In search of attachment:
the experiences of chronically ill women
transitioning between family physicians
in rural Ontario

by
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Thesis Submitted in Partial Fulfillment
of the Requirements for the Degree of
Master of Public Health

in the
Master of Public Health Program
Faculty of Health Sciences

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SIMON FRASER UNIVERSITY
Summer 2012

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Abstract

Most Canadians receive basic health services from family physicians who play an important role in chronic disease management. Canada, however, has an endemic shortage of family physicians and consequently, a large population of unattached patients. Physician scarcity is particularly acute in rural regions, leaving patients transitioning between family physicians at risk for not readily finding a new doctor. To ensure patient-centred solutions to this barrier to care, policymakers need to inform their responses with an understanding of the patient experience. This qualitative study explores the experiences of chronically ill, rurally situated Canadian women transitioning between family physicians with the goal of providing insight into how the system supports these patients. The study reveals the presence of a multi-phase transitioning trajectory. Participants’ accounts indicate that efforts to attach to a regular family physician were hindered by the lack of available doctors and by gaps in system support within each transitioning phase.

Keywords: family medicine; attachment; unattached patients; access; rural
Acknowledgements

I would like to offer my thanks to my senior supervisor, Dr. Valorie Crooks. She was generous in accepting me as her student and taught me a great deal over the course of my thesis. I would also like to thank Dr. Laurie Goldsmith for her ongoing support and mentorship throughout the entirety of my program. Lastly, I would like to acknowledge the agencies that supported my studies: the Canadian Institutes of Health Research, the Public Health Agency of Canada and the Western Regional Training Centre for Health Services Research.
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1. Introduction

Over the last decade, considerable public attention has been paid to the number of Canadians who do not have a regular family physician (1-3), and thereby lack what is known as attachment (4-8). To understand Canada’s population of unattached patients, it is important to situate this phenomenon within the context of the primary care delivery system and to examine the implications of the current shortage of family physicians for a patient’s ability to use health services. It is equally important to examine the experiences of being unattached and searching for attachment from the patient perspective, so that policy and program responses to this gap between supply and demand are informed by an awareness of patient priorities. At this time, we know little about the experience and consequences of being unattached and searching for attachment (9), especially for individuals who are managing health conditions that require ongoing consultation with health care providers (10). The goal of this thesis is to address this particular gap in knowledge by exploring the experiences of rurally situated, chronically ill women who had to transition between family physicians and search for attachment in the midst of a physician shortage.

The intent of this introductory chapter is twofold. Firstly, it is to frame the inability to attach to a family physician, due to the physician shortage, as an issue of access to primary care and within this framework, to examine the heightened need for attachment for those who are chronically ill and the barriers to attachment for those who reside in rural communities. Secondly, against that backdrop, it is to outline the qualitative study I have undertaken for this thesis, which set out to capture the common elements in the

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1 Attachment is a term describing a regular, ongoing relationship between a family physician and a patient. The Health Analytics Branch of the Ontario Ministry of Health and Long-Term Care describes attached patients as those with regular family physicians, while unattached patients are those without regular doctors. Please see Reference #8 for more information.
experiences of a group of chronically ill women in rural Ontario searching for attachment after losing a family physician.

1.1. Problem Statement

Primary care is considered the bedrock of the Canadian health care system (11-13). As a health system domain, the mandate of primary care is to provide patients with ongoing preventive and routine health care, and to enable coordination of specialized care as needed (13). Historically, delivery on this commitment has fallen to the family physician who provides basic care over the life course and serves as gatekeeper to specialist and ancillary services (14). Although most Canadians are attached to a regular family physician (13, 15), it is estimated that roughly a quarter of Canadians encounter barriers when seeking routine care (16) and there are a significant number who are unable to find an available family physician (17). The phenomena of underserved and unattached patients have contributed to a growing pressure to reconsider the health system’s reliance on a primary care delivery model based on a one-to-one patient-family physician relationship (11-13, 15).

Over the last decade, there has been a renewed interest in reinventing primary care, sparked in part by public pressure (18). While Canadians remain committed to a health system long considered a source of national pride (19-21), they have expressed doubts about its performance and long-term sustainability (20-22). At the heart of these concerns lie issues of timely system entry and use of care (21). Polls indicate that only 65% of Canadians feel they have prompt receipt of health care services from family physicians and roughly half are concerned that timely engagement with the health care

2 In Canada, primary care is delivered by both general practitioners and family physicians. In the interests of brevity, in this thesis the term family physician is used to cover both of these designations. While the domain of practice is the same for general practitioners and family physicians, the latter are designated as specialists and have completed two years of postgraduate training in order to be certified. For more information, please see http://www.cma.ca/multimedia/CMA/Content_Images/Inside_cma/Membership/profiles/Family-Practice_e.pdf.
system will worsen in the future (20). In the late 1990s and early 2000s various federal and provincial commissions echoed this concern, and the Kirby and Romanow reports recommended enhancing primary care delivery to ensure Canadians are able to receive the care they need, when and where they need it (11, 12).

As Canadian primary care reform has begun to gain momentum (18), a design weakness in the traditional and still normative model of primary care has become apparent. The almost exclusive reliance on the family physician to shoulder the obligations of primary care has led to a population of unattached patients – those lacking an ongoing relationship with a regular family physician. Changes in the volume and practice patterns of family physicians (23-25) have contributed to roughly 4.4 million Canadians being unattached (17), and there is concern that these patients may be generally underserved (26, 27), particularly with regard to preventive care (28-30).

While policymakers explore the system-level efficiencies to be gained in new delivery models (18), there is a need to better understand the patient experience of both being attached to a personal family physician (31, 32) and of being unattached (9, 10). Little is known, for example, about how patients are managing when they separate from a family physician in the midst of the current physician shortage – both in terms of finding a new usual source of care and arranging to receive care in the interim. To ensure that reform initiatives factor in patient priorities, policy must be informed with an understanding of how attachment, or the lack of it, affects a patient’s ability to use the system. And the need for, and barriers to, use of primary care differ across patient populations. For the growing number of Canadians with chronic disease, need can be very high (33, 34). In rural Canada, where populations tend to have high concentrations of seniors (35) who are, in turn, at greater risk for chronic disease (34), the supply of family physicians tends to be proportionately lower than in urban centres (36, 37). As such, the intersection of high need for care and low supply of available family physicians may prove to create particular challenges achieving attachment to a family physician for chronically ill, rural Canadians. My thesis seeks to examine this phenomenon through the lens of the patient.
1.2. Background

In this thesis I qualitatively explore the experiences of a sample of chronically ill, rural women searching for attachment while transitioning between family physicians. My understanding of the potential challenges faced by these patients, and the design of this study, are informed by two related domains: (1) the centrality of the family physician to primary care in Canada; and (2) the influence of the traditional primary care delivery model and current deficit in family physicians on patients' ability to avail themselves of primary care services, in particular for chronically ill and rural patients. In this section I examine the literature pertaining to these domains.

1.2.1. Primary Care in Canada

Primary care is the foundational level of a health care system that “. . . provides entry into the system for all new needs and problems, provides person-focused (not disease-oriented) care over time, provides care for all but very uncommon or unusual conditions, and co-ordinates or integrates care provided elsewhere or by others” (p.8-9) (38). Within the Canadian health system, primary care serves patients in two fundamental capacities. The first component of primary care is the provision of “first-contact services” over the life course, ranging from prevention to ongoing care for basic medical conditions to palliative and end-of-life care (13). The second component of primary care is the coordination of specialized care through referral to secondary and ancillary providers and hospitals (13). These services are typically delivered by means of patient attachment to a regular family physician (13, 15).

Having an ongoing attachment to a single family physician is the norm in Canada (14, 15, 17). Within the Canadian health care system, the primary care physician is uniquely charged with fulfilling the mandate of primary care by assuming stewardship of fundamental cradle-to-grave patient care and serving as gatekeeper to specialist, and in some instances, ancillary services (14). And while changes on the supply side of primary care, from reduced numbers of family physicians to new delivery models, mean that some Canadians receive primary care services through alternatives to this patient-family physician dyad (17, 33), the medical home model, endorsed by the College of Family
Physicians of Canada (CFPC), stresses the importance of achieving ongoing attachment to a personal family physician (14, 39, 40).

The concept of a medical home has been identified as an effective model for delivering the four essential dimensions of primary care, namely: first point of contact with the health care system; ongoing care; comprehensive care; and coordination of and referral to specialist care as needed (38, 41). This model positions the personal family physician at the centre of the care experience (14, 39, 40). In September 2011, the CFPC published a vision statement recommending that every Canadian have a medical home that supports the *Four Principles of Family Medicine* – the first of which is the centrality of the patient-physician relationship (14). While the CFPC medical home model espouses team-based care, they are careful to stipulate that every patient should have a “most responsible provider” in order to realize the benefits of an ongoing, trusted relationship with a primary care physician (14). Acknowledging that there are currently too few family physicians to meet the needs of Canadian patients, the CFPC has set a goal of every Canadian having a personal family physician by 2020 (14).

Attachment to a personal physician offers patients the opportunity to experience continuity of care, considered by many to be an essential attribute of good primary care (42, 43). Continuity of care has been described as encompassing three longitudinal dimensions (44, 45). *Informational continuity* is the development of knowledge about a patient over time and the application of that knowledge to ongoing care (44). *Management continuity* is the coordination of care over time in response to a patient’s changing needs (44). While these two dimensions are critical factors in primary care, it is *interpersonal continuity* that is considered the signature characteristic of this level of care (44). This dimension of continuity is also the only one that is absolutely dependent on attachment to a usual source of care provider. It is the product of a relationship built over time and characterized by personal knowledge, affiliation and a sense of ongoing commitment and responsibility on the part of the physician toward the patient (44, 46, 47). This level of commitment to a patient paves the way to “being known” – a state that extends beyond a physician’s simple familiarity with a patient’s history to encompass an awareness and acknowledgement of the patient’s personal values and preferences regarding care (48).
Studies have shown that patients generally prefer having an established relationship with a regular doctor (49-51), and interpersonal continuity has been associated with a number of patient benefits. Such continuity has, for example, been credited with facilitating communication between patient and physician, and elevating the sense of trust in a physician’s care (10, 44, 48, 52). Good patient-physician communication has been positively associated with an increased sense of patient well-being and symptom resolution (53), while interpersonal continuity has been positively correlated with patient satisfaction (52-54) and a sense of security in being cared for (55). From a clinical perspective, a critical review of the literature reveals that interpersonal continuity has been associated with increased exposure to preventive care, and reduced hospitalizations (32).

The value of family physicians has been measured in various ways. Primary care physician supply has been associated with greater life expectancy and higher self-rated health (56), better health status as measured by the Health Utility Index (57), and greater use of preventive care (58). And there is a substantial body of evidence in support of an array of benefits associated with receiving care from a regular primary care physician (59). Patients who reported having a primary care physician as their usual source of care were found to have lower adjusted subsequent five year mortality rates than patients whose usual source of care was a specialist (60), indicating better overall health (59). Other benefits include timely system entry (30, 61), greater ease of communication (62), lower use of emergency departments (63), greater receipt of preventive care (30, 63, 64), better rates of screening (65), fewer unmet needs (41), and greater patient satisfaction (41) compared to patients without a usual physician. While there is a considerable body of evidence supporting the benefits of receiving primary care services from a regular family physician, less is understood about the health consequences of being without one for a sustained period of time. Preliminary evidence, however, indicates these patients may receive fewer preventive health services (10, 29).

