

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

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problem is strongly predictive of frequent consulting⁵ and that FCs are more likely to have a combination of physical, psychological and social problems than LFCs.⁵ 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^{6–9} 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^{10,11} 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 consult¹², 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.³ 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 to investigate possible explanations for frequent

attendance, such as views on the role of the GP, beyond the burden of multiple 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.^{13,14} Forty-one people born in the early 1950s were purposively subsampled from a longitudinal community health survey in the west of Scotland¹⁵ 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

TABLE 1 *Respondent characteristics*

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

^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.

symptoms, the impact of conditions on daily life and the consultation process. Second, participants were invited to complete a 2-week symptom diary. Finally, a follow-up semi-structured interview, approximately 3 weeks after the first, allowed a greater focus on management of symptoms, help seeking and the role of the GP. All interviews were conducted by AT. The diary entries served as detailed prompts for the second interview. The design facilitated in-depth descriptions of patient perspectives of managing multiple chronic illnesses and detailed, systematic comparisons between the FCs and LFCs relating to the nature and severity of their symptoms, the severity and stability of their conditions, the impact illness had on their daily lives, their self-management resources and techniques and their use of the GP services. Of the 23 who completed the first interview, 20 undertook the second interview and 14 completed or partially completed the diary.

Analysis

AT checked all transcripts for accuracy against the audio recordings at the earliest opportunity. A systematic analysis of the data was informed by a combination of qualitative approaches. Features of grounded theory¹⁶ included simultaneous collection and analysis of data, a two-step coding process, constant comparison methods and memo writing. This was in an attempt to construct theory from the data, based on as far as possible, the lived experiences of the participants. As analysis progressed, relationships were identified in the data, and theory building from concrete description (descriptions of using the GP as a last resort) to more abstract concepts (constructing moral identities) was undertaken. A framework approach¹⁷ was used in the early stages of analysis to further synthesize the emerging themes on paper. All the data were charted thematically, and mapping and interpretation was carried out in a systematic way. Finally, a narrative analysis¹⁸ focussed on the temporal aspects of the accounts and the form of the language used. This approach highlighted how participants talked about changes over time, offered a way of checking for consistency of emerging themes (e.g. rhetorical devices used in the accounts to manage positive moral identities) and highlighted the significance of the past, on current illness experiences, and participants' sense of a coherent self. All authors independently read initial transcripts to identify early themes for discussion. Consistency between and within transcripts, and deviant cases, was sought. Through negotiation, themes were reaffirmed, refined or revised. Early themes included the impact of symptoms on daily life and the construction of the GP consultation as a 'last resort'. Higher-level themes, such as symptom management and daily life and the reflexive work that informed consulting decisions were identified with further analysis and discussion. When a new

theme emerged, previous interviews were reanalysed to establish whether they referred to the theme implicitly. This approach facilitated constant comparisons. The software package nVivo offered practical benefits in facilitating systematic analytic scrutiny, allowing large sections of text to be retrieved and revisited, avoiding fragmentation as far as possible. The detailed analysis of the transcripts was conducted without reference to whether the participant had been sampled as a FC or LFC until the final stages of analysis when the explicit comparisons presented here were undertaken. Data extracts are anonymized.

Findings

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'.¹⁹ 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 consulters 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,^{20,21} 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

Box 1. Differences between the accounts of FCs and LFCs' symptoms and conditions

'... I can't stand for long, or (get) up and down; my leg, which is a pain, but its not sore, I mean there's lots of things I do do, ... It doesnae' hold me back ... I got so used to it I think that's maybe why I never really bothered that much about it' (Martha, LFC).

'I'm struggling with the stairs. When I come down in the morning I dread having to go back up to the toilet, I dread it' (June, FC).

'I can see the reasons why I am the way I am and in that way I'm quite confident in that. There's nothing really happening that's out of my control I don't believe, you know, or it's out of my expectations' (Peter, LFC).

'... on a day to day basis, I can't get up and have a bath or plan the day. I can't get up and say "Right I'm going to have a bath, I'm going to have a shower"... Or, "I'll do such and such tomorrow". I can't do that. I have to take it as it comes. I have to get up in the morning and see whether I'm fit to have a bath ... Or I might have to stay in bed with the nebuliser ... if it means putting off a bath, or putting off a visit, then I'll put that off so I can't plan' (June, FC).

Box 2. Differences between the accounts of FCs and LFCs in success of self-management strategies

'I figure I manage it quite well. It doesn't stop me doing much, anything really that I want to do ... If your back's affecting you take your painkillers When I do get sore I can come in ... (taxi driving is) probably the only job I could do ... Aye, I've got constant back and neck pain. It's controllable But I know if I do something manual I'll get a sorer back, it's always there. But I take a lot of quite strong painkillers every day now I use special things too, like a chair ...' (Paul, LFC).

'... either my asthma's playing me up or my colitis. It's a catch 22 situation... I would just love to be normal ... I don't live, I exist ... When my asthma is bad the first thing I do is I up my inhalers and I will give it a day or two, if I feel it's getting bad I'll double the dosage again and if it's not any better then I'll have to phone the doctor And then if it's bad I get put on steroids for asthma ... I know how long my colitis will go, and it's maybe a week I'll have constant diarrhoea, and then I can work out, how severe it is ... I go to the doctors and say right I need. And he'll examine me and say: "Right you'll need to come back". If I'm bleeding heavy, that's what he'll say. Nearly all people with these type of illnesses know what to do ... you cannae just phone the doctor and say, constant' (Lesley, FC).

Box 3. *Perceived suitability and availability of alternative treatments and resources*

'I continued with the homeopathic remedies ... I go swimming, and for a sauna, I have to pay membership, but it makes me feel so relaxed, anything that you enjoy helps, I would not like to give that up' (Marie, LFC).

