Frequent consulting and multiple morbidity: a qualitative comparison of ‘high’ and ‘low’ consulters of GPs

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Background. Frequent consulting is associated with multiple and complex social and health conditions. It is not known how the impact of multiple conditions, the ability to self-manage and patient perception of the GP consultation combines to influence consulting frequency.

Objective. To investigate reasons for frequent consultation among people with multiple morbidity but contrasting consulting rates.

Methods. Qualitative study with in-depth interviews in the west of Scotland. Participants were 23 men and women aged about 50 years with four or more chronic illnesses; 11 reported consulting seven or more times in the last year [the frequent consulters (FCs)] and 12, three or fewer times [the less frequent consulters (LFCs)]. The main outcome measures were the participants’ accounts of their symptoms, self-management strategies and reasons for consulting a GP.

Results. All participants used multiple self-management strategies. FCs described: more disruptive symptoms, which were resistant to self-management strategies; less access to fewer treatments and resources and more medical monitoring, for unstable conditions and drug regimens. The LFCs reported: less severe and more containable symptoms; accessing more efficacious self-management strategies and infrequent GP monitoring for stable conditions and routine drug regimens. All participants conveyed consulting as a ‘last resort’. However, the GP was seen as ‘ally’, for the FCs, and as ‘innocent bystander’, for the LFCs.

Conclusions. This qualitative investigation into the combined significance of multiple morbidities and self-management on the GP consultation suggests that current models of self-management might have limited potential to reduce utilization rates among this vulnerable group. Severity of symptoms, stability of condition and complexity of drug regimens combine to influence the availability of effective resources and influence frequency of GP consultations.

Keywords. Frequent consulting, self-management, multiple chronic illness, qualitative.

Introduction

Primary care physicians are the major health care providers for people with multiple morbidities.1 In Britain, people with chronic health problems account for about 80% of consultations in primary care and people with three or more chronic problems are over four times as likely to see their GPs compared to those who reported no conditions.2 That people with multiple morbidities are heavy users of health services was confirmed in a recent literature review of frequent attendance in general practice care3 which showed that frequent consultation is associated with having a higher number of physical health problems,4 that the presence of a mental health
problem is strongly predictive of frequent consulting and that FCs are more likely to have a combination of physical, psychological and social problems than LFCs. It is hoped that the adoption of the chronic care model in primary care services with major emphasis on the value of self-management programmes will have the effect of reducing health care utilization as well as providing more effective care for those with chronic illness.

The association between social deprivation and frequent consulting and that frequent consulting is not associated with any particular types of morbidity have led to suggestions that frequent consulting is associated with characteristics of individuals, rather than with the symptoms with which they consult, and that GPs may act as a social resource. Despite research spanning 35 years, which identifies the complex and multiple aspects associated with frequent consulting, there has been very little qualitative research in this area. As a consequence, we know little about how the range of potential explanations for frequent consultation identified in quantitative studies (such as the impact of multiple long-term illness, the ability to self-manage and seeing the GP as a social resource) combine and interact to influence consulting frequency.

In this paper, we present the results of a qualitative study that compared the experience of people who reported multiple morbidity but contrasting consulting rates. The sample included people who had reported four or more chronic illnesses; half were ‘FCs’ (seven or more GP consultations in the previous 12 months) and half ‘LFCs’ (three or fewer consultations in the previous 12 months). We also sought to include equal numbers of men and women, and people from a range of socio-economic backgrounds, in both groups. Thirteen women and 10 men participated. Table 1 gives a brief summary of participant characteristics, including their reported health conditions.

### Methods

#### Sampling and participants

Sampling was specifically designed to compare the experiences of people with similar levels of multiple morbidities but contrasting consulting rates. Sampling and data collection are described in detail elsewhere. Forty-one people born in the early 1950s were purposively subsampled from a longitudinal community health survey in the west of Scotland on the basis of responses given in 2000–2003 (20-07 Study). The sample included people who had reported four or more chronic illnesses; half were ‘FCs’ (seven or more GP consultations in the previous 12 months) and half ‘LFCs’ (three or fewer consultations in the previous 12 months). We also sought to include equal numbers of men and women, and people from a range of socio-economic backgrounds, in both groups. Thirteen women and 10 men participated. Table 1 gives a brief summary of participant characteristics, including their reported health conditions.

#### Data collection

Data collection entailed three stages. First, a semi-structured interview focussed on conditions and attendance, such as views on the role of the GP, beyond the burden of multiple conditions.