1.2.2. The family physician shortage as a barrier to access to primary care

Andersen and Davidson define access to health care as the “actual use of personal health services and everything that facilitates or impedes their use” (p.3) (66).
This definition captures Andersen’s dimensions of realized access as the actual use of services and potential access as the relative presence of “enabling resources” that facilitate that use (67). In this typology, variance in realized access that is primarily determined by differences in demographics and individual need for care is deemed equitable (66-68). Equitable access, therefore, presupposes that a health care system is appropriately configured and adequately resourced so that services are distributed to meet the needs of the population it serves. When, however, access to care is determined by factors beyond demographics and need, such as socio-cultural factors like ethnicity or individual resources like personal income, this is deemed inequitable access (66-68). Given the organization of primary care delivery in Canada, an inadequate supply and distribution of family physicians could precipitate a state of inequitable access if actual use of health services is impeded by lack of attachment to a regular doctor as a consequence of being unable to find an available physician.

Andersen and Davidson’s model of health services use identifies two domains of influence on access. At the individual level, use is influenced by three categories of characteristics: predisposing (e.g. age); enabling (e.g. having insurance); and need (e.g. a diagnosis) (66). These individual characteristics are, in turn, influenced by the same three categories of characteristics at the contextual level. Contextual predisposing characteristics include cultural norms about seeking care; enabling characteristics encompass health policy and system configuration; and need at this level is a function of the overall health of a community (66).

For health policymakers interested in facilitating access, there is a pragmatic need to focus on characteristics that are both influential and within their power to manipulate – i.e. those that are policy sensitive (68, 69). Andersen described variables that are “mutable” or modifiable in ways that can positively influence access. Factors such as age are deemed to have low mutability; contextual level enabling resources, on the other hand, are seen as highly mutable (67, 70). From a policy perspective the concept of potential access, which is foundational to equitable access, rests on the premise that policy-sensitive enabling resources can be manipulated to increase or decrease the likelihood of system use (66).
Potential access involves enabling characteristics at both the individual and contextual levels. Andersen and Davidson’s model describes an influential relationship between these levels (66). At the individual level, having a usual source of care is considered an enabling characteristic and in the Canadian health care system, the centrality of the family physician to the delivery of primary care renders attachment to a regular doctor particularly important. One’s ability to attach, however, is profoundly influenced by health system enabling characteristics at the contextual level – namely health policy, financing and system organization (66). In Canada, primary care is organized so that successful use of health care services is predicated on an individual having some means of engaging with a family physician, whether through an ongoing relationship with a single doctor or serial relationships with multiple family physicians. For access to be equitable, then, the health system should be resourced with an adequate supply and distribution of family physicians to meet the needs of all patients seeking care. Currently, however, there is a gap between patient demand and physician supply within Canadian primary care.

1.2.2.1. Canada’s family physician shortage

Canada, like other countries, is grappling with a shortage of family physicians (71-73). In 2010 Statistics Canada estimated that approximately 13% of Canadians, or roughly 4.4 million people, were without a regular family doctor (17). While in some instances, managing health care needs without a usual physician was found to be a matter of choice (17), for most patients being unattached to a regular doctor was a function of a lack of available family physicians (17, 36, 71, 72).

The rate of growth in volume of all Canadian physicians slowed in the late 1980s and through the 1990s as policies were implemented reducing seats in medical schools and restricting numbers of international medical graduates practicing domestically (24, 74). Using data from the Canadian Institute for Health Information, Evans and McGrail demonstrated that the number of family physicians per 10,000 population fell over the course of the 1990s and the early 2000s – in part because of reduction in medical school enrollment and in part because of a new requirement introduced in 1993 extending family practice residency by a year (74). Growth in volume, however, is on the rise again: the number of overall physicians per 100,000 Canadians was 203 in 2010,
compared to 151 per 100,000 in 1980 (23). Numbers of family practice graduates are also starting to increase again (74). Nevertheless, despite these positive trends, concerns about a family physician shortage persist (24, 74), as does the considerable population of Canadians currently without a regular doctor (17).

While absolute numbers of physicians are on the rise, there is a countering trend that may be contributing to the phenomenon of unattached patients, namely a shift in the balance of volume between family physicians and secondary and tertiary specialists (e.g. neurologists, anaesthetists, cardiologists). This redistribution became apparent during the 1990s as greater numbers of medical students chose to specialize (15, 24). In 2010, for example, specialists in Quebec and Ontario outnumbered family physicians (23). Historically, these two groups have been roughly equal in number (23). A review of the Canadian Resident Matching Service data from 1994 to 2004 found that applicants whose first choice was family medicine dropped from 423 in 1994 to 339 in 2004 (75). Reasons for this shift away from family practice vary. There is evidence of a growing lack of interest in this discipline (73, 76, 77) and it has been posited that the rapid growth of technology, and with it the sub-specialties, has shifted both focus and prestige away from family practice (25). Reports of long working hours and relatively lower remuneration have also been suggested as potential disincentives to selecting this discipline of practice (25).

Demographic trends among doctors and changes in approach to practice are also thought to be affecting family physician capacity with regard to workload volume. The percentage of the family physician workforce that is female has risen steadily over the last 20 years (78). Female family physicians tend to bill fewer hours than their male counterparts, spending less time on direct patient care (24, 78, 79). The family physician population is also aging, and physicians over 65 tend to have reduced volume compared to younger practitioners (24). And as older physicians begin to prepare for retirement, their willingness to take on new patients diminishes and is not being offset by younger physicians who tend to have smaller practices (74). Changes in practice patterns among new family physicians may also be contributing to shortages. A review of intergenerational shifts in workload volume found that in 2001, physicians under the age of 35 had provided between 18%-23% fewer office assessments than physicians in the same age group had in 1992 (79). A Canadian cohort analysis found that over the period
from 1983 to 2002, the average hours of weekly direct patient care reported by family physicians fell by almost 16% (78).

The shortfall in physicians required to adequately meet the needs of Canadians has been estimated at roughly 3200 family physicians (71). While causes for the lack of available family physicians may be various, it is clear that many Canadians remain vulnerable to challenges gaining entry to care. Over the last decade Canadians have reported difficulties receiving needed primary care (33, 80-82). In a 2008 survey of over 11,000 Canadians, 13% of the respondents who reported needing routine or ongoing care also reported barriers to receiving that care, while 21% of those who needed to receive primary care services rapidly for an acute minor problem experienced challenges doing so (33). When asked to describe the nature of those challenges, the most common responses were delays or difficulty in getting an appointment and delays in actually seeing a physician (33). Some of the survey respondents were part of the population of over four million unattached Canadians. In general, little is known about how these patients are engaging with the system and with what degree of success (9, 10), although Statistics Canada has reported that a majority of unattached patients responding to the Canadian Community Health Survey availed themselves of walk-in clinics or emergency departments (17). Whether a patient’s challenge is getting a timely appointment or finding an available family physician, it is apparent that the current volume and practice patterns of these practitioners are influencing patients’ ability to use care. And for those patients who find themselves unable to attach, this phenomenon highlights how deficits in enabling resources at the contextual level can translate into barriers to use of health services at the individual level.

1.2.3. **Considering attachment to a family physician as an enabling resource for two patient populations**

My thesis explores the experience of searching for attachment within a group chronically ill women living in rural communities. The concept of potential access posits that having sufficient enabling resources facilitates use of health services and in the Canadian context, attachment to a regular family physician is a key enabling resource at the individual level. Chronically ill and rural patients each have a set of distinct pressures to consider with regard to achieving that attachment. For the chronically ill, there is an
elevated need for primary care that may render attachment especially important. Rural patients, on the other hand, whatever their level of need, have particular barriers to consider when searching for attachment.

### 1.2.3.1. The importance of attachment for patients with chronic disease

In Canada, as around the world, chronic disease is on the rise (83-85). A recent Canadian analysis revealed important trends associated with seven chronic conditions (arthritis, cancer, chronic obstructive pulmonary disease, diabetes, heart disease, high blood pressure, and mood disorders) (34). One of these trends is that roughly a third of Canadians experience one of these diseases, with prevalence rising to 75% among patients over 65. Further, of those who experience a chronic condition, approximately one third have more than one chronic diagnosis; arthritis and high blood pressure, for example, are often diagnosed in the same patient. Chronically ill patients are more likely to be women (36% versus 29% for men) and to report poorer health status and moderate to severe disability.

If equitable access to primary care is understood as use primarily determined by need (66), then the health care system has to be appropriately and sufficiently resourced to service patients with complex conditions and high needs, including those managing chronic illnesses. Vertical equity can be understood as ensuring that those with greater than usual need for care have a greater than usual opportunity to receive that care (86, 87). The medical management of chronic conditions involves ongoing oversight of medication and care plans (88), requiring continual engagement with the primary care system. An analysis of health service utilization patterns indicates high usage rates for chronically ill patients, especially for those with multiple conditions or co-morbidities (34). Patients managing chronic illnesses, comprising about 33% of Canadians, account for 51% of family physician consults and 55% of consults with specialists. Chronically ill patients, therefore, can be seen as having an elevated need for attachment, making an adequate supply of available family physicians vital for meeting that need.

Family physicians are considered the lynchpin in providing optimal care for those living with chronic conditions (39, 40), and chronically ill patients in Canada are more likely to have a regular family physician (92% versus the national average of 85%) than patients without chronic disease (34). An international survey of chronically ill patients
found that those who were attached to a regular physician within a medical home model, reported fewer gaps in care coordination and more opportunities to learn about managing their own care (89), compared with patients who were not receiving care from a medical home. Attachment, and with it the opportunity for interpersonal continuity of care, could be anticipated to hold higher value for chronically ill patients whose health concerns are often complex, are typically not resolvable and must be managed over time. Data on patient preference do indeed indicate that both chronically ill patients and women (who in turn are at a higher risk for chronic disease) prefer to have a consistent, ongoing relationship with a family physician (10, 48, 50, 51, 55, 90), and it has been suggested that those who are vulnerable, including those managing chronic illnesses, may have a greater need for the security that comes with attachment (90).

Chronically ill patients who had experienced both short- and long-term relationships with physicians identified key aspects that brought value to a long-term relationship. These include trust, confidence, and an overall sense of coherence to the patient experience, culminating in a sense of security (48, 55). These sentiments are echoed by a group of chronically ill, unattached Canadian patients who perceived the value of attachment to extend beyond the benefits of ongoing clinical care. For these patients, attachment encompassed a trusting relationship with a family physician which they felt supported greater honesty on their part, as well as greater comfort with the processes of care (10).

While it is apparent that chronically ill Canadians are largely managing to attach to a family physician (34), there is nonetheless evidence that they are having challenges with physicians having adequate capacity to meet their needs. An international survey of chronically ill patients from eight nations found that Canadian patients were the least able to secure same-day or next-day appointments when ill (81). It was also found that their rates of use of emergency departments for matters they felt could have been dealt with by a family physician, had she or he been available, were the highest (81). As such, there is evidence that the burden of potential access, in terms of adequate system resources, is not being sufficiently met for this population of patients.
1.2.3.2. Barriers to attachment for rural patients

Health and the experiences of seeking attachment and receiving care are influenced by many factors, including place. Rural communities are characterized as places with small populations, limited access to material and financial resources, and a greater vulnerability to health service and health human resource shortages due to their distance from major urban centres (36, 91-93). The influence of rurality on health has been described as both an asset and a liability (94). Rural living is seen as health promoting in many aspects, from the potential for close, supportive interpersonal relationships that arises from life in small, tight knit communities, to the benefits of residing within natural, idyllic environments with ample opportunity for recreation (94-96). At the same time, rural communities may also be seen to undermine health given their association with social vulnerability, lower incomes and poverty, and poorer health status when compared to urban communities (94, 97-99). For rural residents with poor health status, including those with chronic disease, the inherent vulnerability to health service provider shortages may leave them at risk of not being able to use health services according to their needs.

