

5 Abstracts and research tools

1 Allergic rhinitis

Organisation supporting this study: AstraZeneca (Australia) Pty Ltd

Issues: Point prevalence allergic rhinitis; current treatment; previous treatment.

Sample: 4,077 encounters from 102 GPs; data collection period: 17/08/1999 – 20/09/1999.

Method: Detailed SAND methods are provided in Chapter 2.

Methods for this study: GPs were asked to ascertain (either by asking the patient or from their knowledge of the patient) whether the patient currently had allergic rhinitis.

If the patient did have allergic rhinitis the GP was asked to determine if the patient was currently taking medication for the problem; if so, which medications; and what previous medications had been used and for how long, to manage their allergic rhinitis.

Summary of results

The age-sex distribution of the respondents was similar to that of the total BEACH sample. The majority of the respondents were females (57.5%).

The point prevalence of allergic rhinitis among the survey population was 18.7% (95% CI: 16.5–20.9). The highest prevalence was among people aged 25–44 years old (24.4%) and the prevalence of allergic rhinitis was similar for males and females (17.0% and 20.0%, respectively).

Among people with allergic rhinitis, 34.4% of people were currently using medication to manage the condition. Roughly half (49.6%) of those currently taking medication used nasal corticosteroid. The most common generic medication was budesonide topical nasal, used by 30.9% of those using medication for allergic rhinitis.

Antihistamines were the most common medication previously used by people with allergic rhinitis. Of people who had previously used antihistamines, 32.4% had used them for over 1 year.

Among people currently using nasal corticosteroids, 40.8% had previously used antihistamines and 13.1% had used no previous medication.

The following page contains the recording form and instructions with which the data in this abstract were collected.

PLEASE READ CAREFULLY

The shaded section of the following forms asks questions about **RHINITIS and SMOKING**.
You may tear out this page as a guide to completing the following section of forms.

INSTRUCTIONS

This form has been filled in as an example.

<p>Smoking status Ask ALL patients aged 18yrs+:</p> <p>Which of the four categories best describes their smoking status?</p> <p><i>Tick one box.</i></p>	<p>ASK ALL PATIENTS Ask each patient if they have allergic rhinitis (either as a chronic or an acute problem).</p> <p>If NO - no further questions.</p>	<p>Current drugs for this problem:</p> <p>Indicate any drugs currently used to treat this problem.</p> <p>Indicate drug name, dose and regimen. If there are no current medications, tick 'nil medication'.</p>	<p>Previous medication(s) for allergic rhinitis:</p> <p>Medication Indicate which types of drugs have been used to treat this condition in the past.</p> <p>Tick as many medication types as apply. For drugs not listed, tick other and specify the type of drug in the space provided.</p> <p>Duration Indicate the approximate duration of use of these drugs by writing a number and circling days, months or years.</p>																										
<p>If patient is 18+yrs:</p> <p>Smokes daily <input checked="" type="checkbox"/></p> <p>Occasional smoker <input type="checkbox"/></p> <p>Previous smoker <input type="checkbox"/></p> <p>Never smoked <input type="checkbox"/></p> <p>B155</p>	<p>Does this patient have allergic rhinitis? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Current drug(s) for this problem:</p> <p><input type="checkbox"/> Nil medication</p> <table border="1"> <thead> <tr> <th>Drug(s)</th> <th>Dose</th> <th>Regimen</th> </tr> </thead> <tbody> <tr> <td>1. <i>Rhinocort</i></td> <td><i>100mcg</i></td> <td><i>bd</i></td> </tr> <tr> <td>2.</td> <td></td> <td></td> </tr> </tbody> </table>	Drug(s)	Dose	Regimen	1. <i>Rhinocort</i>	<i>100mcg</i>	<i>bd</i>	2.			<p>Previous medications for allergic rhinitis (Tick one or more)</p> <table border="1"> <thead> <tr> <th></th> <th>Duration (number) (Circle option)</th> <th></th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/> No medication</td> <td>_____</td> <td>days/months/yrs</td> </tr> <tr> <td><input checked="" type="checkbox"/> Antihistamines</td> <td><u>6</u></td> <td>days/months/yrs</td> </tr> <tr> <td><input type="checkbox"/> Nasal Corticosteroids</td> <td>_____</td> <td>days/months/yrs</td> </tr> <tr> <td><input type="checkbox"/> Allergen treatment injections</td> <td>_____</td> <td>days/months/yrs</td> </tr> <tr> <td><input type="checkbox"/> Other-specify _____</td> <td>_____</td> <td>days/months/yrs</td> </tr> </tbody> </table>		Duration (number) (Circle option)		<input type="checkbox"/> No medication	_____	days/months/yrs	<input checked="" type="checkbox"/> Antihistamines	<u>6</u>	days/ months /yrs	<input type="checkbox"/> Nasal Corticosteroids	_____	days/months/yrs	<input type="checkbox"/> Allergen treatment injections	_____	days/months/yrs	<input type="checkbox"/> Other-specify _____	_____	days/months/yrs
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2 Anxiety/stress, consultation time, level of education

Organisation supporting this study: Commonwealth Department of Veterans' Affairs

Issues: Prevalence of stress and anxiety in general practice and Veterans' Affairs patients; seeking help; level of education; consultation time.

Sample: 3,684 encounters from 100 GPs; data collection period: 18/01/2000 – 18/02/2000.

Method: Detailed SAND methods are provided in Chapter 2.

Methods for this study: There were two components to this SAND. One provided information on patients relating to level of stress and anxiety while the other concerned level of education and length of consultation. The effects of stress and anxiety on the patient and help seeking behaviour were investigated for patients who reported experiencing stress or anxiety in the previous 12 months. The highest level of education obtained by the patient and the length of time each consultation had taken were reported.

Summary of results

Female patients made up 59.4% of the 3,684 respondents, a finding similar to that of the total sample. The age distribution of patients also corresponded with that of the total BEACH sample, with 21.0% of patients aged less than 25 years, and approximately 26% in each of the age groups 25–44, 45–64 and 65 years or older.

Forty per cent (95% CI: 36.8–43.0) of respondents reported experiencing a period of anxiety or stress lasting 2 weeks or more in the previous 12 months. This rate was similar to prevalence reported by those patients who indicated they held a Department of Veterans' Affairs health card (39.6%, 95% CI: 27.2–52.0). Females (44.6%, 95% CI: 39.9–49.3) were more likely to have experienced anxiety or stress than males (33.0%, 95% CI: 28.3–37.8). The highest prevalence of stress and anxiety was among females aged 45–64 years (55.6%, 95% CI: 43.5–67.7).

Among the 1,470 patients who had experienced anxiety or stress, a significant proportion reported that sleep had been affected (79.1%, 95% CI: 75.8–82.3), and more than half felt their relationships had been affected (55.1%, 95% CI: 51.0–59.2). Seventy-five per cent (95% CI: 71.5–78.6) of patients who had experienced stress/anxiety had sought help or treatment. Patients were significantly more likely to have sought help from general practitioners (57.9%, 95% CI: 53.6–62.2) than from other health professionals (16.3%, 95% CI: 13.9–18.7) or from family/friends (33.5%, 95% CI: 28.5–38.6).

