to your last consulting session (or another recent session)? Can you recall a person who you think would have had five (5) or more visits to GPs in the past year?

What was the reason(s) for their visit that day? (Several vignettes)

Why did you think they saw you rather than anyone else?

Have they consulted you/your practice before?

What did you appreciate about the consultation -Why?

What didn’t you like about the consultation -Why?

Would this person keep coming back to you - Why?

What would make it likely that they’d see another GP/another practice when they next need to go?

2. LIFE MAP AS A GP

I’d like to get a picture over time of your general practice experience with those people who attend often and who see several different GPs.

(Explore - with the aid of a diagram:

• the nature of their experience
• over a lifetime continuum of practising
• whether they know/try to influence patients re seeing various different doctors

3. SPLEEN

Have you ever had the experience

- where you felt the real cause of a patient’s problems has not been identified? or
- where you’ve suspected that the person’s concern about their health has been unnecessary?

Can you tell me about some of them? (draw out several stories)

How did you feel?

What did you do?

Does uncertainty play a part - if yes, how do you cope with it?

In retrospect, is there anything that could have improved the situation
- that you could have done? - that the patient could have done? - anyone else?
4. LIFE MAP

I'd like to get a picture over time for one of these people - of who this person sees for their health problems and of the nature of their problems.
(Explore - with the aid of a diagram and/or the medical record:
• the nature of the health problems and
• whether they go to one doctor a lot or
• various different doctors
• over a lifetime continuum
• what they were looking for
• the reasons for changing
• the reasons for sticking
• who they sought advice from about potential doctors)

5 ALTERNATIVES

I'd like to get a picture over time of who else this person sees for their health problems.
Do you know if they've seen other health care providers?
What is your attitude to this - e.g. encourage, neutral, discourage?
What do you think patients are looking for from these other health care providers?

5. IDEALS

What is your idea of the ideal patient?
What is your idea of the ideal GP visit?
(What you are looking for and what you don't want)
What is your idea of the ideal GP?
What is your idea of the ideal doctor - patient relationship?
What is your idea of the ideal general practice?
What is your idea of the GP's role in Australia?
What do you get from your current practice(s)?
Why do you stay/what would prompt you to leave?
How do these ideals measure up to the realities?
(satisfaction/dissatisfaction)

FREE EXPRESSION ABOUT THE INTERVIEW - CONTENT, PROCESS, EMOTIONS......anything at all.
Appendix 7.3  Coding framework

(1)  /Documents
(1.1) /Documents/Indepth interviews
(1.1.1) /Documents/Indepth interviews/Q last visit
(1.1.2) /Documents/Indepth interviews/Q spleen
(1.1.3) /Documents/Indepth interviews/Q life map
(1.1.4) /Documents/Indepth interviews/Q alternative health
(1.1.5) /Documents/Indepth interviews/Q ideals
(1.1.6) /Documents/Indepth interviews/Q GP experience
(1.1.7) /Documents/Indepth interviews/Q pts' life map
(1.1.8) /Documents/Indepth interviews/Q extra

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(2.1.2.1) /Participants/GPs/Age group/25-44 years
(2.1.2.2) /Participants/GPs/Age group/45-64 years
(2.1.2.3) /Participants/GPs/Age group/65-74 years
(2.1.2.4) /Participants/GPs/Age group/75+ years
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(2.1.3.2) /Participants/GPs/Languages/NESB
(2.1.4) /Participants/GPs/Practice
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(2.1.4.1.2) /Participants/GPs/Practice/Co-GPs/2 or 3 GPs
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(2.1.4.1.4) /Participants/GPs/Practice/Co-GPs/Extended hours
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(2.1.5.2) /Participants/GPs/Years as GP/10-19 years
(2.1.5.3) /Participants/GPs/Years as GP/20+ years
(3.2.4) /Current problems/Organisational factors/Practice organisation
(3.3) /Current problems/Communication problems
(3.3.1) /Current problems/Comm problems/Records problems
(3.3.2) /Current problems/Communication problems/Descriptions of
(3.4) /Current problems/Ending GP-Pt relationships
(3.5) /Current problems/Problems with GP service

