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.


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.
### Instructions

This form has been filled in as an example.

#### Smoking status
**Ask ALL patients aged 18yrs+**:
Which of the four categories best describes their smoking status?
- Tick one box.

#### Current drugs for this problem:
- Indicate any drugs currently used to treat this problem.
- Indicate drug name, dose and regimen.
- If there are no current medications, tick 'nil medication'.

#### Previous medication(s) for allergic rhinitis:
- Medication: Indicate which types of drugs have been used to treat this condition in the past.
- Tick as many medication types as apply.
- For drugs not listed, tick other and specify the type of drug in the space provided.
- Duration: Indicate the approximate duration of use of these drugs by writing a number and circling days, months or years.

#### Does this patient have allergic rhinitis?
- Yes [ ] No [ ]

#### Current drug(s) for this problem:
- Tick one or more:
  - [ ] No medication
  - [x] Antihistamines
  - [ ] Nasal Corticosteroids
  - [ ] Allergen treatment injections
  - [ ] Other-specify

<table>
<thead>
<tr>
<th>Drug(s)</th>
<th>Dose</th>
<th>Regimen</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Rimesart</td>
<td>100mcg</td>
<td>bd</td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Previous medications for allergic rhinitis:
- Duration (number) (Circle option):
  - [ ] No medication _______ days/months/yr
  - [x] Antihistamines _______ days/months/yr
  - [ ] Nasal Corticosteroids _______ days/months/yr
  - [ ] Allergen treatment injections _______ days/months/yr
  - [ ] Other-specify _______ days/months/yr
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:


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).

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.

Highest educational qualification obtained
Ask the patient their highest educational qualification obtained.
Circle ONE option only.

If YES...
1. Did this affect your:
   Sleep ............... Yes x
   Appetite ............ Yes x
   Work performance .... Yes x
   Relationships .......... Yes x

2. Did you seek help from:
   GP ................................. Yes x
   Other health professional......... Yes x
   Family or Friends ............ Yes x
   Nobody .......................... Yes x

3. Did you take medication?.... Yes x

In the past 12 months, was there a time lasting 2 weeks or more, when you felt anxious or stressed?
Yes No

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

If patient 18yrs:
Smokeys daily Yes x
Occasional smoker No
Previous smoker No
Never smoked No

Smoking status
Ask patients aged 18yrs:
Which of the four categories best describes their smoking status?
Tick one box:

$19$
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 nebules.

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:

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

---

**Severity of asthma reference card**

**Children**

<table>
<thead>
<tr>
<th>Severity*</th>
<th>Common features</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infrequent episodic</td>
<td>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.</td>
</tr>
<tr>
<td>Frequent episodic</td>
<td>Attacks &lt;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.</td>
</tr>
<tr>
<td>Persistent</td>
<td>Symptoms most days; nocturnal asthma &gt; 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.</td>
</tr>
</tbody>
</table>

**Adults**

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

* 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**

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

**ADULTS**

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

*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 / nebulizer) 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.)

**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**

<table>
<thead>
<tr>
<th>Asthma?</th>
<th>Yes</th>
<th>No</th>
<th>→ End</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severity</td>
<td>Child</td>
<td>Adult</td>
<td></td>
</tr>
<tr>
<td>Infrequent</td>
<td>Very mild</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Frequent</td>
<td>Mild</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Persistent</td>
<td>Moderate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Severe</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Current drug(s) Dose Regimen Form**

1. MDI / DPI / NEB
2. MDI / DPI / NEB
3. MDI / DPI / NEB

*MDI=metered dose inhaler DPI=dry powder inhaler NEB=nebulizer

**Spacer device used:**
Large vol. | Small vol. | For drug(s) 1/2 3 | For drug(s) 1/2 3
None | None | |

**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.
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.
Has the patient ever been diagnosed with any of the conditions shown:

- **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.

NB. Ischaemic heart disease may refer to stable angina, unstable angina, myocardial infarction or other ischaemic heart disease not specified.