The average length of these consultations was 16.6 minutes (95% CI: 15.2–18.1). Consultations ranged from approximately 12 minutes for patients in the 5–14 age group to 18 minutes for patients over the age of 75 years.

The highest level of education reached by these patients was most commonly lower secondary school. Patients with TAFE/post secondary other than university level apparently had the longest consultations, but no significant differences were found in consultation length between patients with different levels of education.

For other related abstracts see: 10 Length of consultation; after-hours arrangements; co-morbidity, 13 Perceived stress, 16 Effect of day and time of GP visit on billing method, 41 Time of visit and billing status, 47 Management of depression and anxiety and Section 4.5 Length of consultation.

Further reading:

Bindman A.B., Forrest C., Britt H., Crampton P., Majeed A. 2007, 'Diagnostic scope of and exposure to primary care physicians in Australia, New Zealand and the United States: cross sectional analysis of results from three national surveys', *British Medical Journal* (Epub ahead of print).

Britt, H., Valenti, L., & Miller, G. 2002, 'Time for care. Length of general practice consultations in Australia', *Australian Family Physician*, vol. 31, no. 9, pp. 876–880.

Britt, H., Valenti, L., Miller, G. C., & Farmer, J. 2004, 'Determinants of GP billing in Australia: content and time', *Medical Journal of Australia*, vol. 181, no. 2, pp. 100–104.

Britt, H. C., Valenti, L., & Miller, G. C. 2005, 'Determinants of consultation length in Australian general practice', *Medical Journal of Australia*, vol. 183, no. 2, pp. 68–71.

The following page contains the recording form and instructions with which the data in this abstract were collected.

PLEASE READ CAREFULLY

The shaded section of the following forms asks questions about **CONSULTATION TIME, EDUCATION, ANXIETY & SMOKING.**
 You may tear out this page as a guide to completing the following section of forms.

INSTRUCTIONS

This page has been filled in as an example (see below).

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Ask the patient:

In the past 12 months - was there ever a time lasting 2 weeks or more, when you felt anxious or stressed ?

Tick 'Yes' or 'No'.

If YES,ask the 3 questions shown in the section below:

1. Did this affect your sleep, appetite etc?
 Tick one box for each 'Yes' response.

2. Did you seek help from, a GP / other health professional / family or friends?
 Tick a box for each correct option, or leave blank if no help sought.

3. Did you take medication:
 Tick 'Yes' or 'No'.

START TIME

Record the time the consultation STARTED in hours and mins and circle whether the time is AM or PM.

Smoking status

Ask patients aged 18yrs+:

Which of the four categories best describes their smoking status?

Tick one box.

FINISH TIME

Record the time the consultation FINISHED in hours and mins and circle whether the time is AM or PM.

Highest educational qualification obtained

Ask the patient their highest educational qualification obtained.

Circle **ONE** option only.

Start Time 9 : 05 AM PM (please circle)	In the past 12 months, was there a time lasting 2 weeks or more, when you felt anxious or stressed ? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
Highest educational qualification obtained? Postgraduate degree 6 University undergraduate degree/diploma 5 TAFE /other post secondary 4 Higher Secondary (eg HSC) 3 Lower Secondary (eg school certificate) 2 Primary school 1	If YES... 1. Did this affect your: Sleep <input checked="" type="checkbox"/> Appetite <input type="checkbox"/> Work performance <input type="checkbox"/> Relationships <input checked="" type="checkbox"/>
	2. Did you seek help from: GP <input checked="" type="checkbox"/> Other health professional <input type="checkbox"/> Family or Friends <input type="checkbox"/> Nobody <input type="checkbox"/>
	3. Did you take medication? <input checked="" type="checkbox"/>

If patient 18+yrs:

Smokes daily
 Occasional smoker
 Previous smoker
 Never smoked

Finish Time
 9 : 25 AM PM
 (please circle)

3 Asthma

Organisations supporting this study: AstraZeneca (Australia) Pty Ltd and Aventis Pharma Pty Ltd

Issues: The prevalence of asthma in the general practice patient population; its severity; current medications for asthma; their effectiveness and any adverse effects of medications.

Sample: 4,285 encounters for 213 GPs; data collection period: 30/03/1999 – 07/06/1999

Method: Detailed SAND methods are provided in Chapter 2.

Methods for this study: Levels of severity of asthma for children and adults were listed on a patient card with descriptions of each level. Severity classes for children included infrequent episodic, frequent episodic, and persistent. For adults, the severity classes were very mild, mild, moderate and severe. The severity levels were adapted from the National Asthma Council Asthma Management Handbook 1998.

Summary of results

The age-sex distribution of the respondents was similar to the distribution for BEACH overall, with the majority (55.8%) of patients being female.

The prevalence of asthma among the 4,285 respondents was 14.7% (95% CI: 13.3–16.1). The highest prevalence was found among patients aged 5 to 14 years (26%, 95% CI: 14.2–37.8). Among children (aged <18) with asthma, 68.5% had infrequent asthma, 21.0% had frequent and 4.9% had persistent asthma. Among adults, 32.9% had very mild asthma, 27.3% had mild asthma, 27.7% had moderate and 7.9% had severe asthma. There was no gender difference in the distribution of asthma severity for children or adults.

Ninety per cent (90.3%, 95% CI: 87.7–93.0) of patients with asthma used some form of medication to manage their asthma. Eighty-three per cent of these patients used reliever medications, 49% used preventer medications and 7% used controller medications. Use of relievers alone was the most common treatment regimen and salbutamol inhaler was the most common single medication used. Twenty-one per cent of patients taking medication used a spacer device, 30% using a small device and 68% using a large device.

Treatment regimens differed by the severity of asthma among children and adults. Relievers alone were the most common regimen for children with infrequent asthma and adults with very mild asthma. Relievers and preventers were most common among children with frequent or persistent asthma and adults with mild or moderate asthma. Ipratropium plus other medications was most common among adults with severe asthma. Salbutamol inhalers were the most common single medication used by patients in all severity categories, except children with persistent asthma who were more frequently prescribed salbutamol nebulas.

Among patients taking medication, the effectiveness of the current regimen was rated 5 (effective) on a scale of 1–5 for 46.4% (95% CI: 40.8–51.9). Patients taking relievers only medications were most likely (60.4%) to have a rating of 5 for effectiveness of the medication. Multivariate logistic modelling showed that severity of asthma was associated with effectiveness of treatment but the treatment regimen was not. Seventy-one per cent of patients taking medication reported no adverse effects of the current regimen. Adverse effects were most likely for patients taking ipratropium alone (45%). The most common adverse effect reported was tremor/shakes followed by palpitations. Multivariate logistic modelling showed that severity of asthma was associated with adverse effects of treatment but that medication regimen was not.