(4) /The Good Relationship
(4.1) /The Good Relationship/Re GP provider
(4.1.1) /The Good Relationship/Re GP provider/GP attributes
(4.1.1.1) /The Good R'ship/Re GP provider/GP attributes/General
(4.1.1.2) /The Good R'ship/Re GP provider/GP attributes/Boundary
(4.1.2) /The Good R'ship/Re GP provider/GP support
(4.1.2.1) /The Good R'ship/Re GP provider/GP support/Own GP
(4.1.2.2) /The Good R'ship/Re GP provider/GP support/Group practice
(4.1.2.3) /The Good R'ship/Re GP provider/GP support/Debriefing
(4.2) /The Good Relationship/Re Consumer
(4.2.1) /The Good Relationship/Re Consumer/Competent care
(4.2.2) /The Good Relationship/Re Consumer/Information
(4.2.3) /The Good Relationship/Re Consumer/Autonomy
(4.3) /The Good Relationship/Attributes
(4.4) /The Good Relationship/Good Communication
(4.5) /The Good Relationship/Holism
(4.6) /The Good Relationship/Successful mx of uncertainty

(5) /Barriers to good relationship
(5.1) /Barriers to good relationship/Uncertainty
(5.1.1) /Barriers to good relationship/Uncertainty/Triggers
(5.1.2) /Barriers to good relationship/Uncertainty/Feelings
(5.1.3) /Barriers to good relationship/Uncertainty/Fears
(5.1.4) /Barriers to good relationship/Uncertainty/Responses
(5.1.5) /Barriers to good relationship/Uncertainty/Labels
(5.2) /Barriers to good relationship/Fragmentation
(5.3) /Barriers to good relationship/Communication problems
(5.4) /Barriers to good relationship/Structural problems
(5.4.1) /Barriers to good relationship/Structural problems/Time
(5.4.2) /Barriers to good relationship/Structural problems/Money

(6) /Solutions
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Appendix 8.1  The health diary

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Appendix 8.2  The case summaries of the individuals who preferred
the same GP and called the doctor, My GP

Adele - female aged 64 years - hypertension; influenza.

Adrian - male aged in his 25 years; bleach in the eye; chest pain due to pericarditis;
superannuation medical examination.

Alice - female aged 4 years; no visits.

Annette* - female aged 33 years; GP delivery; postnatal check; skin lesion.

Antony* - male aged 74 years; malignant melanoma; hypertension; back pain and chronic
cough; stress reaction to uncertainty.

Austin* - male aged 6 years; chronic purulent otitis media; encopresis.

Barbara* - female aged 66 years; surgical decompression of carpal tunnel syndrome;
hypertension; chest pain; influenza immunisation; viral illness causing gastroenteritis and
upper respiratory tract infection (URTI); monitoring of cystic lesion of kidney.

Bernard - male aged 54 years; chronic leg ulcer; trauma to hand; gastrointestinal stoma.

Beryl - female aged 66 years - pernicious anaemia; influenza immunisation; osteoporosis and
on hormone replacement therapy (HRT); history of colon cancer; influenza and cough;
recurrent cystitis; solar keratoses.

Bianca* - female aged 2 years; gastroenteritis and URTI.

Billy - male aged 5 years; skin rash; burn to lower leg.

Bob - male aged 60 years - hypertension; history of cerebrovascular accident (CVA);
ophthalmological referral; arthritis; hiatus hernia and dyspepsia; naevus check;
psychiatric condition for which he takes lithium.

Claire - female aged 5 years - bronchitis; URTI.

Deborah - female aged 3 years; cough, earache and ringworm; corneal abrasion.