In a scenario of equitable access, actual need for health services should be a primary determinant of use. While there is evidence that rural patients do not differ remarkably from their urban counterparts in believing in the value of seeking care (100), they have been found to use primary care services less often, for both ongoing and acute problems, than urban patients (101, 102). It has been suggested that differences in other health beliefs may partially explain this trend. A study looking at low income rural residents, for example, discovered they were less likely to seek preventive care and more likely to turn to family and friends before seeking medical care than urban patients (103). A survey of rural and urban patients found the rural residents had different decision making priorities when choosing to go to a physician (104). Rural patients put greater stock in their relationship with their family physician, while urban patients were more likely to shop around for care and use more services (104).

Differences in perceived need for care can lead to an equitable variance in realized access to care. If needs are equal, however, horizontal equity mandates an equal opportunity to use care (86, 87). Patients in rural Canadian communities have
particular challenges with enabling resources that affect their capacity to achieve attachment and use health services (102, 105-107). One of these challenges is the distribution of health care services within the context of rural geography. Rural areas tend to have widely dispersed populations, small communities with constrained service capacity, and centralization of “higher order” facilities and services in scattered urban centres (108, 109). Rural patients may, therefore, have fewer local services and a greater requirement to travel for care (109).

The physical distribution of services is one supply-side consideration affecting a rural patient’s ready use to primary care services. A related consideration is the actual quantity of available health human resources. Volume of providers is often imbalanced between urban and rural regions (36). The challenges of recruiting and retaining family physicians in these low resource settings often constrain the supply of local doctors and render that supply unstable (36, 110). Many, but not all, of the areas thought of as rural within Canada fit within Statistics Canada's rural and small town or RST definition: namely communities lying outside the commuting zone of a census metropolitan area (population ≥ 100,100) or a census agglomeration (population 10,000-99,999) (111). For Canadians living in RST communities, finding a physician can be challenging. In 2004, the RST population comprised 21.1% of Canadians, yet only 16% of family physicians and only 2.4% of specialists had practices in these communities (36). In keeping with these numbers, a study looking at health service utilization in rural Canada found that anywhere between 35% and 61% of rural patients who were not attached to a family physician reported this as a function of lack of available physicians, compared to only 13.2% of unattached urban residents (109). Further, rural physicians are not only in somewhat short supply. They also have markedly high rates of turnover – in some instances as much as 40-100% higher than in urban areas (112-114). The reasons for this turnover range from isolation, to lack of local amenities, to high workload (113).

The high workload reported for rural family physicians is, in part, a consequence of a trend toward a broader scope of practice for these providers, due to low volume of local specialists (36). With specialists concentrated in urban areas, rural family physicians often expand their practice boundaries to provide elements of complex care typically covered by specialists (36). This can render attachment to a personal family physician even more valuable in a context where they may also be in very short supply.
And rural communities tend to have a high proportion of seniors (35). Seniors have an elevated risk for developing chronic disease (34), which tends to carry with it a heightened need for care across the continuum.

There are, therefore, features of the rural care experience that can serve, individually or collectively, to exacerbate the imbalance between patient demand for attachment to a family physician, and the system’s ability to consistently meet that demand. This imbalance once again underscores the critical relationship between contextual and individual enabling resources in facilitating realized access.

1.3. Thesis Purpose

The overall goal of my thesis is to contribute to the knowledge base about the patient experience of searching for attachment to a primary care physician in the current climate of family physician scarcity, by shedding light on how a deficit in system level enabling resources translates at the individual level. To date, the experience of patients searching for attachment as they transition between physicians has not been well examined. This qualitative study explores the perceptions of a sample of chronically ill women who had to manage transitioning, starting with separation from one family physician through to attachment to a new usual source of care, in rural communities where physician supply was limited and physician turnover was high (115, 116). The objective of this exploration is to identify and describe the participants’ shared understandings of the nature of the transitioning process and the extent to which the system enabled or impeded these patients through that process. My research question is, therefore: How do chronically ill women living in a rural area characterized by high rates of family physician turnover experience transitioning between family physicians?

The population of patients selected for this study, namely women managing rheumatic diseases in rural Ontario, was chosen because their health conditions elevated the likelihood that participants would have considerable need to access primary care (117, 118). Their place of residence also elevated the likelihood that they might need to transition between family physicians (36, 109, 113, 114), and encounter difficulties doing so. It was anticipated that this particular confluence of heightened
demand and constrained supply would throw into relief the phenomena of searching for, and achieving, attachment.

The participants of this study resided in Grey and Bruce Counties, located in southwestern Ontario. Largely rural, Grey County had a population of 92,568 in 2011, while Bruce County’s population was 66,102 (119, 120). In keeping with many rural Canadian communities, there is a strong and growing cohort of seniors in both Counties. The 2011 census figures showed an increase in residents over the age of 80 since 2006: in Grey County there was a 19% increase in this age group (119, 121); in Bruce County, an 11% increase (120, 122). And these Counties have a history of physician shortages. A study on access to general practitioners in Grey and Bruce Counties using census data and medical directories from the period of 1901 to 1981 found this area followed trends that characterize rural communities in Canada (123). In the latter half of the study period, there was a move toward centralization of medical services, an influx of retirement-age residents, and a concentration of family physicians in urban areas, leaving the smallest and least urbanized communities at a disadvantage (123). Challenges with a physician shortage continue in the Counties to this day and have sparked local initiatives to counter this deficit. In Grey County signs have been posted along county roads welcoming doctors (115), while the Grey-Bruce Health Service now assists local residents with registration in Health Care Connect, the provincial program designed to assist unattached patients connect with available family physicians (116).

1.4. Thesis Rationale

A robust primary care system is essential to meeting the health needs of Canadians (13), especially as the population ages and the prevalence of chronic disease rises (124, 125). A new wave of Canadian health reform began in the early 2000s (18), catalyzed in part by reports from the Kirby and Romanow Commissions which urged greater investment in primary care (11, 12). In 2002 the Primary Health Care Transition Fund allocated $800 million to support pilot initiatives and research designed to strengthen the foundations of primary care (18, 126), and the 2003 Health Accord and the 2004 10-Year Plan both reconfirmed a national commitment to prioritizing improvements to this level of care (18, 127). Principal reform goals include improving
access to primary care, exploring alternative models of delivery and bolstering support for chronic disease management (18). In response to these goals, reform initiatives are being piloted across the country, many of which centre on exploring new primary care delivery models (18). The Canadian Institutes of Health Research (CIHR), recognizing the critical importance of primary care at the community level, recently launched a Signature Initiative that allocates funding for research in support of stronger primary care (128). The goals of this initiative are “... to improve access to appropriate community-based primary healthcare; enhance the patient experience; and contribute to better health outcomes” (128).

Understanding the challenges that Canadians are experiencing finding available family physicians is an integral component of this primary care policy and research agenda. While all the reasons behind the Canadian family physician shortage may not be fully identified or the tactics for redress fully agreed upon (74), there is a general consensus that a gap exists between demand and supply for Canadians who are not attached to a family physician and wish to be (1-3, 74). In addressing any barrier to system use, there is a pragmatic imperative to focus on factors that are within the system’s control and have the potential to positively influence potential access (105). Recognition that Canadians are having attachment issues has begun to drive a variety of system-based efforts to address this barrier to care, from increasing enrollment in medical schools (18, 74), to provincial pilot programs aimed at helping unattached patients (129-131), to demonstration projects of new team-based delivery models (18).

Initiatives to address the family physician shortage, however, are in their early stages (18), and will necessarily take time to structure, implement and evaluate. In the meantime, there persists a population of Canadians who are not attached to a family physician in a system where the family physician remains the principal gatekeeper to the full spectrum of care. During this formative period, I believe it is critical that the patient perspective be captured as an input to the development and evaluation of primary care reform. Accordingly, my research contributes to understanding one dimension of that patient perspective by shedding light on how chronically ill, rural patients perceive their experience of losing, and then having to find, a family physician in a climate of scarcity. Our appreciation of how patients currently manage the transition to a new doctor, especially if it involves an extended period of being unattached, is relatively undeveloped.
Understanding how these patients move between family physicians will provide valuable information about how the system is, or could be, enabling this transition.

1.4.1. Capturing the patient perspective

While designing health service delivery to be patient-centred remains more of an aspiration than a reality (132), there is a growing awareness that the values and needs of the patient constitute an important input into policy decisions (132-134). A patient-centred system is one in which policies are developed and services are designed with the intent of first and foremost meeting patient needs. Such a system must, therefore, be founded on an understanding of how the patient prioritizes elements of the care experience (133). Achieving that goal can only be fully accomplished by viewing system engagement through the patient’s eyes (134-136), rendering the patient experience a critical datum for health policymakers and administrators (88). I view my thesis as an opportunity to provide on-the-ground evidence, drawn from patients’ lived experiences, which can inform patient-centred policy decisions.

When considering issues of system entry and use, health policymakers tend to focus on data that are easily captured and quantified, such as utilization rates or numbers of personnel or availability of services (105). While these data are important, this quantitative lens fails to capture the experience of the actual patient who is, or is not, able to use the system according to his or her need. Although it is likely that in the rural context the family physician shortage may pose a challenge for patients seeking to attach, this can only be confirmed by capturing patients’ first hand perspectives on searching for attachment.

Capturing the patient perspective in any depth is best achieved through qualitative methods, which are increasingly used in research informing social policy (137) and are seen as an effective means of providing insight into the actual experiences and “world view” of the actors for whom policy is being developed (138). Ritchie and Spencer outline a spectrum of four categories of policy-relevant questions that qualitative research can address: contextual (identifying what is); diagnostic (examining the causes of what is); evaluative (gauging the effectiveness of what is); and strategic (identifying policies or plans) (137). Delineating the context and defining the actual
problem are critical first steps in the process of creating policy (139). This manner of foundational exploration is needed to enable identification of the processes of transitioning and attachment from the patients’ vantage point because, as yet, the patient version of ‘what is’ is not well understood. Qualitative methods are particularly appropriate when issues need to be identified in the early stages of understanding a phenomenon (140) because they allow access to experiential data that illuminate the context and dimensions of an issue (137). This makes a qualitative approach a natural choice for gaining an understanding of the patient experience of transitioning between family physicians in rural Canada, as this phenomenon remains relatively undefined.

Rural health policymakers are charged with making discretionary decisions about allocating scarce resources to enhance primary care delivery to meet the needs of an aging population with a growing prevalence of chronic disease (141, 142), and they must do so with an unstable and often inadequate supply of family physicians. For policymakers interested in developing a patient-centred solution, I believe it is critical for them to understand how patients trying to find a doctor in the midst of this shortage define “the form and nature” (137) of transitioning. This will allow policymakers to hear first hand how system level attributes impact the patient experience, thereby enabling them to factor patient priorities into a policy response. Gaining a solid grounding in “what is” from the patient’s perspective opens up the opportunity to identify mutable factors that will allow the system to support patients in search of attachment, in both the short- and long-term.