For other related abstracts see: 22 Asthma – prevalence, severity and management, 39 Severity of asthma, medications and management, 48 Asthma prevalence and management, 63 Asthma-prevalence, management and medication side-effects, 70 Inhaled corticosteroid use for asthma management, 96 Inhaled corticosteroid use for asthma management, 104 Asthma management and medication use among patients attending general practice.

Further reading:

Henderson, J., Knox, S., Pan, Y., & Britt, H. 2004, 'Changes in asthma management in Australian general practice', *Prim.Care Respir.J.*, vol. 13, no. 3, pp. 138–143.

The following page contains the recording form and instructions with which the data in this abstract were collected.

Severity of asthma reference card	
Children	
Severity*	Common features
Infrequent episodic	Episodes 6-8 weeks or more apart and from 1 to 2 days up to 1-2 weeks duration; usually triggered by URTI or environmental allergen; attacks generally not severe; symptoms rare between attacks; normal examination and lung function except when symptomatic.
Frequent episodic	Attacks <6 weeks apart; attacks more troublesome; minimal symptoms such as exercise induces wheeze between attacks; normal examination and lung function except when symptomatic; commonly troubled through winter months only.
Persistent	Symptoms most days; nocturnal asthma > 1/wk with sleep disturbance; early morning chest tightness; exercise intolerance and spontaneous wheeze; daily use of beta2 antagonist; abnormal lung function; history of emergency room visits or hospital admissions.
Adults	
Severity*	Common features
Very mild	Episodic
Mild	Occasional symptoms (up to 2/wk); exacerbations >6-8 weeks apart; normal FEV ₁ when asymptomatic
Moderate	Symptoms most days; exacerbations <6-8 weeks apart which affect day-time activity and sleep; exacerbations last several days; occasional emergency room visit.
Severe	Persistent; limited activity level; nocturnal symptoms > 1/wk; frequent emergency room visits and hospital admission in past year; FEV ₁ may be significantly reduced between exacerbations.
* The severity classes are adapted from the NAC Asthma Management Handbook 1998 edition, updated March 2002	

PLEASE READ CAREFULLY

The shaded section of the following forms asks questions about **ASTHMA**.
You may tear out this page as a guide to completing the following section of forms.

INSTRUCTIONS

CHILDREN

Severity*	Common features
Infrequent episodic	Episode 6-8 weeks or more apart; attacks generally not severe; symptoms rare between attacks; normal examination and lung function except when symptomatic.
Frequent episodic	Attacks < 6 weeks apart; attacks more troublesome; increasing symptoms between attacks; normal examination and lung function except when symptomatic.
Persistent	Symptoms most days; nocturnal asthma > 1/wk; attacks 4-6 weeks apart; daily use of beta2 agonist; abnormal lung function; history of emergency room visits or hospital admissions.

ADULTS

Severity*	Common features
Very mild	Episodic
Mild	Occasional symptoms (up to 2/wk); exacerbations > 6-8 weeks apart; normal FEV ₁ when asymptomatic.
Moderate	Symptoms most days; exacerbations < 6-8 weeks apart which affect day-time activity and sleep; exacerbations last several days; occasional emergency room visit.
Severe	Persistent; limited activity level; nocturnal symptoms > 1/wk; frequent emergency room visits and hospital admissions in past year; FEV ₁ may be significantly reduced between exacerbations.

*Severity categories are adapted from the NAC Asthma Management Handbook, 1998 Edition

Current medications used:
Describe the current medications used in the treatment of asthma listing dose and regimen.

The medication form (metered dose inhaler/ dry powder inhaler / nebulers) for each listed drug should be circled.

Spacer device used:
Is any spacer device used?
If so, tick whether it is a large or small volume spacer and circle a number(s) to indicate the drug(s) for which the spacer is used. (Multiple response allowed).

Effectiveness of current regimen:
Circle on the scale the effectiveness of the current medication regimen used in the treatment of the patient's asthma.

Adverse effects of current regimen:
Circle on the scale the level of adverse effect ('withdraw' indicates the patient will cease the drug due to adverse effects).

List up to two adverse effects (if any) experienced by the patient with the current regimen, regardless of the effect's severity.

ASK ALL PATIENTS
Ask each patient if they **currently suffer from asthma**.

If NO asthma - no further questions.

Severity of asthma
Ask the patients with asthma about the severity of their asthma (see tables above):

Note that your research pack contains a card copy of these tables for easy reference.

FOR ALL PATIENTS		Current drug(s)	Dose	Regimen	Form*	Effectiveness of current regimen (circle)
Asthma? Yes <input type="checkbox"/> No <input type="checkbox"/> → End		1.			MDI / DPI / NEB	1 2 3 4 5 Not effective Effective
Severity		2.			MDI / DPI / NEB	
Child	Adult	3.			MDI / DPI / NEB	1 2 3 4 5 None Minor Withdraw
Infrequent <input type="checkbox"/>	Very mild <input type="checkbox"/>	*MDI=metered dose inhaler DPI=dry powder inhaler NEB=nebulers				
Frequent <input type="checkbox"/>	Mild <input type="checkbox"/>	Spacer device used: Large vol. <input type="checkbox"/> For drug(s) 1/ 2/ 3				1. _____
Persistent <input type="checkbox"/>	Moderate <input type="checkbox"/>	None <input type="checkbox"/> Small vol. <input type="checkbox"/> For drug(s) 1/ 2/ 3				2. _____
BILL	Severe <input type="checkbox"/>					

4 Cardiovascular disease

Organisation supporting this study: Aventis Pharma Pty Ltd

Issues: Prevalence of selected cardiovascular disease; recent cardiologist consultations and hospital admissions for these cardiovascular diseases (CVDs); current medication.

Sample: 2,119 encounters from 106 GPs; data collection period: 17/07/1999 – 16/08/1999

Method: Detailed SAND methods are provided in Chapter 2.

Summary of results

The age-sex distribution of the respondents was similar to the expected distribution for general practice, with the majority (58.8%) of patients being female.

One in four (26.0 %, 95% CI: 22.5–29.6) respondents had been diagnosed at some time with hypertension, congestive cardiac failure, stroke, or ischaemic heart disease (IHD) (including IHD with or without angina, myocardial infarction). Prevalence in males (25.1%) and females (26.8%) was similar. CVD was more prevalent in males aged 45–64 years than in women in this age group but in elderly patients (75+years) it was more prevalent in women than in men. The condition of highest prevalence was hypertension (20.6%, 95% CI: 17.4–23.7) followed by IHD of any type (8.5%, 95% CI: 6.0–10.9). Within the IHD group stable angina was the most prevalent condition (4.9%, 95% CI: 2.11–7.6). The prevalence of Congestive Cardiac Failure (CCF) was estimated to be 3.9% but the small sample size generated wide confidence intervals (0.0–8.4). The same could be said of the prevalence estimates for stroke (2.1%, 95% CI: 0.0–7.5). As expected, the prevalence of each condition increased with age.

Of the 551 patients with a CVD 24.3% (95% CI: 18.9–29.7) had seen a cardiologist in the previous 12 months and 15.8% (95% CI: 8.5–213.1) had been admitted to hospital in the previous year for the condition.