### Table 1  Respondent characteristics

<table>
<thead>
<tr>
<th>Pseudonym</th>
<th>Employment</th>
<th>Conditions reported at wave 4 of Twenty-07 study 2000-2003</th>
<th>Consultations in previous yeara</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dick</td>
<td>Not working</td>
<td>Angina, anxiety, depression, asthma, liver problems, hernia, cataracts</td>
<td>FC</td>
</tr>
<tr>
<td>Jim</td>
<td>Not working</td>
<td>Disc injury, kidney problems, depression, arthritis, hypertensive, penicillin allergy</td>
<td>FC</td>
</tr>
<tr>
<td>Ian</td>
<td>Not working</td>
<td>Asthma, sore stomach, abdominal hernia, hypertension, angina, two heart attacks, spondylitis, back pain, torn discs</td>
<td>FC</td>
</tr>
<tr>
<td>Rick</td>
<td>Not working</td>
<td>Osteoarthritis, depression, anxiety, bronchitis, heart murmur, pins and needles in both hands, alcohol problems</td>
<td>FC</td>
</tr>
<tr>
<td>Roger</td>
<td>Not working</td>
<td>Depression, disc problem, hypertension, high cholesterol, anxiety, osteoarthritis, migraine</td>
<td>FC</td>
</tr>
<tr>
<td>Janet</td>
<td>Not working</td>
<td>Asthma, hypertension, diabetes, osteoporosis, blood clots, depression, allergy, depression</td>
<td>FC</td>
</tr>
<tr>
<td>Barbara</td>
<td>Working</td>
<td>Hypertension, angina, two heart attacks, depression</td>
<td>FC</td>
</tr>
<tr>
<td>Betty</td>
<td>Not working</td>
<td>Hypertension, irritable bowel syndrome, sinus problems, sciatica, ovarian cyst, migraine, tinnitus</td>
<td>FC</td>
</tr>
<tr>
<td>Louise</td>
<td>Working</td>
<td>Cystitis, arthritis, depression, breast cancer</td>
<td>FC</td>
</tr>
<tr>
<td>Lesley</td>
<td>Not working</td>
<td>Hypertension, asthma, colitis, duodenal ulcer, thyroid problems, anxiety, depression</td>
<td>FC</td>
</tr>
<tr>
<td>June</td>
<td>Not working</td>
<td>Emphysema, angina, asthma, hypertension</td>
<td>FC</td>
</tr>
<tr>
<td>Tommy</td>
<td>Not working</td>
<td>Ulcerative colitis, arthritis, gastric problems, hypertension</td>
<td>LFC</td>
</tr>
<tr>
<td>Derek</td>
<td>Not working</td>
<td>Diabetes, depression, schizophrenia, peptic ulcer, hiatus hernia, hypertension</td>
<td>LFC</td>
</tr>
<tr>
<td>Johnny</td>
<td>Working</td>
<td>Diabetes, kidney problems, hypertension, depression, alcohol problems</td>
<td>LFC</td>
</tr>
<tr>
<td>Paul</td>
<td>Working</td>
<td>Mechanical back pain, joint pain, photosensitive, stomach problems, hay fever</td>
<td>LFC</td>
</tr>
<tr>
<td>Peter</td>
<td>Working</td>
<td>Proctectomy and ileostomy, pelvic abscess, asthma, eczema</td>
<td>LFC</td>
</tr>
<tr>
<td>Sarah</td>
<td>Working</td>
<td>Irritable bowel syndrome, migraine, hypertension, inner ear problems</td>
<td>LFC</td>
</tr>
<tr>
<td>Mary</td>
<td>Not working</td>
<td>Osteoarthritis, partial deafness, gastric ulcer, sinus trouble</td>
<td>LFC</td>
</tr>
<tr>
<td>Martha</td>
<td>Working</td>
<td>Hypertension, collapsed lumbar disc, osteoarthritis, long-sightedness</td>
<td>LFC</td>
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<tr>
<td>Jane</td>
<td>Working</td>
<td>Stress, anxiety, oesophageal reflex, numbness in right hand, back pain, patchy keratosis</td>
<td>LFC</td>
</tr>
<tr>
<td>Marie</td>
<td>Working</td>
<td>Myalgic encephalitis, cyst on thyroid gland, palpitations, allergy to dust</td>
<td>LFC</td>
</tr>
<tr>
<td>Susan</td>
<td>Working</td>
<td>Depression, irritable bowel syndrome, sinusitis, hay fever</td>
<td>LFC</td>
</tr>
<tr>
<td>Rita</td>
<td>Working</td>
<td>Breast cancer, anxiety, depression, panic attacks, gastric ulcer</td>
<td>LFC</td>
</tr>
</tbody>
</table>

aFC, those who reported seven or more consultations in the 12 months prior to the 20-07 Survey interview and LFC, those who reported three or fewer GP consultations in the 12 months prior to the 20-07 Survey interview.
participants described their symptoms, illnesses and their impact in detail and focussed on the extent to which they were able to contain symptoms and control conditions. They all used multiple strategies and resources to manage their illness, providing detailed accounts of working hard to limit disruption, and maintain familiar lives and a moral obligation to manage their illness ‘well’.