Duncan* - male aged 65 years; back pain; Paget's disease of the bone; prostate symptoms.

Gerald* - male aged 63 years; hypertension and ischaemic heart disease; emergency triple
bypass for cardiac arrest during angiography.

Graham - male aged 44 years - breast lump; gastroenteritis; influenza; strained shoulder.

Gregor* - male aged 30 years; work-related chronic shoulder injury; dyspepsia.

Hazel - female aged 85 years; tingling and numbness in feet and lower legs; vitamin B12 and
folate deficiency; osteoporosis; PH of trauma to back in MVA; intraocular lens implant; neck
pain; stress causing weight loss, breathlessness and feeling unwell; irritable bowel syndrome;
trauma to left foot.

Hilary - female aged 62 years; hypertension - problems with medication; gastric reflux;
infected spots on face; influenza immunisation; cough; carcinoma of the breast treated with a
lumpectomy, axillary clearance and radiotherapy with the complication of a radiation burn.

Jane - female aged 35 years; general check-up including blood pressure measurement,
premenstrual tension; influenza; urinary tract infection.
Jean - female aged 71 years - solar keratoses; depression; indigestion; chest pains; migraine.

Jocelyn* - female aged 64 years; osteoporosis and on hormone replacement therapy (HRT) then on calcitriol - monitoring blood tests; asthma; history of plastic surgery for trauma to lower leg; influenza immunisation and mammogram.

Justin - male aged 1 year; gastrointestinal bleeding, nappy rash and cold; traumatic avulsion of a toenail; asthma and respiratory distress; asthma and dehydration; hand, foot and mouth disease (coxackie virus); breath-holding and ?fits.

Kingsley - male aged 68 years - influenza immunisation; gastroenteritis; prostatism; manic depressive psychosis; back pain; removal of a skin lesion on nose; mouth ulcers; diabetes insipidus from Lithium; cough.

Kylie - female neonate with URTI; immunisations; infant with URTI; feeding problems.

Lawrence - male aged 2 years - influenza; otitis media; immunisation; URTI; history of ureteric reflux.

Liam - male aged 8 years; infected hair follicle, history of recurrent otitis media; acute suppurative otitis media.

Mandy* - female aged 31 years; neurological problem of uncertain aetiology. ?multiple sclerosis; panic attack.

Nancy* - female aged 63 years; ophthalmological problem; dyspepsia; genital prolapse; chronic pain in a cholecystectomy scar; arthritis causing back and knee pain.

Octavius - male aged 26 years; eye infection.

Prue* - female aged 60 years; recurrence of malignant lymphoma - having chemotherapy and radiotherapy; back and chest pain; mitral valve prolapse.

Reynard - male aged 60 years - tachycardia, ischaemic heart disease and PH of CABG, hypertension, depression.

Ruth - female aged 73 years - chest infection; depression; recurrent cystitis; mycosis fungoides; influenza; anxiety.

Samantha - female aged 44 years; fractured coccyx; hormone therapy; immunisations for overseas travel; stomach pain requiring gastroscopy; gastric dilation; arthralgia.

Sharron - female aged 25 years; allergic rhinitis; mother of three children under five years of age; separated from her partner.

Shelley - female aged 25 years; depression and anxiety; vaginal discharge; oral contraceptive pill (OCP) prescription; recurrent skin rash (pityriasis versicolor).

Vivienne* - female aged mid-20s; Pap smear (by usual GP); referral for abnormal smear.

Wanda - female aged 35 years - tonsillitis.

Zac - male aged 4 years; cough, fever and earache.

Zita - female aged 70 years - asthma; bronchitis; hypertension; history of myocardial infarction.
Appendix 8.3 The case summaries of the individuals who preferred one practice and called it *My practice*

Alison - female aged 6 years - immunisation; (also had an urinary tract infection after the 9 month study period).

Anita - female infant aged 1 year - immunisation; fever; vomiting ? bacterial enteritis.