Fifteen per cent of these 551 respondents had an angiogram at some point and 8.0% had undergone a coronary artery bypass graft (CABG).

Ace inhibitors were the most common medication group, being taken by 37.0% of CVD patients and a third of these were taking no other medication for their CVD. Aspirin was also taken by about one-third of respondents with CVD (33.4 %, 95% CI: 28.5–38.3).

The following page contains the recording form and instructions with which the data in this abstract were collected.

PLEASE READ CAREFULLY

The shaded section of the following forms asks questions about **CARDIOVASCULAR DISEASE**.
 You may tear out this page as a guide to completing the following section of forms.

INSTRUCTIONS

<p>Has the patient ever been diagnosed with any of the options shown.</p> <ul style="list-style-type: none"> • Tick one or more boxes to indicate the condition(s) with which the patient has been diagnosed. You may tick as many boxes as apply to the patient. <p>NB. Ischaemic heart disease may refer to stable angina, unstable angina, myocardial infarction or other ischaemic heart disease not specified.</p> <ul style="list-style-type: none"> • If the patient does not have any of these conditions, NO FURTHER questions need be asked. 	<p>In the past 12 months, for the condition(s) described, has the patient had:</p> <ul style="list-style-type: none"> • a cardiologist consultation • a hospital admission for this problem. <p><i>Tick one or more boxes</i></p>	<p>Has the patient had any of the treatments listed? (either during a hospital admission or as an outpatient)</p> <ul style="list-style-type: none"> • indicate which treatment(s) the patient has had (<i>at any time</i>). <p><i>Tick one or more boxes</i></p>	<p>Which cardiovascular medication(s) is the patient currently taking?</p> <p>Tick the types of cardiovascular medications currently being taken by the patient.</p> <p><i>Tick one or more boxes</i></p>
<p>Patient ever diagnosed with: (✓ one or more)</p> <p>Ischaemic heart disease <input type="checkbox"/></p> <p> Stable angina <input type="checkbox"/></p> <p> Unstable angina <input type="checkbox"/></p> <p> Myocardial infarction <input type="checkbox"/></p> <p>Hypertension <input type="checkbox"/></p> <p>Congestive cardiac failure <input type="checkbox"/></p> <p>Stroke <input type="checkbox"/></p> <p><i>If NONE of the above - END here</i></p>	<p>In the past 12 months (for this condition/s), has the patient had:</p> <p>Cardiologist consult <input type="checkbox"/></p> <p>Hospital admission <input type="checkbox"/></p>	<p>Has the patient had any of these treatments: (Tick one or more)</p> <p>Angiogram <input type="checkbox"/></p> <p>Angioplasty <input type="checkbox"/></p> <p>Stenting <input type="checkbox"/></p> <p>CABG (bypass) <input type="checkbox"/></p> <p>Thrombolysis <input type="checkbox"/></p> <p>Not known <input type="checkbox"/></p>	<p>Which cardiovascular medication(s) is the patient currently taking? (Tick one or more)</p> <p>Nitrate-sublingual spray/tablet .. <input type="checkbox"/></p> <p>Nitrate - transdermal / oral <input type="checkbox"/></p> <p>Beta blocker <input type="checkbox"/></p> <p>Ca channel blocker <input type="checkbox"/></p> <p>Potassium channel opener <input type="checkbox"/></p> <p>Diuretic <input type="checkbox"/></p> <p>ACE inhibitors <input type="checkbox"/></p> <p>A2 antagonists <input type="checkbox"/></p> <p>Aspirin <input type="checkbox"/></p> <p>Other anti-platelet agents . <input type="checkbox"/></p> <p>Warfarin <input type="checkbox"/></p> <p>Heparin (UFH / LMWH) ... <input type="checkbox"/></p>

5 Depression

Organisation supporting this study: Commonwealth Department of Health and Aged Care (Pharmaceutical Branch)

Issues: The point prevalence of depression in general practice patients, the types of depression and methods of management by GPs.

Sample: 8,333 encounters for 309 GPs; data collection periods: 13/07/1999 – 17/08/1999, 26/10/1999 – 30/11/1999, 22/02/2000 – 27/03/2000.

Method: Detailed SAND methods are provided in Chapter 2.

Methods for this study: 'Major depressive disorder' was defined according to DSM-IV (Diagnostic and Statistical Manual of Mental Disorders, 4th edition) criteria to provide guidance for general practitioners reporting this condition.

Summary of results

The age-sex distribution of the respondents was similar to the expected distribution for general practice in BEACH, with the majority (59.4%) of patients being female.

The prevalence of depression among the respondents was 14.4% (95% CI: 13.1–15.7). The prevalence of depression for females (16.2%, 95% CI: 14.7–17.7) was significantly higher than for males (11.8%, 95% CI: 9.6–14.0). The highest prevalence rate of depressive disorder was among patients aged 45–64 year (20.3%, 95% CI: 18.4–22.4).

For nearly half (44.0%) of the patients reported by the GP as having depression, the GP classified the depression as a major depressive disorder. This represents a prevalence of major depression of 6.4% for the total sample. Prevalence of major depression among females was 7.1%, (95% CI: 6.0–8.3) and males 5.3% (95% CI: 3.2–7.4), indicating that there was less difference between males and females in prevalence rates of major depression compared with rates of depression overall.

Of all those with depression, 61% were receiving medication (with or without counselling), 25% were receiving counselling only, and 7% were receiving no treatment. Of those with major depression 85% were receiving medication and 2% were receiving no treatment.

89% of medications taken for depression were antidepressants. The most common medication (generic) reported was sertraline, which accounted for 19.1% of medications for depression and 21.4% of medications for major depression. Selective serotonin reuptake inhibitors was the most common subgroup of antidepressants recorded, accounting for 49% of medications.

For those respondents who were currently taking antidepressant medication, a GP had initiated the course of medication in the majority of cases (72.9%).

Counselling was provided by a GP in 48.5% of cases where the respondents were reported to have depression.

For other related abstracts see: 23 Depression, 47 Management of depression and anxiety.

The following page contains the recording form and instructions with which the data in this abstract were collected.

PLEASE READ CAREFULLY

The shaded section of the following forms asks questions about **DEPRESSION and SMOKING STATUS**.
 You may tear out this page as a guide to completing the following section of forms.

INSTRUCTIONS

This form has been filled in as an example.

BOX 1

Criteria for major depression* *DSM-IV (Diagnostic and Statistical Manual of Mental Disorders, 4th edition).
 At least FIVE (5) of the following symptoms for at least TWO WEEKS (symptom 1 or 2 must be present):

(1) Depressed mood	(6) Fatigue or loss of energy
(2) Loss of interest or pleasure	(7) Feelings of worthlessness or excessive guilt
(3) Significant appetite or weight loss or gain	(8) Impaired thinking or concentration, indecisiveness
(4) Insomnia or hypersomnia	(9) Suicidal thoughts/thoughts of death
(5) Psychomotor agitation or retardation	

Indicate the **current treatment** for the patient's depression.
 Tick **ONE** or **MORE** of the following options.