1.5. Thesis Study Design

The study undertaken for this thesis constitutes the analysis of an existing dataset that had not previously undergone formal analysis. For my thesis project, I was initially given non-contextualized access to the dataset in that I was not provided with the original study protocol, recruitment materials, interview guides or research question. My project scope included deriving a research question unique to my thesis, based on my examination of the data. The emergent thesis research question, however, aligned directly with the original research question. As a consequence, while the data collection and analysis were undertaken by different researchers, this study is not a conventional
instance of secondary analysis in the sense of “answering new questions from the old data” (p.3) (143). In fact a case has been made that the distinction between primary and secondary analyses may need reconsideration given that “. . . data are necessarily constituted, contextualised and recontextualised within any project” (144). This study does, however, reflect an important benefit associated with secondary analysis in that a new conceptual lens was brought to bear on a shared dataset (145), as the application of elements of Andersen and Davidson’s model to frame the exploration of transitioning was not part of the original study design.

1.6. Thesis Structure

My thesis is paper-based and, as such, is centred on a manuscript written for publication. The thesis comprises three chapters, of which this is the first. The second chapter is a manuscript written for submission to a peer-reviewed journal, *BMC Family Practice*, which profiles the qualitative research study undertaken for this thesis. The third chapter situates the findings from this study within the current context of access to primary care in rural Canada and suggests further opportunities for related research.
2. In search of attachment: a qualitative study of chronically ill women transitioning between family physicians in rural Ontario, Canada

2.1. Abstract

2.1.1. Background

Most Canadians receive basic health services from a family physician and these physicians are particularly critical in the management of chronic disease. Canada, however, has an endemic shortage of family physicians. Physician shortages and turnover are particularly acute in rural regions, leaving rural residents at risk of needing to transition between family physicians. The knowledge base about how patients manage transitioning in a climate of scarcity remains nascent. The purpose of this study is to explore the transitioning experience for chronically ill, rurally situated Canadian women to provide insight into if and how the system supports transitioning patients and to identify opportunities for enhancing that support.

2.1.2. Methods

Chronically ill women managing rheumatic diseases residing in two rural counties in the province of Ontario were opportunistically recruited to participate in face-to-face, semi-structured interviews. Interview transcripts were analysed thematically to identify emergent themes associated with the transitioning experience.

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3 This chapter will be submitted to BMC Family Practice with co-authors V.A. Crooks and L.J. Goldsmith.
2.1.3. Results

Seventeen women participated in this study. Ten had recently experienced transitioning; four with long-standing family physicians anticipated doing so soon; and the remaining three expressed concerns about transitioning. Thematic analysis revealed the presence of a transitioning trajectory with three phases. Descriptions of the detachment phase focused on activities related to the termination of a physician-patient relationship, including haphazard notification tactics and the absence of referrals to replacement physicians. For those unable to immediately find a new doctor, there was a phase of unattachment during which patients had to improvise ways to receive care from alternative providers or walk-in clinics. The final phase, attachment, was characterized by acceptance into the practice of a new family physician.

2.1.4. Conclusions

Participants often found transitioning challenging, largely due to perceived gaps in support from the health care system. Barriers to a smooth transition included inadequate notification procedures, lack of formal assistance finding new physicians, and unsatisfactory experiences seeking care during unattachment. The participants’ accounts reveal opportunities for stronger system presence during transition and a need for further research into alternative models of primary care delivery.

2.2. Background

For most Canadians the usual means of engaging with the health care system is through a family physician. This practice is reinforced by the system’s design which designates the family physician as chief steward of care over the life course and gatekeeper to specialist care (14). Canada, however, like many countries, is grappling with a shortage of family physicians for reasons varying from a growing lack of interest in family practice to changes in practice patterns (25, 73, 74, 77). At any given time over the last decade between four and five million Canadians were without a regular doctor (1, 17, 146), due in large part to an estimated deficit of roughly 3200 family physicians (71). This deficit is particularly acute in rural regions where on-going challenges with recruitment and turnover limit physician supply (36, 110, 112, 113). While 21% of
Canadians live in rural areas, only 16% of family physicians practice in rural communities (36). Rural rates of physician turnover, often linked to isolation and high workload, can be as much as 40-100% higher than in urban areas (112-114). As a consequence, rural Canadian patients are at risk of needing to transition – to detach from one family physician and source and attach to another. With an insufficient physician supply, this can be a challenging proposition.

Given the centrality of the family physician to the delivery of primary care in Canada, patients seeking on-going and preventive care, as well as specialist referrals, are best served through attachment to a family physician (14). Patients who are not attached have been found to be at risk for reduced receipt of preventive care and screening (29, 147). The traditional patient-family physician dyad, on the other hand, is seen as key to ensuring continuity of care (44), long considered an indicator of good health care (42, 43). There is a solid body of evidence pointing to the benefits associated with having a usual family physician, including more timely system entry (30, 61), more preventive care (30, 63, 64), better rates of screening (65), and greater patient satisfaction (41) when compared to patients who lack a regular family physician. And for rural patients there is the potential for an added benefit. With specialists concentrated in urban areas, some rural family physicians expand their scope of practice to encompass at least a portion of the services patients might normally receive from a specialist, including aspects of cancer care and chronic disease management (36).

In this study, rural communities are understood as places with small populations, limited material and financial resources, and a heightened vulnerability to health service and health human resource shortages as a consequence of their distance from urban centres (36, 91-93). These communities tend to have a high proportion of seniors (35), a group at risk for chronic disease (34). And in Canada, as around the world, the number of patients managing chronic illnesses is on the rise (83-85). Roughly a third of Canadians will develop at least one chronic disease, with prevalence rising to 75% among those over 65 (34). It is reasonable, therefore, to expect a high demand for chronic disease care in rural Canada.

Chronically ill patients have a heightened need for primary and specialist care (148). In the Canadian system, it is the family physician who is best positioned to
coordinate an integrated care plan across the full spectrum of health services – the foundation of optimal chronic disease management (39, 40). Health service utilization patterns confirm this reliance, with chronically ill patients accounting for 51% of family physician consults (34). Rural communities, therefore, are often in the unique position of contending with the simultaneous pressures of an aging population, rising rates of chronic illness, and endemic family physician shortages – all of which combine to put chronically ill, rural patients at risk for inadequate receipt of needed care.

For Canadians who become detached from a family physician, there is no guarantee of being referred to, or easily finding, a new regular physician. In a climate of family physician scarcity, a patient who detaches from a family physician may enter a process of searching for attachment that includes a protracted period without a usual doctor (149, 150). Detachment in rural communities is often triggered by turnover or retirement which can leave an entire practice of patients facing transition at the same time (149, 151). Many Canadian provinces issue guidelines regarding practice closure but their recommendations about assisting patients in finding new physicians vary (152-155), and it is unclear if and how these guidelines are being implemented by physicians. While there is evidence that turnover is associated with reduced patient satisfaction (156, 157), there is a relative dearth of research exploring this phenomenon and its effect on patients (156). And little is known about the experience of being unattached for a prolonged period of time which, in a climate of physician shortage, may happen following detachment (9, 10). There is scant understanding, for example, of how patients who are unattached manage care (9, 10), although it is believed they rely on episodic care through walk-in clinics and emergency rooms (17, 72). For most Canadians, however, managing care this way is not optimal (17). The ultimate goal for most unattached patients is attachment to a new doctor and a majority of patients express a preference for an on-going relationship with a regular physician (49-51).

With thousands of Canadian patients transitioning in a climate of scarcity, the knowledge base about how they are managing the process from detachment to attachment remains nascent. In this article we identify and examine common elements in this transition for chronically ill women managing rheumatic diseases in rural Ontario, Canada. These women live in communities where endemically low supplies of family physicians, exacerbated by high rates of turnover (36, 110, 112-114), can leave patients
at risk of losing and having to source new family doctors (112-114). As Canadian health policymakers work to facilitate attachment and system use through a range of primary care reform initiatives (18, 130, 158, 159), there is a need to inform system performance evaluation and policy development with an understanding of the patient experience (132, 133, 160, 161). We contend that understanding the experiences of these patients will provide policymakers and clinicians with needed insight into if and how the system supports rural patients faced with transitioning, and with that insight, the opportunity to explore short- and long-term possibilities for mitigating the challenges they encounter along the way.

2.3. Methods

The goal of this qualitative study was to explore the experiences of rurally situated women managing rheumatic disease (e.g., osteoarthritis, lupus, rheumatoid arthritis, fibromyalgia syndrome, scleroderma, gout, bursitis) who had transitioned or anticipated transitioning between family physicians as a consequence of physician turnover or retirement. Patients with rheumatic diseases were selected because of the prevalence of these conditions (34) and because management of this group of diseases can largely be undertaken at the primary care level (117, 118), heightening the importance of attachment to a family doctor. Female patients were targeted because they experience most rheumatic diseases at higher rates than men (34, 162) and they tend to place higher value on the continuity of care which can be an outcome of attachment, than male patients (163). The participants resided in Grey and Bruce Counties in Ontario, Canada. These counties were chosen because, like many rural areas in Canada, they have experienced a family physician shortage compounded by a high rate of physician turnover or retirement (115, 116), elevating the likelihood that local patients would, at some point, experience the loss of a family physician and need to transition to a replacement.

Given the exploratory nature of this study, and the goal of capturing the patient perspective on transitioning, a qualitative approach was employed. Data were gathered by means of face-to-face, semi-structured interviews which allowed the experience of transitioning to emerge in a patient’s own words and reflect her individual sense of what
was significant. As a patient’s experience with her health and health practitioner may touch upon sensitive issues, it was thought that the use of one-on-one conversation would enable the establishment of rapport and encourage the sharing of personal reflections (164). Approval for the study was granted by the Office of Research Services at York University, and by the Office of Research Ethics at Simon Fraser University.

2.3.1. Recruitment

The study used a purposive sampling frame, targeting women over the age of 18 living in Grey and Bruce Counties who self-identified as managing at least one rheumatic disease and who had experienced a turnover in their family physicians, or were lacking a regular doctor altogether. Participants were recruited opportunistically with the assistance of The Arthritis Society of Ontario, which mailed letters to its members in the pertinent counties containing information about the study, along with dates for the data collection period and contact details for the interviewer (VAC). Those interested in participating were asked to contact the interviewer for further information and to schedule a time and location for a face-to-face meeting. Eighteen women scheduled interviews within the data collection period, thereby creating the initial study sample.

2.3.2. Data Collection

Data collection took place over a three-week period, and all women who had scheduled an interview participated. Semi-structured interviews were selected as the method for data collection. This interview format enables the collection of both historical and current information (165) and allows for the development of a set of framing questions that remain sufficiently open-ended to allow respondents the freedom and flexibility to express their meanings in their own way (166). This flexibility also enables the interviewer to develop new questions and frame follow-up questions using respondents’ terms of reference (167). The interviews were conducted by a single interviewer (VAC) and took place in a location of the participant’s choosing. At the time of the interview, participants were offered the opportunity to select a pseudonym to be used as the unique identifier for their transcripts; all participants elected to do so.

Participants were consented at the outset of the interview. Interviews lasted roughly an hour. Two semi-structured interview guides were developed – one for
participants who had experienced family physician turnover, and one for those who had not but expressed concern about needing to do so in the near future. The basic framework for these guides was identical, sharing four principal categories of questions: (1) health status and history (e.g. health information); (2) health care practitioner history (e.g. frequency of visits to family physician); (3) implications of transitioning (e.g. implications of detachment/discontinuity); and (4) demographics (e.g. employment status). These common categories ensured that all interviews covered the same basic ground, while the open-ended questions allowed both interviewer and respondent the flexibility to explore related content areas (164, 168). The interview guide for those who had experienced physician turnover contained additional questions regarding participants’ experiences transitioning and, if relevant, how they managed to receive primary care services during the period they were without a regular doctor.