Bella - female aged 28 years - Pap smear; migraine on OCP.

Brian - male aged 53 years - rheumatoid arthritis; bronchitis; influenza.

Chloe - female aged 21 years - obstetric care, delivery, knee problem; postnatal check.

Dillon - male aged 11 years - otitis media; asthma; rubella.

Ken - male aged 73 years - multiple squamous and basal cell carcinomata of the skin; peripheral vascular disease; ruptured abdominal aortic aneurysm and ileus requiring a gastroenterostomy; subacute bacterial endocarditis treated by antibiotics and anticoagulation; died on 9/1/94.

Kimberley - female aged 4 years - chicken pox.

Lorraine - female aged 40 years - sinusitis; scabies; facial lesion; discussions re child's asthma management; Pap smear; ears syringed.

Louisa - female aged 31 years - chronic back pain.

Neville - male aged 68 years - deafness; bronchitis; ears syringed; gout; foreign body in eyes.

Patricia - female aged 69 years; venous ulcer on left leg; hypertension; peripheral vascular disease; husband with CVA; stripping of left leg veins; muscular pain in abdomen and back from lifting invalid husband.

Regina - female aged 14 years - recurrent sinusitis.

Stella - female aged 64 years - infected toenail; haemorrhagic skin and middle ear infection ? viral.

Tim - male aged 8 years; no visits.
Appendix 8.4  The case summaries of the individuals who preferred to visit a variety of GPs and called them My doctors

David - male aged 76 years; Repatriation totally and permanently incapacitated (TPI) pensioner; war injuries to back, shoulder and knee; peptic ulcers; nervous disorder (Post Traumatic Stress Disorder).

Eleanor - female aged 56 years; bereavement; neck pain; skin cancers; vaginal prolapse.

Vince - male aged 69 years; athlete's foot (tinea pedis); recurrent sinusitis; toothache; heartburn; cardiac checkup (history of myocardial infarction); hypertension.
Appendix 8.5  The case summaries of the individuals who preferred visit-by-visit use

Christopher - male aged 35 years; throat and abdominal pain, PR bleeding; haemorrhoids; adverse reaction to anaesthetic for colonoscopy.

Clarissa - female aged 19 years; desensitisation treatment; OCP monitoring; Pap smear; removal of wart and spider naevus.

Jack - male aged 69 years; arthritis; vertigo; actinic skin lesions.

Jonathon - male aged 31 years - hypercholesterolaemia; tonsillitis.

Patrick - male aged 12 years; lacerated eyelid requiring sutures; ?fractured wrist.

Toby - male infant; feeding difficulties; immunisations; vomiting thought to be due to an allergy to rice.

Victoria - female aged 20 years; myalgic encephalitis (ME); commencing the OCP for dysmenorrhoea; eczema and asthma; weight loss.
Appendix 8.6  The case summaries of the individuals who remained unclassified

Orson - male aged 50 years - one casualty visit for abrasions and tetanus immunisation after a fall.

Rosa - female aged 30 years.
Appendix 8.7 Continuity indices

This appendix defines and presents seven individual and visit-based continuity indices that were calculated for each participant in the longitudinal study. The continuity indices are shown in tables 8A1 to 8A9.

Note in these formulae that \( n \) = number of GP visits; \( S \) = number of different GPs visited; \( \Sigma \) = the sum of calculated values; and \( p_i \) = ith pair of visits.

MCI is the Modified Continuity Index (Godkin & Rice, 1984) \( \text{MCI} = 1 - (S/(n+0.1)) \) which has a range from 0 to 1.

COC is the Continuity of Care index (Bice & Boxerman, 1979), \( \text{COC} = \sum_{i=1}^{S} \frac{(n^2 - n)}{n(n-1)} \) and this has a range from -1 to +1.