Medications
 If the patient is taking medication:
 • write the medication name(s)
 • indicate whether the medication was initiated by a GP or specialist (circle response).

Counselling / therapy:
 Who is providing the counselling or therapy?
 You may circle more than one option if necessary.

No treatment - if the patient is not currently receiving any treatment, tick this option.

If you believe the patient's depression is a MAJOR depressive disorder according to the criteria shown above in Box 1 - tick 'yes'
 If NO - tick 'No'
 and describe the type of depression that in your opinion the patient is suffering from.
For example...
 • depression & anxiety (not major)
 • manic-depression
 • chronic mild depression
 • adjustment disorder with depressed mood

In your opinion, does the patient currently have a depressive disorder?
 Tick 'Yes' or 'No'.

Does this patient currently have a depressive disorder? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No → If No, End here	How is the patient's depression currently being treated? <input checked="" type="checkbox"/> Medication (name) <u>Initiated by</u>
Is this a major depressive disorder? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	1. Fluoxetine hydrochloride GP / Specialist
If NO...How would you describe it?(specify) Mild depression and anxiety	2. GP / Specialist
	<input checked="" type="checkbox"/> Counselling / therapy <u>Provided by</u> <input type="checkbox"/> No treatment GP / Specialist / <u>Other</u>

6 Employment status and workers' compensation claims

Organisation supporting this study: National Occupational Health and Safety Commission

Issues: Employment status; work-related problems and workers' compensation claims

Sample: 8,833 encounters from 221 GPs; data collection period: 21/09/1999 – 26/11/1999

Method: Detailed SAND methods are provided in Chapter 2.

Summary of results

The age–sex distribution of the respondents was similar to the expected distribution of general practice patients, with 51% in the 25–64 age group and the majority of patients (59%) being female.

Of the 8,833 respondents, 52.3% were not in the labour force. Those not in the labour force were mainly retirees (27.0%) and those engaged in home duties (12.9%).

The problems managed at encounter were analysed in relation to total encounters, employment status and workers' compensation claims. Hypertension was the most common problem managed in the total sample (at a rate of 7.7 per 100 encounters, 95% CI: 6.7–8.7). Upper respiratory tract infection (URTI) was the most common problem managed for employed persons (6.4, 95% CI: 5.0–7.7), though this rate was lower than the URTI rate in the total sample. Common problems managed at a higher rate for employed persons than for all persons were back complaints (3.2 per 100 encounters, 95% CI: 0.7–5.6 compared with 2.9, 95% CI: 2.1–3.6) and sprains/strains (2.6, 95% CI: 0.8–4.4 compared with 1.7, 95% CI: 1.0–2.5). Overlapping confidence intervals show no significant differences were found.

Back complaint was managed at the higher rate of 3.9 per 100 encounters with self-employed persons, compared with a rate of 2.9 per 100 total encounters. Malignant neoplasms of the skin were also more often managed among the self employed, at a rate of 2.8 per 100 encounters (compared with 0.9 per 100 encounters in the total data), but numbers were small at this level of analysis precluding statistical comparisons.

Of the 8,833 encounters, 272 (3.1%) included the management of at least one problem that was work-related. A workers' compensation claim was made for 182 (67.0%) of the work-related encounters. Back complaint was the most common problem managed at an encounter where a workers' compensation claim was made.

Of the 90 respondents who stated they had a work-related problem but did not make a claim, only 50 gave a reason why a claim was not made. The most common reason given was 'not serious enough' (22.0%). The 'other' category made up 48% of reasons for not claiming, and an examination of this category showed that most of the reasons given (18% of all reasons) were that respondents were 'self employed'. Another 18% of patients gave 'not covered by employer' as their reason for not making a claim.

For other related abstracts see: 80 Employment status and workers compensation claims in general practice patients, 11 Patient employment status and occupation.

The following page contains the recording form and instructions with which the data in this abstract were collected.

PLEASE READ CAREFULLY

The shaded section of the following forms asks questions about **EMPLOYMENT STATUS, WORKERS' COMPENSATION CLAIMS & SMOKING.**

INSTRUCTIONS

Patient's current employment status

Ask all patients aged 15 years or over, how they would describe their current employment status?

(Including part-time and casual employment)

Select ONE category only.

Smoking status
Ask patients aged 18yrs+:

Which of the four categories best describes their smoking status?

Tick one box.

For any conditions managed today that are work-related, ask the patient if they have made any worker's compensation claim.

IF YES - indicate the problem number by circling.
IF NO - go to next question

If no work-related conditions were managed at today's encounter - stop here.

IF NO worker's compensation claim has been made -

For each **work-related problem managed** indicate the reason for not making a claim.

Circle the problem number(s) next to the reason that applies to that problem.

NB.
'Not covered by employer' = the problem was not covered by the employer's compensation scheme, or the employer did not have a compensation scheme.

If patient 18+yrs: <input type="checkbox"/> Smokes daily <input type="checkbox"/> Previous smoker B165 <input type="checkbox"/> Occasional smoker <input type="checkbox"/> Never smoked		(If no work-related conditions were managed today - STOP here) For any work-related conditions managed today: was a worker's compensation claim made? <input type="checkbox"/> Yes - For problem 1 / 2 / 3 / 4 <input type="checkbox"/> No																																					
PATIENTS 15yrs+: How would you describe your current employment status? Self-employed 1 Student & not working 6 Employed by other 2 Retired 7 Unemployed 3 Unable to work due to health problems 8 Home duties 4 Other (specify) 9 Student & working 5		If NO claim was made: Reason for not claiming																																					
		<table border="1"> <thead> <tr> <th colspan="2">Reason for not claiming</th> <th colspan="4">Problem</th> </tr> </thead> <tbody> <tr> <td colspan="2">Not covered by employer</td> <td>1</td> <td>2</td> <td>3</td> <td>4</td> </tr> <tr> <td colspan="2">Covered by other means (eg employer paid)</td> <td>1</td> <td>2</td> <td>3</td> <td>4</td> </tr> <tr> <td colspan="2">Not serious enough</td> <td>1</td> <td>2</td> <td>3</td> <td>4</td> </tr> <tr> <td colspan="2">Didn't know I could</td> <td>1</td> <td>2</td> <td>3</td> <td>4</td> </tr> <tr> <td colspan="2">Other (specify) _____</td> <td>1</td> <td>2</td> <td>3</td> <td>4</td> </tr> </tbody> </table>		Reason for not claiming		Problem				Not covered by employer		1	2	3	4	Covered by other means (eg employer paid)		1	2	3	4	Not serious enough		1	2	3	4	Didn't know I could		1	2	3	4	Other (specify) _____		1	2	3	4
Reason for not claiming		Problem																																					
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Covered by other means (eg employer paid)		1	2	3	4																																		
Not serious enough		1	2	3	4																																		
Didn't know I could		1	2	3	4																																		
Other (specify) _____		1	2	3	4																																		

7 Health service utilisation, lifestyle status and chronicity

Organisation supporting this study: Commonwealth Department of Veterans' Affairs

Issues: GP visits; hospital admissions; medications taken; independent living; institutionalisation

Sample: 2,124 encounters from 106 GPs; data collection period: 08/06/1999 – 09/07/1999

Method: Detailed SAND methods are provided in Chapter 2.