2.3.3. Data Analysis

All interviews were recorded and transcribed verbatim. After an initial transcript review one participant was excluded from the study as she did not meet the inclusion criteria, bringing the final sample size to 17 participants. De-identified demographic data were entered into a spreadsheet to create a descriptive profile of each participant. Transcripts and profiles were identified by participants’ chosen pseudonyms, allowing them to be linked. After a preliminary review of the transcripts, a thematic analysis was undertaken. Given this was an exploratory study seeking to identify common elements of a shared experience, thematic analysis enabled a data-driven, inductive approach that allowed for the identification of first macro and then more granular themes associated with transitioning (169).

The first step in the analytic process involved transcript reviews by the first and second authors (ER and VAC). Specifically, a subset of the transcripts was systematically reviewed to identify and describe emergent themes. Following independent review, the investigators came together to discuss dominant themes and their interpretation. Many themes were “indicated by the data” (170), wherein key concepts were embedded in participants’ accounts of transitioning or their concerns about needing to transition in the future. An important emergent concept was that of the
‘transitioning trajectory’, which involves three temporally-driven themes, each reflecting a different phase in the trajectory.

After consensus was reached between the first and second authors about the scope of the analytic focus, the first author drafted an interpretive matrix that outlined the structure of the analysis and identified distinct experiences that characterized each theme. The matrix was shared with the second and third authors (VAC and LJG) for feedback and was compared to the existing literature. A coding schema was then developed by the first author with input from the second author, labelling and defining the basic thematic and sub-thematic categories, and giving guidance about inclusion and exclusion in order to prevent drift during coding (165, 169). Coding was undertaken in a word processing program and data central to each code were extracted and combined in separate documents. Following coding, the first author identified data extracts that best characterized the set of distinct experiences that made up each of the three temporally-driven themes and further refined the interpretive matrix. Relationships within and across themes were established through a review of the extracts and the populated matrix. To enhance the rigour of the analytic process, the extracts were reviewed by the second author to confirm interpretations. The quotes shared in the results section were selected for inclusion by the first author, and are drawn from the extracts included in the fully populated interpretive matrix. Pseudonyms selected by participants are used when quotes are provided in order to acknowledge and personalize the women’s direct contributions.

2.4. Results

Seventeen women participated in the study. They varied in age from 39 to 87 years and two-thirds were between 44 and 62 years old. All participants self-identified as being chronically ill with at least one type of rheumatic disease and the majority described having more than one health issue. Osteoarthritis, rheumatoid arthritis and fibromyalgia syndrome were the most commonly cited rheumatic diseases. Eight women were not working and received disability benefits; the remainder were employed or in retirement. Ten participants reported having transitioned from at least one family physician within the preceding decade; seven of those ten had transitioned two or more
times. In most instances, transitions had been, or were going to be, initiated by the physician due to retirement, relocation, a switch in practice focus, or physician illness. The seven women who had not recently transitioned had long-term relationships (15-32 years) with their current family physicians. These women fell into two categories: those who were expecting to transition and those who sought means to avoid transitioning. Four women actively anticipated transitioning in the near future due to the imminent retirement of their doctors. Three elected to adopt means to sustain a long-term relationship and avoid detachment: two saw practitioners in neighbouring communities as a means around having to find a local doctor, and one remained with a local physician she was not satisfied with for fear of not finding another.

In the remainder of this section we examine the trajectory that dominated participants’ discussions of transitioning between family physicians. Although not asked explicitly to comment on phases associated with transitioning, participants routinely and consistently described elements of three distinct, temporally-driven phases. The concept of a multi-phase transitioning trajectory emerged from these accounts of their experiences. Descriptions of the phase of detachment encompassed activities related to the termination of a physician-patient relationship by the physician. For the participants who struggled to find a new family physician, there was a phase of unattachment, during which patients were without a regular family physician and had to find alternative means of receiving primary care. This phase was also often characterized by unsuccessful attempts to find a new doctor. The final phase was attachment, during which patients successfully sourced a new physician and were accepted into her or his practice.

2.4.1. Detachment Phase

Several participants acknowledged the connection between physician scarcity and their place of residence, with one woman noting that there “weren’t enough doctors around” (Barbara). These women indicated awareness that detachment from a family physician in a rural area with a physician shortage and high physician turnover might lead to difficulties finding a replacement, and therefore was something to be avoided. Three participants described conscious choices to avoid detachment. Referencing the local doctor shortage, for example, one woman explained that she chose not to detach from her family physician, despite not being satisfied with her care experience, because
it would be like “. . . giving up gold . . . or a million dollars” (Bernadette). Another woman, alluding to physician turnover, noted that she travelled to see a physician in another community rather than trying to find one locally because of the risk that local physician instability might lead to involuntary detachment: “. . . the problem is, they [family physicians] could only be here for a few months and then leave” (Wilda).

The majority of women who had transitioned spoke to the experience of detachment. While a patient or a physician can initiate detachment, the experiences described by participants in this phase of the transitioning trajectory were those resulting from physician-instigated separation. Accounts focused on two key features of detachment, both reflecting perceived failures of the system to adequately support patients during this process. The first feature was patient notification. Means of notification varied from calls, to letters, to no notice at all. There was a sense expressed by some participants that there was an unreasonable degree of randomness in how notifications were handled. One woman received no notification and learned of her doctor’s departure from a friend. Two women received letters outlining the upcoming departure of their physicians during previously scheduled appointments, raising questions about what might have happened if they had not had these appointments booked. As Anne explained: “…they didn’t send anything out. So if I had of been of good health, I would never have known.” Two other participants reported that their physicians ran newspaper ads announcing practice closure. One woman reflecting on her experience of being notified, described it as follows:

So that [reading about the practice closure in the paper] really kind of ticked me off, that that was how I found out. Mind you, he had a lot going on and I guess that was the way he felt he had to deal with it, was just put something in the paper and then if you happened to see it and you went in, then…that was fine (Kathy A).

The second feature of detachment described by participants was the relative absence of referrals to a new family doctor by the departing physicians. Only two women described being referred. One woman who had transitioned more than once was referred to an incoming physician in her earlier transition, but had not received a referral in her most recent experience. A second woman received a notice of practice closure suggesting that she try putting her name on the list of a new physician opening a
practice. She did not do so, however, as she was then informally referred by her exiting physician who arranged for her to see his wife who was also a family physician. The remaining participants described detachments without a formal referral to a new practice. One participant who had received a formal letter of notification pointed out that it “. . . didn’t make any suggestions of where to go for help or what to do” (Doreen).

The experiences of participants who had detached were echoed in the accounts of the four women who were anticipating transitioning because their long-term physicians were soon to retire. While one woman had been assured by her physician that he would help her find a new doctor when the time came, the remaining women had discussed the upcoming detachment with their physicians and had not been presented with specific plans for how they should transition, nor been offered referrals. One participant ascribed the lack of referrals to the local physician shortage, noting that: “There was just nobody to refer to. They [the community] were already clamouring for doctors at that time” (Joye).

The absence of referrals, or other formal supports for transition, prompted some participants to describe their distress at detachment. One woman characterized her sense of being left to manage transition alone: “I felt like I was being abandoned” (Kim), while another expressed concern that detachment brought loss of the “peace and comfort of knowing that you have a doctor to call on” (Doreen). The absence of guidance, in tandem with awareness of the physician shortage, heightened anxiety. One woman, who had been through detachment before and was facing it again, summed it up this way:

So I don’t know…I’m at a loss of what I can do, because there are no doctors in [community] or any of the areas around [community]…the apprehension of not knowing whether you’re going to get one…gives you sleepless nights (Doreen).

Participants recognized that detachment, within the context of a physician shortage, could lead to prolonged periods without a physician. One woman, contemplating her doctor’s upcoming retirement, voiced this anxiety: “I’m scared to death, because there aren’t any. There aren’t any doctors. You can’t get one” (Leslie).
2.4.2. **Unattachment Phase**

Only three participants described transitions that did not include a phase of being unattached. One of these women had recently moved to a new community. She avoided this phase by maintaining her relationship with her original physician, a three hour drive away, for a period of a year until her name rose to the top of a local physician’s wait list. This enabled her to move directly from detachment to attachment. The other two participants received referrals, allowing them to bypass unattachment.

In the absence of available local physicians and supports for reattachment, however, most detached participants spent considerable time without a regular family physician. Seven of the 10 women who had transitioned described phases of unattachment lasting several months to years. Three women were without a regular doctor for more than one year and two women were unattached for approximately four years. The inability to readily attach to a new family physician meant these participants had to assume responsibility for improvising interim means of receiving primary care. When describing her general sense of “winging it on your own” when managing care during this phase, one woman spoke to her sense of aloneness in navigating the health system: “... when . . . you’re ‘orphaned’, you know . . . you really do feel like an orphan” (Kathy A). Her reference to herself as an “orphan” reflects the emergence of this term in the common lexicon as a label for patients who have been unable to find and attach to an available family physician (2, 3, 149, 150, 171).

Three participants managed care during unattachment by relying on alternatives to a family physician, and found they were able to receive care that at least met the needs of their chronic illness. One woman, for example, sought care from her rheumatologist, a solution she felt worked well until she became ill with something

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4 The label “orphanhood” was considered for this phase, but the term “unattachment” was considered more generally representative as not all unattached patients necessarily view themselves as orphans. Orphanhood connotes isolation and abandonment and while many study participants who experienced unattachment did feel abandoned by the system, the more neutral term of “unattachment” allows for the experiences of patients who choose to be unattached, or are comfortable being so.
beyond his scope of practice. She augmented this care by using a walk-in clinic. Two others elected to seek care with non-physician providers and both reported very positive experiences. A woman with diabetes who had been unattached for a year came to rely heavily on her diabetes educators – a nurse and a dietician. Her experience under the care of these educators was so positive that she continued to depend on them for diabetes care after she found a new family physician. Another participant sought care from a nurse practitioner and spoke highly of that experience, saying the nurse practitioner had given her “the best medical I ever had” (Yvonne).

Four women availed themselves of walk-in clinics during unattachment. Three relied exclusively on these clinics as their source of care during this phase, augmenting this strategy as necessary with visits to the Emergency Department at a local hospital. These women tended to speak less positively about their experiences than those who had developed other strategies for receiving primary care services, citing a range of concerns from inability to book ahead to restricted hours to long wait times:

The worst thing about that was you’d have to sit there for four or five hours. That was terrible . . . No, you cannot make an appointment . . . you walk in, you sit down, there could be 50 people sitting. Well, you’ve got to wait your turn (Sandy).

The women spoke of using these clinics reactively, out of necessity, to deal with specific, unavoidable health issues such as filling prescriptions. One woman described using clinics only for acute conditions like bladder infections and not for her chronic disease management, until her chronic symptoms became so acute she had no choice but to seek medical attention. Participants also spoke to the phenomenon of having serial physicians while using clinics – seeing whatever doctor happened to be available instead of having a consistent, continual care relationship with a single physician. All except one of the women who used walk-in clinics reported seeing multiple physicians, with one participant estimating that she saw four or five doctors over the period she used the clinic as her source of primary care.

Along with finding means to manage their health care needs, four of the participants who had experienced unattachment described unsuccessful search efforts during this phase, detailing on-going efforts to find a new regular physician who was
accepting patients. One woman reported using a system resource – the Ontario College of Physicians and Surgeons website. She found the information on the site was outdated and that physicians she contacted who were listed as accepting patients, in fact were not. Another woman described a cycle of failed attempts: “I phoned a lot of places that people would suggest . . . and there was no way [to find a new doctor this way], every doctor is, 'I'm not taking any more patients’” (Sandy). In an effort to exit unattachment two participants opted to expand the geographic domain of their search for a new physician and contemplated travelling for care beyond the confines of their own community: “I mean I looked up . . . anywhere that was get-at-able, to see if there were any doctors that were taking new patients” (Doreen).