Here, we contrast the experiences of FCs and LFCs in terms of their levels of illness, control of symptoms and self-management strategies, perceived suitability and availability of other treatments and resources and reasons for consulting a GP.

**Levels of illness: symptoms and conditions**

Despite all participants reporting four or more chronic conditions, the FCs described more illness than the LFCs. They described more severe symptoms, greater functional impairment, less control over their bodies and more disruption and loss in their daily lives than the LFCs. The severity of their symptoms was matched by more unstable illness conditions, which needed more frequent and vigilant monitoring while the symptoms were resistant to treatments and other self-management techniques. Both groups described functional problems. However, the LFCs described their problems as surmountable. The consequences of their functional problems were not described as impacting on their daily life. For example, they were able to ‘normalize’ and accommodate symptoms, saying, for example: ‘it’s (pain) a bit awkward … but it’s just general wear and tear … I’ve lived with it’ (Jane, LFC). In contrast, the FCs described a relentless range of symptoms and functional problems, saying, for example: ‘I feel it (a range of symptoms) never ends. I wake up in the morning, when I wake up I go “What is it today?” It just seems to always be something’ (Lesley, FC). The FCs’ descriptions of problems with routine actions often conveyed more severe, disabling, problematic and unpredictable symptoms that were less surmountable (Box 1).
Control of symptoms and self-management strategies

All participants spoke of a complex range of self-management strategies but there were clear differences in the accounts of how successful these were and the level of control through self-management that participants were able to achieve. The LFCs spoke in terms of controllable symptoms: ‘Aye I’ve got it (pain), hit it on the button’ (Mary, LFC); ‘It’s routine (pain) . . . I’ve got that under control, yeah’ (Sarah, LFC); ‘I just don’t let it (anxiety) get the better of me anymore’ (Rita, LFC). In contrast, the FCs commonly described little control over unpredictable or ongoing symptoms in their daily life: ‘My head starts, once something goes in my head it just goes round and round’ (Dick, FC); ‘I’m fighting with myself . . . ’ (Ian, FC); ‘. . . it just hit me like a bolt from the blue . . . ’ (Janet, FC); ‘. . . as I think I’m getting on top of things something else smashes . . . my life is turned upside down’ (Betty, FC). Box 2 contains two accounts to illustrate that LFCs more often described successful self-management strategies whereas FCs typically spoke of how they had to resort to the GP for help despite trying a range of strategies.

Perceived suitability and availability of other treatments and resources

The LFCs used a range of alternative treatments alongside conventional medicine, although some were sceptical about them and were careful in using them. However, alternative treatments were not often seen as an option by FCs. Reasons included anxiety about taking any actions that might aggravate symptoms, expense, lack of knowledge and risk to an already compromised body (Box 3). The LFCs often described using over-the-counter medications while FCs were unlikely to do so; they felt that they would be ineffective and might disrupt their routine regimen or aggravate their conditions. LFCs were more likely to have paid work (see Table 1), which helped them maintain a wide social network and opportunities for information and knowledge exchange with others. The FCs talked of worlds disrupted and diminished by their illness. They had fewer opportunities to self-manage more severe and unpredictable symptoms, relatively small social networks, and few had been able to maintain paid employment, leaving them with more limited access to social, economic and material resources. They enjoyed fewer benefits of information and knowledge exchange in their informal circles.

Reasons for consulting a GP: ‘a last resort

Both the FCs and LFCs described using the GP as a resource in the same way, i.e. only when symptoms were severe, unpredictable, ongoing and resistant, or for unstable conditions. There was no difference between the ways the consultants perceived and utilized the GP consultation; it was conveyed as a last resort. Both women and men reported using GP services only when they felt it was absolutely necessary. For example: ‘I only go if I really need to go’ (Sarah, LFC); ‘. . . I try not to go unless it’s something that’s really annoying me’ (Mary, LFC); ‘I would only go if I was in real bad pain or very, very sick . . . ’ (Betty, FC). An underlying assumption that GP services were a scarce resource and should be used sparingly was evident. In common with other studies, symptoms that were unfamiliar, inexplicable or resistant to self-management strategies were common reasons given for consulting a GP. Importantly, all participants described consulting for the
same reasons: severe, unpredictable, debilitating, resistant symptoms and unstable conditions. However, for the less FCs such episodes were rare and for the FCs they were ongoing and ‘on a day to day basis’.