Summary of results

The age-sex distribution of patients was similar to that of the total BEACH sample.

At least one prescribed medication had been taken routinely in the past 6 months by 69.6% of the respondents. Between one and three medications had been taken routinely by 47.0% of respondents. Almost two-thirds of respondents (60.8%) had routinely taken at least one over-the-counter (OTC) medication. Relatively more older patients were routinely taking either prescribed and/or OTC medications. The proportion of females who routinely took at least one prescribed medication was 74.2% compared with 63.1% of males. Similarly, a greater proportion of females (43.3%) than of males (32.3%) had routinely taken at least one OTC medication over the past 6 months.

The majority of respondents (52.1%) had visited a GP on between one and four occasions in the preceding 6 months. Again, elderly patients reported more GP visits, with 41.5% of patients aged over 75 years visiting the GP between five and eight times. At least one admission to hospital in the previous 6 months was reported by 18.0% of respondents. Allied health consultations were reported by 17.3% of respondents, while 37.2% had visited a specialist at least once in the past 6 months.

Of the 2,124 respondents, 11.5% were dependent on a carer, with a high proportion of patients aged 75 and over being dependent. Almost 3.0% of respondents resided in an institution.

At least one indicator of chronicity (e.g. falls, cognitive impairment, social isolation, incontinence) was reported for 19.8% of respondents. One indicator only was reported for 64.0% of respondents, with three or more reported for 10%. The prevalence of all indicators of chronicity increased with age. Falls/poor mobility was reported for 7.5%, and 6.0% were reported to be cognitively impaired. There were 5.6% who were socially isolated and 2.3% incontinent. Amongst those who were dependent on carers and others, and particularly for those living in institutions, individual indicators were more often reported, especially falls/poor mobility (21.7% and 66.7%) and cognitive impairment (14.0% and 53.7%). Almost one-third of the 54 patients living in institutions (30.8%) had been taking seven or more medications routinely in the past 6 months.

GPs reported that there were health plans for a relatively small number of respondents, with around 1% having either Department of Veterans' Affairs health care plan or another health care plan.

For other related abstracts see: 37 Prevalence of common morbidities in patients encountered in general practice.

The following page contains the recording form and instructions with which the data in this abstract were collected.

PLEASE READ CAREFULLY

The shaded section of the following forms asks questions about **PATIENT USE OF HEALTH CARE AND DEPENDENCE**.
 You may tear out this page as a guide to completing the following section of forms.

INSTRUCTIONS

ASK ALL PATIENTS
These questions refer to the past 6 months.
 Write a **number** in the space provided for:

- How many medications they take/ have taken on a routine basis.
- Please distinguish between OTC (over the counter) and prescribed medications.
- The number of times they have visited any GP.
- The number of times they have visited a specialist.
- The number of hospital admissions.

Tick the appropriate box for:

- The number of times they have consulted an allied health professional (AHP).

Patient lifestyle:
 Choose ONE option to describe the patient's lifestyle at the moment.

Health Care plans
 Indicate whether the patient has a Department of Veterans' Affairs care plan or any other co-ordinated care plan.

Present status:
 As far as you are aware, do any of the following options apply to the patient?

Please note that 'incontinent' applies to normally continent individuals (ie not infants).

<p>In the PAST 6 MONTHS:</p> <p>No. of medications routinely taken: Prescribed <input type="checkbox"/> OTC <input type="checkbox"/></p> <p>No. of GP visits: <input type="checkbox"/></p> <p>No. of specialist visits: <input type="checkbox"/></p> <p>Hospital admissions: <input type="checkbox"/></p> <p>No. AHP Consults: 0 <input type="checkbox"/> 1-5 <input type="checkbox"/> 6-10 <input type="checkbox"/> 11+ <input type="checkbox"/></p>	<p>Patient lifestyle: (Tick ONE only)</p> <p>Living in the community independently <input type="checkbox"/></p> <p>Dependent on carer/other: in the community <input type="checkbox"/></p> <p>Living in an institution <input type="checkbox"/></p> <p>Does the patient have either of :</p> <p>DVA Health Care Plan <input type="checkbox"/></p> <p>Other Co-ordinated Care plan <input type="checkbox"/></p>	<p>Present Status - GP assessment B13L</p> <p>(Multiple response allowed)</p> <p>Falls/ poor mobility? <input type="checkbox"/></p> <p>Cognitive impairment/ psychiatric problem? <input type="checkbox"/></p> <p>Socially isolated, carer stress, loneliness? <input type="checkbox"/></p> <p>Incontinent? <input type="checkbox"/></p>
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8 Hormone replacement therapy (HRT)

Organisation supporting this study: Aventis Pharma Pty Ltd

Issues: Menopausal status among female patients; proportion taking hormone replacement therapy (HRT).

Sample: 2,063 encounters (females aged 18 years +); data collection period: 30/11/1999 – 14/01/2000

Method: Detailed SAND methods are provided in Chapter 2.

Methods for this study: GPs were asked to ascertain (either by asking the patient or from their knowledge of the patient) for female patients aged 18 and over, whether the patient was premenopausal, perimenopausal or post menopausal. The GP was also asked to determine whether the patient had previously had a hysterectomy or experienced menopausal symptoms, was currently on HRT and (if so), whether they were taking HRT for symptom management, to avoid bone loss, for cardiovascular protection, or for another reason, which they were asked to specify.

Summary of results

Four thousand encounter forms were completed with the HRT questions. The age and sex distribution of these respondents were similar to those for general practice as a whole. The majority of respondents (59.3%) were females, with 2,063 of these aged 18 years and over.

Six per cent of the women in this subsample were perimenopausal. Thirty-two per cent of these women were aged between 40 and 59 years. Three hundred and thirty-three women (16.1% of respondents) had a past history of menopausal symptoms and 362 (17.6%, 95% CI: 15, 20.1) had had a hysterectomy.

Eleven per cent of respondents were taking HRT. The use of HRT was most common in perimenopausal women and among women aged 50 to 59 years. Among women with a history of menopausal symptoms the proportion taking HRT was 37.5%.

The most common single reason for taking HRT was symptom management (62.7%) followed by bone loss avoidance (50.4%) and cardiovascular protection (23.3%). Even when all the reasons for taking HRT were combined, symptom management only remained the most common reason, followed by the combination of all three reasons – symptom management, bone loss avoidance and cardiovascular protection (19.0%).

Oestrogen alone was the most common HRT used by women irrespective of menopausal status. Almost half of the 34 perimenopausal women on HRT were taking oestrogens alone.

For other related abstracts see: 84 Menopausal status, symptoms and treatment of women aged 18 and over.

The following page contains the recording form and instructions with which the data in this abstract were collected.