2.4.3. Attachment Phase

Successfully identifying and engaging with a physician who was accepting patients was the principal activity described by participants who achieved attachment. Seven women described success in attachment, two of whom were the participants who had received referrals. For the remaining five, the element of chance that had surfaced in descriptions of detachment notification, resurfaced in their accounts of finding a new physician. One woman reported hearing about a possible opening through the grapevine: “It was just luck that I heard that [doctor] was coming into town and I went right away and they gave me an appointment” (Anne). Another woman took a chance and approached a new physician in person, asking if she could be put on her waiting list. The physician instead accepted her immediately, directing her to call in and make an appointment. Yet another participant happened upon a newspaper advertisement run by a new doctor who was accepting patients, and went directly to the physician’s office and was taken on. The role of happenstance in attachment extended to the coincidental value of participants’ social networks to their efforts to identify an available physician. In one woman’s words, success in attaching often came down to having the right connections: “Anybody that gets in usually gets in either by family member or word of mouth” (Joye). The women also described a willingness to attach to any doctor that was available, pointing out that one could not be picky: “. . . if someone is willing to be your doctor, you accept them and put up with the things you don’t like” (Kim).
For participants who succeeded in finding new physicians, the process of entering into a new relationship varied. Some reported completing applications and intake forms, while others described having an initial, detailed interview appointment to go over their histories with the new physician. Participants also described learning the new rules of engagement, with varying success. One woman explained that her new physician expected patients to limit their appointments to talking about one or two key concerns and she had a hard time adjusting to this practice style. She noted that she did not “find the discussion part [of the appointment] happening any more” (Anne), adding that it was difficult with a chronic disease to only talk about one or two issues at a time. Many participants mentioned having to observe time limits to their appointments, ones not observed by their previous physicians. They described being allowed only 10 minutes per visit, leaving some with a sense that appointments were rushed: “You had to kind of cram… you felt that you had five or 10 minutes, and you'd better talk fast” (Kim).

2.4.4. The Transitioning Trajectory

Most participants who had transitioned did not fully describe experiences across all three phases, focusing instead on phases that were of particular significance to them. Two women did, however, provide a snapshot of their entire transitioning trajectory. The first learned of her physician’s departure during a previously scheduled appointment. She did not receive a referral and spent roughly a year as an unattached patient, availing herself of the services of a nurse practitioner in a neighbouring community. She eventually learned by word-of-mouth about a new local physician who was opening a practice, and called the office and was taken on. The second woman learned of her physician’s impending departure through a newspaper notice. She was also not provided with a referral and relied on her diabetes educators to assist her during her year of unattachment. She finally found a doctor taking patients through her social network: “I was just lucky to get into this doctor . . . and the only reason I did was my friend goes to that doctor’s daughter who is also a doctor. So she knew that he was coming in.” (Kathy A). These stories confirm a common theme of being largely left to figure out transitioning on one’s own.
2.5. Discussion

The transitioning experiences completed or anticipated by participants revealed that losing a family physician marked the beginning of a transitioning trajectory involving at least two of three phases. Women who received referrals from their departing physicians experienced two phases, moving directly from detachment to attachment. Those who did not receive referrals typically went through a middle phase of unattachment. The descriptions of the first phase, detachment, centred on losing a family doctor due to practice closure with a focus on two key elements: how patients were notified about the closure and whether they were referred to, or given guidance about finding, a new practice. When detachment included a referral, it led directly to the attachment phase, with participants being taken immediately into a new family practice. This, however, happened in a minority of cases. Most participants described an interim period of unattachment, during which they were without a regular physician and had to manage their primary care needs by employing a variety of tactics, most notably the use of alternative providers and walk-in clinics. About a third of the participants experienced a phase of unattachment lasting a year or longer, and these women described unsuccessful attempts to source a new family physician during this period. The attachment phase, which marks the endpoint of the transitioning trajectory, either flowed directly out of detachment as it did for the patients who were referred, or it followed unattachment. Either way, this phase was characterized by patients finding a successful means of identifying a physician with an open practice and being accepted into that practice.

It was evident from participants’ experiences that place of residence affected their ability to transition. Losing a family physician in communities contending with physician scarcity and turnover (36, 110, 115, 116) appeared to elevate the transitioning process from a simple logistical task to one requiring endurance, ingenuity and compromise. As such, a straightforward transition between doctors proved the exception rather than the rule. The participants’ awareness that their communities suffered from a doctor shortage led some to make concessions in their approach to care, such as remaining with physicians they did not like, managing their chronic illnesses with alternative providers, or seeking and maintaining family physicians in other communities.
2.5.1. **Gaps in system support for transitioning patients**

The participants tended to focus on challenges associated with transitioning and it was apparent that their need to compromise or improvise means of receiving care was engendered by perceived gaps in the health care system’s ability to support their transitions. Aside from the most critical and obvious gap in physician supply, the women identified other system lapses across the trajectory, and most participants described at least one experience during which they felt left to their own resources in managing their transition.

When discussing detachment, participants concentrated on system shortcomings regarding notification, referrals and guidance about transitioning. They spoke of passive notification tactics like newspaper advertisements, or in-office notices – leaving some women feeling that too much was left to chance. With so much at stake in losing a physician, these notification tactics were experienced as haphazard and posed a risk that patients might be deprived of valuable lead-time in their replacement search. Once notified, the pervasive lack of referrals may have been a function of the lack of available local physicians – a reality an exiting physician could not be expected to redress. The women, however, made no specific mention of other efforts made by their physicians to facilitate their transition, raising the question of where physician responsibility is perceived to begin and end – by both patients and physicians.

During unattachment, most participants managed to find ways to receive interim care. Three women availed themselves of providers other than family physicians to manage their chronic illnesses. It was notable that these women were positive about the care they received, even while acknowledging the limitations of this tactic as a means of receiving the full range of primary care. The most widely employed tactic for using primary care services during unattachment, however, was the use of walk-in clinics and, as necessary, emergency departments. While these alternatives offered a means of system entry for care and enabled prescription refills and referrals to specialists, the participants focused on the downsides to walk-in clinics, in particular their wait times. For example, the walk-in experience dissuaded one patient from seeking routine care. She reported, despite her chronic illness, only seeking care at the clinic for acute conditions. And almost all the women spoke to the phenomenon of seeing multiple doctors when
relying on walk-in clinics, which in effect denied them the opportunity for a continual care relationship – known to be associated with receipt of preventive care and positive health outcomes (30, 61, 63-65). The activity of sourcing a new physician also began during unattachment, with this phase being characterized by unsuccessful efforts to identify an available physician. Search strategies varied, from randomly calling physician’s offices to canvassing neighbouring communities – but none were successful. The lone attempt at using a system resource, the College of Physicians and Surgeons website, also failed.

In describing the attachment phase, participants detailed successful efforts finding a new physician. Their accounts identified a need for self-reliance and good personal connections, with luck often playing a critical role in their successes. The means of ultimately achieving attachment were various, from chance encounters with physicians with capacity for new patients to leaning on family and friends. Across the transitioning trajectory the barriers to attachment encountered during detachment and unattachment, and the successful tactics employed in achieving attachment, all speak to an absence of generally available and well-publicized system resources to support patients seeking attachment.

2.5.2. Implications for service delivery, primary care reform, and future research

The participants’ accounts of the challenges they encountered while transitioning shed light on health care system shortcomings. They also highlight opportunities for both short- and long-term system response. During detachment, the women identified issues with notification and lack of referrals. Guidelines issued by provincial or territorial Colleges of Physicians and Surgeons do specify that physicians ending a relationship should be “as helpful as possible” in assisting patients with finding new providers (172, 173). These guidelines, however, vary across jurisdictions, with some recommending assistance be provided to all patients (153) and others indicating this is necessary only for “selected patients” (152). Some guidelines suggest that the provision of letters of introduction and lists of interim and emergency resources is adequate (154, 155). There is also variance in guidelines about notification: in some provinces or territories a newspaper notice is considered sufficient (153), while others advocate for letters to be mailed to patients’ homes (154, 155). The extent to which rural family physicians are
aware of, or adherent to, guidelines is unclear. Research has identified multiple barriers to guideline uptake, from lack of awareness to cost (174). Understanding how the system can best and most practicably support patients and physicians during detachment would be a useful, immediate point of focus for both health policymakers and the provincial and territorial professional bodies.

The positive experiences receiving care from providers other than family physicians described by unattached participants lend support to the growing recognition that the traditional one-to-one patient-family physician relationship requires reconsideration beyond simply increasing numbers of family physicians. A critical thrust of primary care reform is the exploration of new delivery models (175, 176), including the expansion of privileges and responsibilities for providers other than family physicians (177, 178). The participant experiences affirm reform initiatives such as nurse practitioner-led primary care clinics, which have opened in Ontario with considerable early success (2, 177). The less positive experiences of participants who used walk-in clinics and emergency departments warrant further exploration, as does the totality of the unattached patient experience (9, 10). While it has been postulated that unattached patients place an undue burden on emergency departments, the findings remain equivocal (179). And not much is known about the long-term health consequences of relying on walk-in clinics and emergency departments for episodic primary care, especially for persons with chronic illness, although being unattached has been associated with a deficit in preventive care (9, 10, 29, 147). Given the large numbers of unattached Canadians, understanding how these stopgap service resources affect patient engagement with the system, as well as their on-going health management, is an important future research consideration.

During unattachment and attachment, participants’ efforts to identify available physicians underscore a need to evaluate the current system response to unattached patients. Responding to what is now widely recognized as a crisis in primary health care (1, 146, 180), Canadian provinces have started to focus efforts on assisting patients seeking attachment (130, 158, 159). The Attachment Initiative in British Columbia, for example, is piloting “locally appropriate strategies” in three communities, including clinics targeting unattached patients (129), while in Ontario the Health Care Connect registry links patients with available physicians. Evaluating the adequacy and effectiveness of
such programs will take time; in the meantime it may prove worthwhile to explore options for creating a centrally maintained, well-publicized information portal that is both current and comprehensive, and includes information on available physicians and support programs for unattached patients, as well directories of local walk-in clinics.

2.5.3. Limitations

There are three main limitations to this study. First, the interviews for this study were conducted at a single point of time after the women who had transitioned had completed this process. The time of the described transitions varied across the sample, with some having taken place five to 10 years prior to the study. The retrospective nature of the interviews, in combination with the complexity of a process that unfolds over time, elevates the risk that key details may have been forgotten. Second, given that the original intent of the study was to examine the general experience of transitioning, and the concept of a transitioning trajectory emerged from the data, each participant who had transitioned was not queried specifically about each phase. As a consequence there are occasional gaps in the data with some women’s narratives about both the individual phases, and the trajectory in its entirety, being more complete than others. These gaps made it difficult to explore variance in experiences across the sample. Third, the time constraints on the data collection period imposed limits on the sample size as participants had to be available within a fairly narrow window of time.

2.6. Conclusions

Many Canadians are unable to find an available family physician, and rural Canadians may have particular challenges doing so because physician supply in their communities tends to be limited and unstable (36, 113). Against this backdrop, this study explored chronically ill women’s perceptions and experiences of transitioning between doctors in a rural area with a known physician shortage (115, 116). The women characterized a distinct transitioning trajectory with three phases: detachment, unattachment and attachment. Their accounts revealed that moving through these phases was often difficult, largely because of a perceived lack support from the health care system.
Family physicians were recognized as a scarce resource and awareness of the physician shortage created anxiety for those facing transition and caused three participants to avoid transitioning by remaining with physicians under less than ideal circumstances. The descriptions of those who had transitioned tended to validate this apprehension, confirming challenges across the trajectory that were largely associated with an absence of system resources to facilitate ready attachment to a new physician.