UPC is the Usual Provider Continuity (Breslau & Reeb, 1975) \( \text{UPC} = \frac{n(\text{usual GP})}{n} \) and this can vary from 0 to 1.

FOC is the Fraction of care provided by 1st or current GP (Smedby et al, 1984), \( \text{FOC} = \frac{n(\text{last GP})}{n} \) and its range is 0 to 1.

SECON is the Sequential continuity (Steinwachs, 1979) \( \text{SECON} = \sum_{i=1}^{n-1} \frac{(p_i)}{(n-1)} \) where \( p_i \) = ith pair of visits. i.e \( \text{SECON} = 1 \) if the same GP seen on successive visits, otherwise =0.

SGP and KGP were described by Smedby et al, 1984. Sequential GP (SGP) is 1 if the 2nd last/ current GP is the same as the 1st GP; SGP = 0 otherwise. The Known GP, KGP = 1 if the last GP has been visited before in the period; KGP = 0 otherwise.

There were no distinctive patterns of indices for one-practice and one-GP, one-practice trajectory and preference, visit-by-visit trajectory and preference, and variety-of-GPs and one-GP. The numbers of participants for the other combinations were too small to permit analysis of their groupings.

None of the indices demonstrated predictive power between the first half and second halves of the trajectories.
Table 8A1  Trajectory pattern and preferences for one GP

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<tr>
<th>Name and practice</th>
<th>Trajectory pattern</th>
<th>GP preference</th>
<th>n</th>
<th>S</th>
<th>MCI</th>
<th>COC</th>
<th>UPC</th>
<th>FOC</th>
<th>SECON</th>
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1 Individuals have been given pseudonyms to protect their identity. The practice is indicated by the number in the bracket.
Appendix 9.2  Summary of the information for consumer participants in the second round meetings

1) Answers that 15 consumers gave in the more detailed interviews to questions about 'problems where the cause was unclear' (chapter 7).

These problems involved nearly every bodily system and included persistent sore throat, problems associated with the menopause, irregular pulse, sinusitis, skin problems, gall-bladder symptoms, detached retina, migraines, and haemorrhoids.

2) Summary of the consumers' reactions to having these health problems.

In the detailed interviews they had stated that they felt nervous, frightened, unhappy, frustrated, robbed of their dignity, overwhelmed, and apologetic.

_I got very stressed ... they treated me as if I was a neurotic (laugh). When I got home I just cried and cried._

_I was beginning to think that I was mad, you know, it was all in my mind, but it turned out in the end that I actually had glandular fever and the doctors didn't pinpoint that._

_I felt apprehensive because I thought this is not getting better and then it ... escalates in your mind._
Appendix 9.3 Information for participants in the third round meetings

In both third round meetings I read two interview extracts. The first extract traces a woman's decision to change (specialist) doctors because she had lost faith in the treating doctor. The excerpt included the woman mentioning that she appreciated her consultation with the new specialist was audio taped. She had reviewed the doctor's advice and developed a list of questions to ask during the next consultation. The second extract describes two GPs' approaches to uncertainty.

First interview extract

Prue lives in the country and goes to a provincial centre for medical treatment of a lymphoma. In this consultation she describes her decision to go to Sydney for further treatment:

The original plan was spelt out fairly clearly by the doctor in Sydney - what the treatment would entail and then the provincial doctor would carry it out. After seeing the provincial doctor I came home and felt very negative about the treatment and my chances of survival - I was very low last night - we thought about it and decided to change.

The doctor in Sydney communicates the treatment plan very clearly and with a certain confidence ... he's very confident in himself and not only agreed to, but encouraged us to tape the consultation. We found it tremendously helpful to be able to refer back to that tape (of the initial consultation) because in 45 minutes there's a lot of information given and you either forget some of it or misconstrue or misinterpret some of it. So we found we were able to go back ....we said that to him and asked if we could tape this (second) interview...and indeed its been very helpful again. I asked him if he thought it was treatable this time and he said, 'Of course it's treatable and probably curable'. That's encouraging. The psychological thing in all illness is so important isn't it?