PLEASE READ CAREFULLY

The shaded section of the following forms asks questions about **HORMONE REPLACEMENT THERAPY and SMOKING**. You may tear out this page as a guide to completing the following section of forms.

INSTRUCTIONS

This form has been filled in as an example.

44

MENOPAUSAL SYMPTOMS
include the following:

- hot flushes
- sleep disturbances
- excessive sweating
- dyspareunia
- urinary incontinence

Indicate

- whether the patient is currently on HRT?
Tick 'yes' or 'no'
- reason(s) for taking HRT
Tick one or more options

Current HRT medications
Is the patient taking:

- any medication containing *oestrogen only*
- any medication containing *progesterone only*
- any medication containing a *combination of oestrogen & progesterone* (either combination pack or combined tablet)
- another medication for HRT

Brand name

- write the brand name of the medication prescribed

Monthly regimen

- write the **daily dose** of each medication
- for doses which change through the cycle, write the days of the cycle and the corresponding dose
- if the medication is taken continuously, write the dose or number of tablets and the regimen - eg *1 tab daily*.

Smoking status
Ask ALL patients aged 18yrs+:

Which of the four categories best describes their smoking status?

Tick one box.

FOR ALL FEMALE PATIENTS aged 18 years and over:

- Classify all female patients according to their menopausal status.
Tick one box

For all female patients 18yrs +:

- Has the patient had a hysterectomy?
- Does the patient have a past history of **any** menopausal symptoms (for example those listed above)?
That is, have they had symptoms in the past, but do not have them anymore.

Circle 'Yes' or 'No' for each question.

FOR FEMALES:		Currently on HRT <input checked="" type="radio"/> Yes <input type="radio"/> No	CURRENT HRT DRUGS		Monthly Regimen			
Menopausal status:		Reason(s) for HRT (if using):	Generic	Brand name	Dose	Days	Dose	Days
Premenopausal	<input type="checkbox"/>	Symptom management	<input checked="" type="checkbox"/>	Oestrogen (O)	<i>Premarin</i>	<i>0.3mg</i>	<i>1-21</i>	
Perimenopausal	<input checked="" type="checkbox"/>	Avoid bone loss	<input type="checkbox"/>	Progesterone (P)	<i>Provera</i>	<i>10mg</i>	<i>1-10</i>	
Post menopausal	<input type="checkbox"/>	Cardiovascular protection	<input checked="" type="checkbox"/>	Combined O & P				
		Other (specify)	<input type="checkbox"/>	Other (specify)				
Past history of:		Hysterectomy	<input type="radio"/> Yes <input checked="" type="radio"/> No	If patient 18+yrs:				
		Menopausal symptoms	<input checked="" type="radio"/> Yes <input type="radio"/> No	Smokes daily	<input type="checkbox"/>	Occasional smoker	<input type="checkbox"/>	Previous smoker
							<input checked="" type="checkbox"/>	Never smoked

9 Influenza and absenteeism

Organisation supporting this study: Roche Products Pty Ltd

Issues: Prevalence (previous 12 months), days of absence from work/study, days off advised, hospitalisation, medical certificate given at consultation.

Sample: 4,228 encounters from 106 GPs, data collection period: 04/05/1999 – 07/06/1999

Method: Detailed SAND methods are provided in Chapter 2.

Summary of results

The age-sex distribution of the respondents was similar to the expected distribution for general practice, with the majority (56.9%) of patients being female.

The prevalence of influenza in the previous 12 months among the respondents was 14.9% (95% CI: 11.2–18.6). The highest prevalence was found among patients aged 15 to 24 years (22.3%, 95% CI: 16.9–27.7), there was no difference between males and females in the prevalence of influenza.

One in five (19.8%, 95% CI: 15.1–24.4) patients who were working/studying reported having had influenza in the previous 12 months. Forty-four per cent of these patients reported having 3 or more days absent from work, 33% reported having less than 3 days absent, and 23% had not had any days absent.

Only 1.6% (95% CI: 0.0–11.8) of patients in work/study had been hospitalised due to influenza in the previous 12 months. In comparison, 3.5% (95% CI: 0.0–9.9) of all patients (irrespective of employment status) had been hospitalised.

For 53 of the patients, influenza was a problem being managed at the current encounter. On average the patient had already had 1 day absent for influenza when seen by the GP and the GP advised a further 1.6 days off at the consultation. Thus the average number of days taken off work/study for influenza was 2.6 days.

A medical certificate was given at 7.8% (95% CI: 5.8–9.8) of the encounters in this sub-sample of encounters. Among those for whom influenza was managed at the encounter, 52.8% (95% CI: 40.2–65.4) were issued a medical certificate.

For other related abstracts see: 27 Prevalence and management of influenza.

The following page contains the recording form and instructions with which the data in this abstract were collected.

PLEASE READ CAREFULLY

The shaded section of the following forms asks questions about **INFLUENZA, ABSENTEEISM & SMOKING STATUS**.
 You may tear out this page as a guide to completing the following section of forms.

INSTRUCTIONS

INFLUENZA

These questions ask about influenza and should be asked of all patients (or carers on their behalf).

Ask the patient if they have had influenza in the past 12 months?
 Use the following definition of influenza to determine whether the patient had influenza or another condition.

Definition of Influenza*

- a) viral culture or serological evidence of influenza virus infection,
- or
- b) Influenza epidemic, plus four of the criteria in (c),
- or
- c) six of the following:
 - sudden onset (within 12 hours)
 - cough
 - rigors or chills
 - fever
 - prostration and weakness
 - myalgia, widespread aches and pains
 - no significant respiratory physical signs other than redness of nasal mucous membrane and throat
 - influenza in close contacts

*Definition used by the Australian Sentinel Practice Research Network.

Absence due to influenza.

1. Ask the patient how many days the patient was absent from work or study due to influenza?

Write the number in the space provided.

- Include halfdays as .5 days.
- If no absences, write '0'.

OR

If the patient is **NOT working or studying** tick the appropriate box.

2. Ask the patient if they have been hospitalised due to influenza.

Write the number of days in hospital.

If not hospitalised, write '0'.

Absence due to problems managed at today's consult.

These questions refer to the problems managed at today's encounter.

1. Indicate if the patient is usually in paid work, studying (including school) or neither, by ticking ONE box.

Note that if the patient is not working or studying, the following questions about work absence need not be answered.

2. If patients usually work or study **AND** are **currently absent** because of the problems managed at today's encounter:

3. Write the number of days already absent up until and including today. (Include half-days, and write nil as '0')

- Indicate the **problem(s)** which caused them to be absent by *circling one or more number*.

4. If you advised them to take time off at today's encounter, write the number of days in the box provided. Include half-days as .5 days.

- Again, indicate the **relevant problem(s)**, by *circling one or more number*.

5. Was a medical certificate provided at today's consultation? Tick Yes or No.

Smoking status

Ask ALL patients aged 18yrs+:

Which of the four categories best describes their smoking status?

Tick one box.

46

This form has been filled in as an example.