The participants’ accounts highlighted facets of the transitioning process that warrant research and policy attention. For example, the concept of a transitioning trajectory deserves further investigation, especially in light of the national shortage of family physicians. Gaining a deeper understanding of how both urban and rural patients, with various health needs, experience the phases of transitioning will afford an opportunity to explore additional possibilities for bolstering the system’s capacity to facilitate this process. The challenges that emerged from these women’s accounts signal a need for system attention to each phase of the trajectory, from notification through to identification of a new regular physician. Longer term, participants’ accounts of care while they were unattached point to a need to deepen our understanding of the role alternative sources of care play in primary care delivery. Considered collectively, these accounts of transitioning rendered a number of issues that merit consideration by rural policymakers and researchers, underscoring the importance of incorporating the patient experience into the on-going development and evaluation of primary care reform.
3. Chapter 3

Conclusion

The goal of my thesis was to explore the perceptions of chronically ill, rurally situated women regarding transitioning with the intent of identifying commonalities in their experiences and the extent to which they felt transitioning and attachment were enabled by the health care system. The reality of a large population of Canadian patients who are not attached to a family physician has been quantified (17, 36), and the contributing factors to the deficit in family physicians have been explored and debated (71, 74, 79, 181, 182). To complement these data and support a patient-centred understanding of the issue, I sought to capture the patient perspective on losing and finding a family physician in the context of physician scarcity.

3.1. Summary of Findings

A key finding of this study was participants’ articulation of a transitioning trajectory. The descriptions of women who had completed transitioning delineated a process with distinct, linear phases. The initiating phase was detachment, or separation from one’s original family physician. While both patients and physicians can initiate transition, in this study detachments were triggered by physician turnover as practitioners closed practices to move, retire, or pursue a change in practice focus. For the minority of participants who received referrals from their exiting physician, detachment was followed immediately by attachment. This phase constituted the successful identification of a new physician and acceptance into his or her practice. More often participants experienced an interim phase of being unattached during which they searched unsuccessfully for a new physician. When unattachment was protracted, women secured primary care services through the use of alternative providers, walk-in clinics and emergency departments. The delineation of this transitioning trajectory
helped to isolate opportunities for enhanced system support within each phase. While it had been expected that participants might identify opportunities for greater support during unattachment and attachment, the need for a more consistent, patient-centred detachment process had not been anticipated.

The interviews revealed a tacit understanding that attachment to a family physician was the desired outcome of transitioning. Although none of the women addressed this explicitly, all those who transitioned, including participants who spoke to positive interim experiences with alternative providers, ultimately sought out and secured a new doctor. Those who anticipated transitioning also indicated that they intended to seek attachment. However the participants’ accounts, whether anticipatory or retrospective, revealed a widespread belief that attachment was likely to be difficult given the local shortage. For some, concerns about availability translated into active avoidance of detachment. Participants who had transitioned tended to confirm these apprehensions, detailing challenges across the transitioning trajectory. Nonetheless, each transitioning participant persisted in her search. This tenacious adherence to the one-to-one patient-family physician model, despite the challenges faced by participants, is notable and speaks to how deep-seated the belief is that this model constitutes the expected and preferred means of experiencing primary care. This may have implications for the uptake of alternative primary care models, at least in the short-term.

Two distinct themes emerged from participants’ descriptions of transitioning. The first was the role that chance appeared to play across the trajectory. The second was a pervasive sense of being left to manage this trajectory, and one’s health in the interim, on one’s own. These two themes combined to create a vivid sense of shortcomings in the system’s capacity to provide adequate support for participants as they made their way from detachment to attachment. In detachment, the perceived randomness of many of the notification strategies left participants concerned that they might not have learned about the impending loss if they had not happened to be in the right place at the right time. The almost total absence of referrals or guidance about finding a new physician left participants feeling abandoned – and often unsure about how to proceed. For women who could not immediately find a new physician, the phase of unattachment was one of improvising access to care. Their accounts spoke to compromise and makeshift arrangements. Those who sought care from alternative providers were largely satisfied,
but noted that this tactic did not allow them to engage with the full spectrum of care. Those who sought care from walk-in clinics were typically unsatisfied with the experience, focusing on logistical issues such as constraints on making appointments and lengthy wait times. A further element of compromise was apparent in the tendency of some participants who used walk-in clinics to limit their use of health services to management of acute issues, lending support to the early literature indicating that unattached patients may be underserved when it comes to preventive and routine care (28-30). The unattached participants also detailed frustrated efforts to source a new physician, largely relying on tactics of their own devising. All participants sought attachment, and ultimately achieved it. Their successes in identifying an available physician, however, aside from those who received referrals, were typically the by-product of happening by chance on an available physician, or of personal networks.

This study confirmed that the shortage of family physicians did impede participants’ ability to readily attach to a new doctor. A key discovery, however, was that the barrier to attachment created by the deficit in this critical enabling resource was often compounded by further missed opportunities for the system to facilitate transitioning. From potentially unreliable notification tactics to the relative absence of formal assists for attachment, these gaps in system support further undermined participants’ ability to secure a new usual source of care and thereby, to readily realize access.

3.2. Study Implications

3.2.1. The value of the patient perspective

The challenges facing patients searching for attachment constitute a pressing health policy issue, one that remains in the early stages of redress. Defining an issue properly is the cornerstone of effective policymaking (139). The implications of the lack of family physicians for a patient’s ability to attach are still being discovered. The preponderance of literature on the physician shortage and challenges with patient attachment is focused on quantifying the problem (17, 71, 146), and exploring tactics to increase the supply and capacity of family physicians (18, 74, 181). As issues of attachment and system use fundamentally affect patients, however, they call for policy
solutions that are patient-centred. Achieving these solutions depends on incorporating the patient's version of ‘what is’ into the foundational conceptualization of the problem (132, 133). My thesis, therefore, set out to explore the patient’s version of transitioning.

Capturing patient perspectives was made possible by employing a qualitative approach. Interviews enabled participants to describe in their words how they viewed the prospect of transitioning and how they experienced its reality, underscoring the important contribution qualitative methods can make to problem definition (137). The participants’ accounts elucidate the nature of the transitioning trajectory and their descriptions of each phase shed new light on the interplay of system and individual level influences that affect attachment and enable access. Their stories provide an expansive and nuanced perspective on how the system did, or did not, meet their needs. While their accounts affirm the disruptive influence of the shortage, they also identify more granular issues that impeded their ability to attach and use care – issues that lend themselves to system adjustments in support of more equitable access. These discoveries affirm the value the patient perspective brings to the delineation of policy issues.

3.2.2. **Implications for access to primary care**

Survey studies over the last decade have revealed that Canadian patients have challenges getting timely care (81, 88, 89, 161) and a population of over four million unattached Canadians further confirms that the system is not adequately meeting the needs of its patients. Attention is now being paid to the development of top-down responses to the family physician shortage and the consequent need to facilitate patient attachment (74, 126, 129-131, 183). These efforts at bolstering potential access range from increasing medical school enrollment allowances (74), to rethinking the dominance of the singular patient-family physician model of primary care delivery (18, 127), to the creation of specific programs designed to facilitate attachment (130, 131). As these reforms are relatively nascent (15, 18) there remains a window to ensure that system refinements aimed at enabling individuals to secure a usual source of care also integrate a patient-centered understanding of the current challenges associated with attachment.

The findings from my thesis research offer a patient-centred contribution to reform efforts by exposing dimensions of the attachment experience from the ground up. Living
in a rural region with a pronounced shortage of family physicians, the participants’ accounts confirmed the expected: need alone did not always drive realized access. Chronically ill patients have high needs for primary care (34). These chronically ill patients all sought attachment, but local physician supply impeded their ability to achieve it. Their predicament highlights the relationship between enabling resources at the system and individual levels. System level decisions designating the family physician as primary steward and system gatekeeper, in concert with those affecting the supply and distribution of family physicians, contributed to the creation of a gap between system supply and individual demand. At the individual level, this gap was experienced as an inability to readily attach to a usual source of care physician.

While the physician shortage was the most obvious influence on participants’ abilities to secure a new doctor, their stories revealed further relevant instances of the dynamic relationship between contextual and individual enabling resources. Other system inadequacies proved influential to the experience of transitioning and one’s relative ability to attach. For example, the lack of a standardized notification process ensuring that all patients were reliably notified about practice closure created a potential disadvantage for any patient who might not have learned about the impending separation in a timely manner. The more random approaches to notification put patients at risk of losing valuable lead-time in seeking a new physician before medical need arose, thereby compounding the existing challenge created by the physician shortage. Lack of referrals, the apparent absence of system resources to provide guidance about interim sources of care, and the lack of an established, centralized means to connect with available physicians also served to impede participants’ abilities to attach.

Success in bridging gaps in system support often came down to a blend of chance and individual resources. Participants who were physically and financially able to travel for care, for example, had an advantage. This ability allowed some women to maintain attachment to physicians in other communities, and enabled those who were sourcing to widen their search beyond their home base. Ingenuity and tenacity proved to be valuable personal resources in the quest for a new doctor, which sometimes required devising multiple tactics. And participants whose social networks encompassed people with connections or insider knowledge of the local health care system appeared to have an edge finding new physicians. Social support arising from personal networks and the
ability to rely on one’s community have been identified as health enhancing characteristics of rural life (94, 96), and it was apparent that for many participants, their close interpersonal relationships were an important asset during their transitions. Conceptually, these personal resources and abilities constitute individual enabling characteristics and in some instances, they allowed participants to successfully compensate for system shortcomings. In this environment, those without these resources ran the risk of being further disadvantaged in their efforts to attach.

System deficiencies denied participants a level playing field from which to achieve attachment – an indication of inequitable access. Andersen’s concept of mutability suggests that remediation must focus on factors that are readily modifiable and policy sensitive (70). Addressing the issue of family physician supply, whether through increased volume or new delivery models or some mix thereof, will be key to moving toward greater equity in access. My research has shown, however, that there are other mutable factors that should also be explored and addressed.

The participants’ accounts suggest a number of possible ground-level adjustments that could improve the transitioning experience and better the likelihood of attachment. Provincial and territorial guidelines that standardize processes relating to physician-initiated detachment hold the potential to alleviate some of the duress associated with losing a physician. Systematic notification ensuring advance notice to all patients, supported by referrals or advice on securing interim care, would better position patients to start searching for attachment. The development of system-based assists for sourcing physicians, from information portals to attachment programs, would leave patients feeling less abandoned and should, if properly maintained, facilitate attachment. Tactics such as these hold real potential for ameliorating the process of transitioning in the short-term while longer-term solutions are being implemented. Identifying these more immediate opportunities for intervention is one of the key benefits of exploring issues using the patient’s own lens.

3.2.3. **Considerations for rural health policymakers**

In recent years, public frustration (1, 20, 21) and government appointed commissions (11, 12) have helped place improved delivery of primary care high on
Canada’s health care reform agenda (13, 15, 18). The findings of this thesis directly support key objectives identified by the Canadian Institutes of Health Research in their Signature Initiative on Community-Based Primary Healthcare (128), namely to strengthen primary care delivery at the community level and to enhance the patient experience. A key value of the patient perspective is that patients are able to describe the mechanisms by which system policies impact their efforts to attach. The participants’ ground-level experiences with transitioning highlight policy-sensitive opportunities worthy of further exploration in support of delivering an easier patient experience during transitioning.