I think intuitively both my husband and I got very negative feelings yesterday (from the provincial doctor), in fact we both did get negative feelings yesterday, from the particular person we consulted. The unit itself is wonderful ... but we came out with such feelings of alarm bells ringing and there was nothing said that was encouraging like, 'We'll pull together on this one' ... there was none of that. We both got the feeling that having
relapsed that was probably it. I came home last night and just cried and cried and cried. I was so stressed out about it all.

(Bronnie: What were the tears saying?) I think it was just the tension that had built up. We’ve waited now for three and a half weeks for treatment to start and it didn’t start. We went down yesterday believing it was to start yesterday and it didn’t. And also I think because I’d had the rug of hope pulled out from beneath my feet. ... Once I thought it through in a logical fashion I came down firmly on the side of the doctor in Sydney - once I’d done that I was all right. It was a tremendous release.

We both feel a hundred percent certain that going to Sydney is the right thing to do.

It’s a very difficult business pursuing this medical treatment when it’s complicated like mine is going to be ... because you come in knowing nothing if you’re not medically trained. It’s individual isn’t it? - some people don’t want to know anything and I feel I can’t understand unless I know so I always go along with a list of questions that I want answered.

It (keeping a list) helps a great deal - between visits my husband or I might say something and we say, ‘Look we’ll ask the doctor next time we see him. We have a permanent list and we just jot things down on the list so by the time we arrive there we have all our little queries that have built up over the interim all written down because you forget them at the time - we have them all written down - most of them we’ve found have been answered in the course of the consultation anyway - but sometimes there are a few that we just want answered - and then I come away feeling well right I know everything that I need to know at the moment.

Issues for discussion

• taping consultations

• being accompanied for consultations: pros and cons

• keeping a list of relevant questions

• importance of confidence - in the doctor, in the potential effectiveness of the treatment, in hope

• what to do when there is loss of confidence in a doctor

• role a GP could have in the decision to change specialists - eg chance to talk the issues through, have the technical aspects explained
Appendix 9.4  Information for participants in the fourth round meetings

Summaries of both group's views about uncertainty and communication.

Issues from GP meeting on 30/8/93: grouped responses to

| Problems where the real cause had not been identified |

GP's are the experts in undifferentiated problems.

Patients come for the answer and clear guidelines about what to do.

GP reactions - annoyance at own ignorance; trainees are allowed to feel uncertain - it's OK - but it's harder to talk to patients about uncertainty; reluctant to admit (he) doesn't know and finds an excuse; does frustration from uncertainty affect quality of care? - research says yes.

GP strategies - feel isolated; corridor consultations; trainees talk about difficult problems; partner/spouse as a sounding board; structured practice meetings (but these address content not feelings); more tests, referrals, prescribing; therapeutic strategies to introduce certainty; leave general practice to specialise; learn to forget/ turn off; effect on GPs' families?; alcohol.

GP issues - we haven't been trained to negotiate with patients but are being asked to make that shift.

GP suggestions - (the research) interview was valued as a chance to talk; recognition that what we don't like about uncertainty, "in my case 90% of it is I don't want to be wrong"; there is a distinction between "uncertainty in a professional/medical sphere (where it's a 'don't know - but not apparently sinister problem') and the lay person/ human sphere " (where we can at least reassure the person along these lines).
Communicating with doctors

General issues of communicating in general practice - doctors said: they prefer/try to reinforce the most important two or three points; some people write things down for themselves; some GPs write notes on paper scraps; some give prepared handouts; discuss worries and possibilities:

It depends on your patient...there (are) just so many variables. I mean (one GP) was saying he writes sometimes, (to) 'exclude cancer' but you have got some patients (for whom it) would be so high up on their list of their worries or probabilities that that's actually the first thing you have to discuss with them ... but ... you may just let it lie and see what happens and that's the trick to me of being a GP. We make mistakes at times. The advantage of being a GP is very rarely do you actually have to make the hundred percent diagnosis right there in that consultation at that minute and sometimes sending them off for a blood count or LFT (liver function test) or something like that actually gives you more time to have a bit of a think and a bit more breathing space because you were probably going to do those tests any way. (For some) you might as well send them off straight away because you know that's the only way we're all going to get any peace. They are not going to sleep at night. They are not going to let you sleep at night so you're going to have to go and do it; (Female GP)

Communicating about uncertainty - doctors said: giving (the patient) confidence; seeming certain while actually being uncertain is a way that a GP covers his own insecurity - it's better to say the answers are not known or make an appropriate referral:

In practice I ...have to be fairly honest with people because half the patients know more than I do anyway. (laugh) (Female GP)

You don't remember the lies you told either. (laughter) (Male GP)

So I'd rather say I don't know. In some areas I can be fairly confident that medicine doesn't know or the world doesn't know like the cure for the common flu. I mean you can be fairly confident that no-one knows... It may be simply that I don't know but someone else may know. Hopefully I've got enough knowledge at least to push them in the appropriate direction but in other cases I'll say I don't know but I don't think it's that important; now why don't we wait and see and get them to be involved in this strategy. They don't know, I don't know but I'm fairly confident waiting a bit isn't going to do
any harm. But to try and waffle... and cover it up and give them placebo treatment or other things, you know I think the pink pills (placebos) went out a long time ago.

(Female GP)

About sharing GP medical notes with patients - doctors said: (their notes were) cryptic and an aide memoir for the GP only or for future reference; difference between notes for self and colleagues vs notes for patients; cooperation card used in obstetrics in the UK had different information on the one for patients compared with the one for the doctors; worry about references to mental illness in notes causing paranoia in patients; concern re medico legal implications; we filter information:

We all like to think that (we) have moved on from those paternalistic days where, ...we knew everything and the patient had no rights to know anything. ...We do filter information. We filter the way it is presented. We don't tell the patient the most alarming thing that is most important in our mind until it (that diagnosis) has moved first up (in the list of possibilities). You know, there are ways and there are ways of talking and writing.

(Male GP)

However some GPs said they were happy to give the medical records to patients; some make notes which are a precis of the consultation (and not only an aide memoir).

About consumers taping their GP consultations (to be able to review the information presented) - doctors said: OK for specialists; not OK for GPs because of medico legal aspects and confidentiality; taping may alter doctors' and patients' behaviour; GP consultations are more personal, people chat about things; GPs are more accessible and share a finite amount of information; discussion is on patient's terms.

About a patient being accompanied during a consultation - doctors said: need twice the time - this is a problem if bookings are tight, running late is a pressure for GP and other patients get annoyed; increased demands on rapport building; doctor needs to feel confident; important to ensure that the patients needs are met - don't let the husband run it; more complex consultation and no extra remuneration; need to be prepared to ask the other person to leave - difficult: can ask straight out, see patient first or relatives in the corridor, examine in a separate room, use a phone call as excuse.
The positive aspects of people being accompanied are for reinforcing the consultation and as an opportunity to educate both people (about the health issue).

GPs' communication reaction when a person says they've lost confidence in a doctor - doctors said: don't criticise the previous doctor or let the patient belly-ache as it endorses their criticisms; GPs shouldn't feel ownership of patients; GPs should cooperate and send notes (to the next GP); explore what the patients wants

*I've often think that's why patients often leave GPs though. I think probably fairly rarely do they actually criticise the technical side of things. I think if they are leaving it is because (the) emotional side isn't being satisfied. Now that emotional side is two-ways and (there is also) a personality thing so that's why we don't all get on with all patients.*

(Female GP)

Communication role of the GP where there's uncertainty: doctors said: to be an intermediary/translator between the patient and specialist; to be accessible and take time to explain things; to know what's happening if something happens acutely; to know how a person is reacting to an illness.