Ask the patient (or carer):

Have you had influenza in the past 12 months? Yes No

Number of days absent from work/study due to influenza? 2 (days absent) or Not working or studying

Number of days in hospital as a result of influenza? 0 (days in hospital)

Is the patient usually in paid work or study?

Paid work Study Neither

If currently absent from work/study for problems managed today:

How many days have they been absent so far? 0.5
 For which problem(s)? 1 / 2 / 3 / 4

How many days off work/study have you advised today? 3
 For which problem(s)? 1 / 2 / 3 / 4

Was a medical certificate given? Yes No

If patient is 18+yrs:

- Smokes daily
- Occasional smoker
- Previous smoker
- Never smoked

10 Length of consultation; after-hours arrangements; co-morbidity

Organisation supporting this study: Commonwealth Department of Health and Aged Care (General Practice)

Issues: Length of consultation; after-hours arrangements; co-morbidity

Sample: 6,328 encounters from 210 GPs; data collection periods: 08/06/1999 – 13/07/1999 and 17/08/1999 – 21/09/1999

Method: Detailed SAND methods are provided in Chapter 2.

Summary of results

The age-sex distribution of the patients was similar to the expected distribution of general practice patients, with the majority of patients (57.2%) being female.

Of the 210 participating GPs, 71.9% were male and 53.9% were aged 35–54 years. Most of the GPs worked 6–10 sessions per week (65.9%) and had graduated in medicine in Australia (70.2%). Solo practitioners accounted for 22.8% of the sampled GP population.

The median length for the 5,803 direct consultations (patient is seen) was 12 minutes, and the mean was 14.7 minutes (95% CI: 14.1–15.4). The median consultation length for male and female patients was similar at 11 and 12 minutes respectively. The median consultation length increased with patient age; patients under 15 having a median of 10 minutes, and those aged 45 years or more had a median of 14 minutes.

Three-quarters (77.7%) of direct consultations were between 5 and 19 minutes duration. Only 1.7% of direct consultations were of less than 5 minutes duration, and 2.7% were of 40 or more minutes duration. Of all direct and indirect consultations, the vast majority (93.9%) were held between the hours of 08:00 and 18:00.

At 7.3% of encounters, GPs stated that there were 'special' after-hours arrangements for that particular patient. One in five of these patients (20.5%) were aged 75 years or more. There was no apparent difference in the types of problems being managed at this encounter for these patients when compared with the problems managed for patients with 'normal' after-hours arrangements.

There were 338 encounters (5.7%) at which the GP reported that this service was provided when the practice was closed. These out-of-practice-hours services were provided by 79 (37.6%) of the 210 GPs. Only 22.5% of the consultations provided when the surgery was closed were between the hours of 18:00–23:00, with the majority (71.9%) being provided between the hours of 08:00–18:00. The consultations when the surgery was closed were longer (11.2% were 40 minutes or more) than all direct consultations (2.7% were 40 minutes or more). The patients seen when the surgery was closed were older (24.3% were aged 75 or older) than patients in the total study (13.1% aged 75 or older).

GPs indicated a variety of arrangements for their normal provision of after-hours service. Sixty-five GPs (31%) used a deputising service alone, while 87 (41%) of GPs used a deputising service together with another arrangement. The next most common arrangement was for 59 GPs (28%) who stated that their practice arranged their own after-hours service. Only two of the 210 GPs had no after-hours service arrangement. None of the GPs in rural or remote areas used a deputising service.

The length of consultation increased with the number of co-morbidities (requiring on-going management or surveillance) not managed at this encounter. Of patients with no unmanaged

co-morbidities, 6.8% (95% CI: 5.7–7.8) had a consultation of 30 minutes or longer, compared with 18.7% (95% CI: 8.1–29.3) of patients with four unmanaged co-morbidities.

Similarly, the length of consultation increased with the number of problems managed at this encounter. For patients with 1, 2, 3 and 4 problems managed there were respectively 5.7% (95% CI: 4.7–6.8), 8.3% (95% CI: 7.1–9.5), 13.5% (95% CI: 10.6–16.4) and 20.1% (95% CI: 11.5–28.8) of consultations which were 30 minutes or longer.

For other related abstracts see: 2 Anxiety/stress, consultation time, level of education, 32 Patient use of after-hours medical services, 37 Prevalence of common morbidities in patients encountered in general practice, 61 Prevalence of chronic illnesses identified as National Health Priority Areas among general practice patients, 89 Estimates of the prevalence of chronic illnesses identified as Health Priority Areas and Section 4.5 Length of consultation.

Further reading:

Bindman A.B., Forrest C., Britt H., Crampton P., Majeed A. 2007, 'Diagnostic scope of and exposure to primary care physicians in Australia, New Zealand and the United States: cross sectional analysis of results from three national surveys', *British Medical Journal* (Epub ahead of print).

Britt, H., Valenti, L., & Miller, G. 2002, 'Time for care. Length of general practice consultations in Australia', *Australian Family Physician*, vol. 31, no. 9, pp. 876–880.

Britt, H., Valenti, L., Miller, G. C., & Farmer, J. 2004, 'Determinants of GP billing in Australia: content and time', *Medical Journal of Australia*, vol. 181, no. 2, pp. 100–104.

Britt, H. C., Valenti, L., & Miller, G. C. 2005, 'Determinants of consultation length in Australian general practice', *Medical Journal of Australia*, vol. 183, no. 2, pp. 68–71.

The following page contains the recording form and instructions with which the data in this abstract were collected.

PLEASE READ CAREFULLY

The shaded section of the following forms asks questions about **TIME OF CONSULTATION, CO-MORBIDITY & AFTER-HOURS SERVICES.**
 You may tear out this page as a guide to completing the following section of forms.

INSTRUCTIONS

After-hours consults
Was this service provided at a time when your practice is normally closed?
 Indicate whether you provided this service after your *normal practice hours*. i.e. You were called out or called back to your practice.

What are the usual after-hours arrangements for this patient:

- None - no special arrangements
- Normal practice - the usual after-hour arrangements that apply to this practice.
- Special arrangements - particularly for this patient.

START TIME
 Record the time the consultation STARTED in hours and mins and circle whether the time was AM or PM.
 eg. | 9:15 |
 (AM) PM

Patient morbidity
 Does the patient have significant morbidity that was not managed at this consultation?
 eg. chronic illnesses or other health problems that require continuing management or surveillance.
 (If more than 4 select the most important)

FINISH TIME
 Record the time the consultation FINISHED in hours and mins and circle whether the time was AM or PM.
 eg. | 9:25 |
 (AM) PM

Start Time	Patient morbidity NOT MANAGED at this consult?	Was this service provided at a time when your practice is normally closed?	Finish Time
: AM / PM (please circle)	1. _____ 2. _____ 3. _____ 4. _____	<input type="checkbox"/> Yes <input type="checkbox"/> No What are the usual after-hours arrangements for this patient? None <input type="checkbox"/> Normal practice <input type="checkbox"/> By special arrangement <input type="checkbox"/>	: AM / PM (please circle)