'I can use it (TENS machine) in the classroom, and it is just in my pocket, so that eases the pain' (Peter, LFC).

'Well, I've not had eh aromatherapy or anything 'cos of the conditions I've got, nobody will touch me. I've tried it ... an aromatherapist, she wouldnae touch me because too much wrong with me, I'd need medical things signed and everything else and she said no. She says go to the doctor' (Lesley, FC).

'I can only afford to go till the end of the month, I don't know what I will do then, I will have to stop my massage, and alternative treatments, because I can't afford them any longer' (Betty, FC).

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

Box 4. *The place of the GP consultation*

'My GP doesn't really do very much. He's sort of just guided by what I want to do and how I feel, and what the hospital (pain clinic) sometimes says. Otherwise, he's just really a sort of innocent bystander, really just a man who fills out prescriptions and things like that, so I don't really speak to him very much' (Peter, LFC).

'I have a lot of aches and pains on my legs, also my neck ... sometimes it's really, really bad ... but no I've never ever said to the doctor when I went "I've got a sore neck". I think maybe once I did and he said: "Ehm just wear and tear". You know, without examining or anything: "Just wear and tear" but of course I didnae make a big thing about it. Sometimes it's quite bad' (Martha, LFC).

AT: 'And why is he really good, what makes him really good?'

Janet: 'Because this doctor takes time to explain the procedures you are going through, he takes time to tell you what is wrong with you, he takes time to examine you and he gets to the bottom of what's wrong with you. He doesn't leave you in limbo. There's none of this, give you a prescription and say: "Right try that, come back in two weeks" ... Somebody to be straight with me ... just get right down to the nitty gritty tell me what's wrong with me and give me something to help me along the way ... I'm not there a lot so when I do go he knows there's something really wrong. It's the only time I do go and this doctor knows that and he sits down, "Right what's the problem"? And he'll discuss it ... and that's what I like about him' (Janet, FC).

'... it's all about the things that's wrong with me ... And her checking it up, and, my blood pressure... It's not just sitting talking about the weather or thingamy or anything like that, it's all about me. But she takes time to sit and listen to you, and if there's anything that she's concerned about it's referred to the hospital. Really brilliant doctor' (Ian, FC).

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.²² Self-management strategies were used to minimize symptoms, stabilize conditions and strive for a normal life¹⁹ 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,²¹ 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

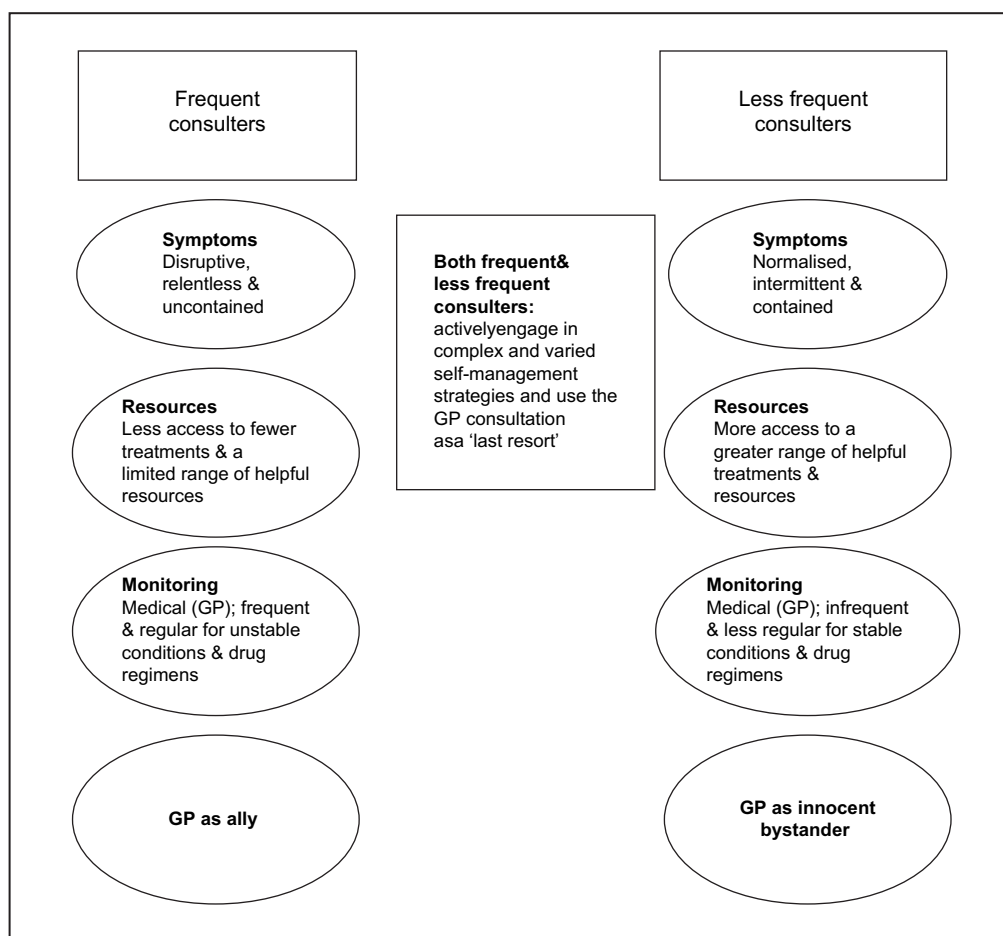


FIGURE 1 Comparison of accounts of FCs and LFCs

symptoms takes place within a moral framework¹⁴ 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,²³ 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

dynamics between experience of illness, self-management and seeking help.

Conclusion

The chronic care model^{6–9} 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 research²⁴ 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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