Issues from consumer meeting on 31/8/93: grouped responses to

| Problems where the real cause had not been identified |

Consumer reactions to experiencing these problems - feeling nervous; feeling frightened; feeling the problem as "very real to me"; feeling not very happy; feeling frustrated; experiencing a lack of dignity; "there's a sense of sin and failing underlying being sick"; a sense of powerlessness; tremendous difficulty getting believed (except by a hypochondriac friend). Feeling tired - the hallmark of not being properly diagnosed; can't get away from it; I wanted to know not so much what I've got as what I haven't got (ie cancer or a life-threatening illness)

Consumer strategies for uncertainty - go back to the doctor; stop going to the doctor; do lifestyle things yourself; get referred to a specialist - referral means the doctor believes you - you're not mad but are being taken seriously (but sometimes referral can be being fobbed off); need an authoritative opinion or something drastic to happen (to demonstrate that there is something
wrong); need support (and presence) of a friend to go to the consultation; making notes to be more assertive; 24 hour clinics are good for a service and communication is more equal, encouraging consumer to get the service they want.

**Consumer issues about communication with the doctor** - being fobbed off by the doctor despite being assertive in other areas of your life (or helping others to be assertive); problems of a knowledge and power imbalance with the GP; sense of grief and rage after the loss of a good relationship with a GP; sadness at all these people not being heard; can be disarmed by GP - re opening remark in a consultation; having an opinion on what's wrong and needing to pretend that you don't; people feel uncomfortable - don't know how to explain symptoms as distinct from what we've made of those symptoms (called pre-diagnosis).

**Consumer suggestions** - about communication with a doctor - need to be comfortable with a doctor - communication may be enhanced by equality via age, same gender, similar circumstances, a 'click' with the doctor; importance of a doctor spending (enough) time:

> A good relationship can come from a 'click', but mostly it comes out of some equalising communication and once you get that into a relationship they automatically know more about you.

(Female consumer)

**Issues from consumer meeting on 19/10/93: grouped responses about**

**Communicating with doctors**

Aspects of good communication - the importance of the doctor allaying anxiety, taking time and giving hope; chatting to see the underlying problem; giving confidence to the consumer that they don't need specialist checkups; caring for the whole picture; the positive value of GP visiting in hospital; (some) female doctors communicate to where you are 'at':

You might get the same answer from a man as you get from a woman but you'll get it in an entirely different way I've found. Not actually a more palatable way either. They can be brutally frank, the same as the men can, but somehow it is in your terms so you can understand it.

(Female consumer)
history is there; choosing a doctor who will stay; GP knows you so well - and tends to hurry - so that contributes to not being heard; powerlessness to have symptoms taken seriously in the face of a 'hope-less' diagnosis eg dementia.

Coping with uncertainty - with the second experience of a condition you know more; ringing casualty to check a drug dosage; patients reading/researching and making their own pre-diagnosis may be wrong; we all do our own pre-diagnosis.

Eroding confidence - locums erode confidence; if a doctor doesn't look at the file; drug side-effects; suspicion of new drugs; some mothers feel they don't have the appropriate background to cope with sick kids (especially in the face of not being believed by the GP).

Consumer suggestions - take a list and 'wear' having a bad memory; ask for written instructions which are dated.

Reactions to GP telling a patient they were uncertain - I'd be happy; some patients will leave and see another doctor; some get better with time and because the GP injects certainty; the important difference between certainty and reassurance:

You can give reassurance to a person who is uncertain without pretending a certainty that isn't there. There is a difference between certainty and reassurance and the doctor's role is that reassurance one that the woman was talking about that she got from a doctor. And he didn't give a certainty, yes we know this treatment will work and you will survive for 20 years. What he did was give her reassurance that they could work through whatever was available together.

(Female consumer)
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