- If the patient does not have any of these conditions, NO FURTHER questions need be asked.

---

### Has the patient had any of the treatments listed?

- **Either during a hospital admission or as an outpatient**
- Indicate which treatment(s) the patient has had (at any time).

- **Tick one or more boxes**

---

### Which cardiovascular medication(s) is the patient currently taking?

Tick the types of cardiovascular medications currently being taken by the patient.

- **Tick one or more boxes**

---

<table>
<thead>
<tr>
<th>Patient ever diagnosed with:</th>
<th>In the past 12 months, (for this condition(s),) has the patient had:</th>
<th>Has the patient had any of these treatments:</th>
<th>Which cardiovascular medication(s) is the patient currently taking?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ischaemic heart disease</td>
<td>Cardiologist consultation</td>
<td>Angiogram</td>
<td>Nitrate-subslingual spray/tablet</td>
</tr>
<tr>
<td>Stable angina</td>
<td></td>
<td>Angioplasty</td>
<td>ACE inhibitors</td>
</tr>
<tr>
<td>Unstable angina</td>
<td></td>
<td>Stenting</td>
<td>Nitrate - transdermal/oral</td>
</tr>
<tr>
<td>Hypertension</td>
<td></td>
<td>CABG (by pass)</td>
<td>A2 antagonists</td>
</tr>
<tr>
<td>Myocardial infarction</td>
<td></td>
<td>Thrombolytics</td>
<td>Beta blocker</td>
</tr>
<tr>
<td>Congestive cardiac failure</td>
<td></td>
<td>Not known</td>
<td>Ca channel blocker</td>
</tr>
<tr>
<td>Stroke</td>
<td></td>
<td></td>
<td>Other anti-platelet agents</td>
</tr>
</tbody>
</table>

*Note: If NONE of the above - END here.*
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.


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

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

Médications
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.

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

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

Does this patient currently have a depressive disorder?  
✔ Yes  ☐ No  → If No, End here

Is this a major depressive disorder?  
☐ Yes  ✔ No

If NO... How would you describe it? (specify)  
Mild depression and anxiety

How is the patient’s depression currently being treated?  
✔ Medication (name)  initiated by

1. Fluoxetine hydrochloride  GP / Specialist

2.  
GP / Specialist

☐ Counselling / therapy  Provided by  
GP / Specialist / Other

☐ No treatment
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.
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.

In the PAST 6 MONTHS:
No. of medications routinely taken: Prescribed
OTC
No. of GP visits: ............
No. of specialist visits: ....
Hospital admissions: ........
No. AHP Consults: 0 □ 1-5 □ 6-10 □ 11+ □

Patient lifestyle (Tick ONE only)
Living in the community independently ...... □
Dependent on care/other in the community □
Living in an institution .......................................................... □

Does the patient have either of:
DVA Health Care Plan .......................................................... □
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).

Present Status - GP assessment □ □
(Multiple response allowed)
Falls/ poor mobility? .................................................. □
Cognitive impairment/ psychiatric problem? .................................. □
Socially isolated, carer stress, loneliness? .................................. □
Incontinent? ................................................................. □
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.
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 care of 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 half-days as .5 days.
   - if no absences, write '0'.

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

3. 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 numbers.

4. If you advised them to take time off at today's
counter, 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.

<table>
<thead>
<tr>
<th>If patient is 18yrs+</th>
<th>Smoking status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smokes daily</td>
<td></td>
</tr>
<tr>
<td>Occasional smoker</td>
<td></td>
</tr>
<tr>
<td>Previous smoker</td>
<td></td>
</tr>
<tr>
<td>Never smoked</td>
<td></td>
</tr>
</tbody>
</table>
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 minute’s 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:


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?
1. 
2. 
3. 
4.

Was this service provided at a time when your practice is normally closed? 
- Yes 
- No

What are the usual after-hours arrangements for this patient?
- None
- Normal practice
- By special arrangement

Finish Time

AM / PM
(please circle)