Medical monitoring
Participants described GP consultations for monitoring their conditions; such consultations were much less common for the LFCs. Typically, these check-ups were driven by the GP practice. The frequent attenders reported repeated follow-ups, to ‘make sure everything’s alright’ (Ian, FC), reflecting their more unstable conditions, severe and uncontrolled symptoms and experimental medication regimens. For example: ‘He (GP) likes to see me, it used to be every fortnight … it’s a routine thing. He just likes to see me every four weeks … to ask me how I am, to check how I am because of the ongoing things not only the MS …’ (Betty, FC). Attendance at these check-ups was presented as a crucial strand of careful self-management, when patient and doctor worked together to minimize health crises.

The place of the GP consultation
The two groups reported contrasting experiences of GP consultations in relation to the way they managed their symptoms. The LFCs spoke of consultations as typically unhelpful (see Box 4 for examples). They discussed how their GP offered them neither symptom relief (medicines or treatment), knowledge (information which eased their symptoms) or hope of improvement (referrals or different treatments) nor moral support (empathic understanding). They appeared currently to gain little physical relief or moral support from GP contact, although they did note that they had in the past and might again in the future in the context of severe episodes of their long-term conditions. In contrast, the FCs talked of their GP as central to their current management strategy. They described being listened to, given time (which helped foster their sense of selves), thoroughly examined (which gave a sense of hope that something was being done) and provided with access to other support through referrals to professionals and services (which was perceived as both practical help and symbolic of improvement) (see Box 4). Thus, their GP was positioned as someone who offered knowledge, treatment, hope, support and symptom relief and as an ally in their ongoing struggle to contain disruptive symptoms.

Discussion
Our findings demonstrate that participants used multiple strategies and resources to manage illness. Self-management strategies were used to minimize symptoms, stabilize conditions and strive for a normal life for FCs and LFCs and for both women and men. Crucially, FCs and LFCs provided similar accounts of reasons for seeing the GP, but the instances of severe illness which initiated an appointment were ‘current’ and ‘ongoing’ for the FCs but in the ‘past’ and ‘rare episodes’ for the LFCs. All participants positioned themselves as judicious users of scarce resources, only consulting the GP when all other avenues of relief had failed or conditions needed monitoring. We have already demonstrated that use of medicines to control
symptoms takes place within a moral framework and these findings further demonstrate the extent of the emotional and moral work that people feel they must do to justify their actions and themselves in the face of chronic illness.

The analysis focussed on differences between the two groups. Compared to the LFC, the FCs’ accounts featured severe, unpredictable and debilitating symptoms and conditions, which required frequent GP monitoring. Their accounts suggested lives diminished by illness and more limited access to resources such as alternative treatments and depleted social networks which together offered fewer opportunities to self-manage, this was expressed by both men and women. Both groups referred to patient–practitioner interaction and offered clear descriptions of valued and productive consultations, as well as consultations which failed to meet their needs. The positive accounts, more evident in the descriptions of the FCs, offered effective clinical management, psychological support and information, in the context of active self-management. Figure 1 identifies both groups as active self-managers and judicious users of the GP consultation and shows the contrasting experiences of the FCs and LFCs in terms of symptoms, resources, medical monitoring and the role of the GP.

The scope of the study was limited by constraints imposed by the larger study used as the sampling frame, including its geographical location. The issues raised may have been particularly salient to people living in west central Scotland and to those experiencing multiple morbidity early in midlife. People at younger or older ages may respond differently.

Although our sampling strategy was designed to include people with similar levels of multiple chronic morbidities, identified through a community health survey, the in-depth qualitative interviews revealed very different experiences of symptoms, illness, their impact and the relative success of self-management strategies between the FCs and LFCs. This is probably because while surveys and analyses of clinical records can easily identify initial differences between FCs and LFCs (such as the presence of multiple health problems and socio-economic status), qualitative methods allow a more in-depth understanding of the impact of reported illness on everyday life and the complex

**Figure 1** Comparison of accounts of FCs and LFCs
dynamics between experience of illness, self-management and seeking help.

Conclusion
The chronic care model6–9 proposes to provide patients with timely and appropriate health care, in an effective and efficient health system. Successful self-management and positive patient–practitioner interactions for better control of both illness and daily life are integral elements of this model. Our results support other research5 that suggests that people with chronic illness already have established patterns of consulting that are seen as appropriate and necessary for ongoing management of their conditions. Both FCs and LFCs shared ideas about when ‘going to the doctor’ was necessary, but the consultation played a central role in illness management for the FCs, offering knowledge, treatment, hope, support and symptom relief and an ally in an ongoing struggle to live with overwhelming symptoms of multiple chronic illnesses. However, it also suggests that while the development of the chronic care model in the delivery of primary care (including identification and activation of community resources such as the voluntary and social care sectors, support for self-management, delivery system redesign and improved patient–professional interactions) might improve care overall, there may be limited potential for it to reduce utilization rates among this vulnerable group with multiple, severe morbidity who see the GP as an essential resource. Further research is needed to explore ways in which models of care can offer effective help and support for this group as they attempt to self-manage.

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References