In summary, the findings from this thesis point to both short- and long-term considerations for rural health decision makers. In the short-term, opportunities to improve patient experience and support enhanced delivery of primary care include:

- auditing current notification procedures for rural family practice closure, with patient input, to inform the development of a set of consistent, practicable guidelines to assist family physicians in providing a more supportive detachment experience; and
- developing a suite of local resource tools that provide current, accurate and readily accessible information to patients during detachment and unattachment regarding community attachment programs, tactics for identifying available family physicians, and guidance on alternative sources of primary care for unattached patients.

In the longer term, the participants’ accounts underscored the importance of understanding patient preferences regarding the nature of primary care delivery. In the context of rural communities, alternative models hold great potential for lessening the dependency on single family physician practices. To this end, the findings of this study signal the value of further exploration into delivery models that move beyond the traditional reliance on an individual family physician, specifically:

- examining the potential for expanding the privileges and practice scope for providers other than family physicians (e.g. nurse practitioners) as a means of creating opportunities for attachment to non-traditional usual source of care providers;
- assessing the relevance of inter-professional team-based delivery models as a means of optimizing the output of scarce health human resources; and
• evaluating the walk-in clinic delivery model to determine if there are opportunities for improving the patient experience and encouraging patients who rely on these clinics to use them for preventive and routine care in addition to treatment for acute issues.

3.3. Opportunities for Further Research Exploration

My research has demonstrated the power of gaining an on-the-ground understanding of a phenomenon from the patient’s perspective. Participants’ accounts shed light on dimensions of attachment that resonated for them during the process of transitioning, uncovering issues that would benefit from further research. In addition to a broader exploration of the transitioning trajectory itself, the women’s stories pointed to other dimensions of the patient experience that warrant investigation, particularly if reform efforts are going to prioritize patient values.

3.3.1. The importance of interpersonal continuity as a proceed of attachment

It was notable in this study that there seemed to be an unspoken assumption among participants that having a one-to-one relationship with a family physician was the ultimate goal of transitioning. This assumption was not directly explored, so it is unclear if this expectation was based primarily on personal preference or was simply a reflection of the fact that this model remains the norm in Canadian health care. However, when women were asked about the value of seeing a physician other than their own, such as one might experience in a multi-physician practice setting, they largely expressed a preference for maintaining an ongoing relationship with their own physician. There is an established literature offering evidence of the merit of having a regular family physician, citing benefits from timely system entry (30, 61) to fewer unmet needs (41) to better rates of prevention and screening (30, 63-65) when compared to patients without a regular doctor. These logistical and clinical benefits are of value to all patients, and particularly those with complex or chronic conditions.

There is also a set of patient benefits that flow from the development of a valued relationship with a single provider. Attachment provides an opportunity to develop interpersonal continuity, thought to be an important value-add for patients. Interpersonal
continuity has been associated with heightened patient satisfaction (52-54), and there is evidence that it facilitates communication and enhances trust in both the provider and the care received (10, 44, 48, 52). While partially a function of a relationship over time, this form of continuity has more to do with a personal connection. McWhinney characterized it as a “contract” between patient and provider, wherein the physician makes an ongoing commitment to the person, rather than the medical issue (47).

Although my study did not specifically query participants’ desire for interpersonal continuity of care, several women spoke to the satisfaction of working with a physician who they felt treated them with respect, and whom they trusted. Those reflections and the apparent assumption that moving forward to a new singular relationship with a physician was the desired outcome of transitioning, raises questions for further consideration as policymakers explore alternatives to the traditional patient-family physician dyad. How important is interpersonal continuity for patients? What exactly comprises interpersonal continuity from the patient’s perspective? How viable will it be to preserve an opportunity for developing these relationships in new primary care delivery models, especially those that are team-based? Team-based delivery should provide ample opportunity for informational and management continuity but we have yet to discover if dispersing routine care across a group of providers will hinder the development of interpersonal continuity, even if a physician remains in the role of most responsible provider (46). Gaining a sense of the patient’s valuation of this relational form of continuity would be critical to the design of a team-based model that preserves some capacity for interpersonal continuity. Further research into the patient experience of this type of continuity is needed. While there is a reasonable literature explicating the concepts of continuity of care, more exploration has been called for to better understand patients’ perceptions about the value and experience of interpersonal continuity in primary care (31, 32, 184).

3.3.2. Exploring alternative models of primary care from the patient’s vantage point

Much of the emphasis in primary care reform centres on the development of alternative delivery models, many of which stand to alter the centrality of family physician to the delivery of primary care. The accounts of participants who endured long phases of
unattachment provide insight into how patients perceive less conventional means of securing primary care services.

Unattached participants who relied on the services of individual providers who were not family physicians expressed satisfaction with these relationships and with the care they received, even if it was limited in scope. Their experiences affirm directions currently being explored to expand the responsibilities and privileges of primary care providers who are not physicians (177, 178, 185). While this study barely scratched the surface of these experiences, the unanimity of the women’s satisfaction supports emerging evidence that alternative models such as nurse practitioner-led clinics can meet patient expectations (177). An important next step is to determine what it is about these relationships with alternative providers that resonates with patients, and where they may fall short. This step also holds true for inter-professional team-based practices, which will expose patients to a wider variety of primary care providers. While none of the participants had experienced this model of care, in rural environments with ongoing challenges recruiting and retaining physicians, this type of delivery model might prove the best allocation of limited health human resources. Preliminary feedback indicates that patients are receptive to team-based care (176, 186). Further exploration could explicate what particular benefits team-based care holds for patients, and shed light on whether patients feel that interpersonal continuity of care is compromised in this model.

This study points to another model of care that deserves investigation, namely the walk-in clinic. In stark contrast to the orphans who received care from alternative providers, those who used these clinics were vocal in their dissatisfaction. Although walk-in clinics vary in their organizational makeup, this delivery model tends to emphasize convenience in location and operating hours over singular patient-physician relationships (187, 188). It was notable, then, that the primary complaints registered by participants were about lack of convenience as result of long waits and the absence of appointments. The perceived usability of a source of care has been conceptualized as a function of availability and acceptability, with availability being the extent to which a patient’s needs fit with the service offered and acceptability being the extent to which a service meets a patient’s expectations (48). According to the participants, their needs did not always fit with the episodic care offered by these clinics, and their dissatisfaction indicated that the clinics did not fully meet their expectations of a positive care
experience. Yet these clinics are the number one primary care resource for unattached patients (17). Much remains to be discovered about the role of these clinics in primary care (189), and the experiences of these participants clearly signals the importance of incorporating the patient perspective into any evaluation of their merit.

3.4. Conclusion

This qualitative study enabled a first-hand glimpse into the patient’s experience of searching for attachment, couched within the distinct contexts of physician scarcity in rural Canada and chronically ill patients’ need for primary care. Participants’ accounts of transitioning confirmed that their ability to engage with and use the system was not always driven solely by need. An insufficient supply of rural family physicians translated into reduced opportunities for attachment at the individual level, and compromised the potential for equitable access. The participants’ stories, however, revealed that their challenges attaching were not simply a uni-dimensional issue of physician supply. The relationships they painted between the potential for access, as a function of system and individual resources, and realized access, proved multi-dimensional and complex. At the contextual level, their accounts revealed that system inconsistencies and inadequacies undermined their abilities to attach, from how they were let go by their original physicians to how they were aided, or not, in their search for a new physician. And at the individual level, their ultimate success in achieving attachment was often a function of their personal abilities to compensate for these system deficits.

Capturing ground-level depictions of losing a family physician and having to search for a new one in a climate of scarcity was only possible through patients’ first hand accounts of transitioning. Their stories reveal factors that hold the potential to either exacerbate or ameliorate the challenge of attaching in a climate of physician scarcity. These accounts also provide an opportunity to hear first hand how isolating and compromising the current experience of transitioning can be:

So it was pretty devastating there for a while, you know. . . . You don’t have a doctor and, you know, the only thing you could do is if you got sick was go to the emerg [Emergency Department] and then you almost felt guilty going there unless you were just about dying . . . Kathy A
As Canadian primary care reform continues to unfold, it is critical that policymakers avail themselves of the rich data to be had from the patient experience for these insights will enhance their ability to fully define critical health policy issues, and point them toward solutions that are truly patient-centred.
4. References


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Appendices
Appendix A.

Interview Guides

Interview Guide for Patients Who Experienced Family Physician Turnover

Interview Guide

Health status & history
- Tell me about your chronic illness.
- What is it? What are they?
- When were you diagnosed and by whom (GP, specialist etc.)
- What are the symptoms you currently experience? How have they changed over time, if at all?
- What do you do to treat it/them? (e.g., Prescription drugs, non-prescription drugs, exercises, CAM, specialists etc.)
- Who are the members of your current health care team? Have they changed over time?
- Where/what are the places you regularly visit for health care? Are they located close to your home? How do you get there (drive, cab, public transportation etc.)?

Practitioner history:
- For how long do you need to see a particular GP before you would consider him or her to be your ‘regular GP’?
  - Do you currently have a regular GP?
    - Yes: Would you like to have a regular GP now? Why, why not?
    - No: How long have you been seeing this person for?
    - Does this person practice locally?
- How frequently do you see the GP? What types of things do you normally discuss during appointments?
  - Has this changed over time?
    - If yes, why?
- When was the last time you transitioned between GPs?
- How long had you seen the previous person for?
- How many GPs have you seen since when you developed your chronic illness?
- What factors have shaped the changes in GPs that you’ve experienced?
  - Choice
    - What factors shaped your decision to leave the practice?
    - Did you expect to find a new regular GP upon leaving?
    - Have you chosen to leave more than one practice?
  - No choice
    - How were you informed of this?
    - Why was the reasoning?
    - Were you referred to a new practice?
- Have you ever been taken into the practice of a non-local regular GP?
  - Yes
    - Why did you not access local care?
    - What was your experience of traveling to receive this care?
- Have you started to see any other practitioners to assist in overcoming the discontinuity you experience in GP care (e.g. nurse practitioners)?

Current situation (if person does not currently have a regular GP):
- Are you actively searching for a regular GP now?
  - Yes:
    - Why?
    - What have you done?
    - How do you find out about practices that are accepting patients?
      - Sources of information?
    - Why do you think your search hasn’t been successful?
    - How could you be better supported in your search?
Interview Guide

- No:
  - Why not?
  - Unsuccessful previous search?

- Where do you currently go for non-specialist care?
  - For how long have you been going there?
  - How frequently do you go?
  - Where is it located in relation to your residence? (ie: local)

Implications of discontinuity of care:
- What are your expectations of GPs? Of health care services in general?
- Are your expectations currently being met?
  - If not:
    - Was there a time they were?

- Have you noticed a difference in quality between your current care situation and when you had a regular GP or when you were seen by a different GP?
- Do you think having a regular GP is important?
- What, if any, are the advantages of not seeing the same GP each time you go for an appointment?
- What do you think you’re missing out on, if anything, from experiencing GP turnover?
- Do you think experiencing GP turnover has had an impact on your health? Your referrals to specialists? Your prescriptions? Your ability to manage your chronic illness?
- What types of things change when you see a new GP?
  - Time spent with doctor
  - Doctor-patient relationship
  - Familiarity with patient file
  - Appointment booking process

- Have you ever experienced turnover whereby the new GP is practicing in the office of your former regular GP? If so, what types of differences have you noticed in the office?
  - Other patients
  - Signage
  - Staf/s issues

- How do you currently prepare for appointments with the GP you are seeing? Is this process different at all from how you previously prepared for appointments with your other GPs you have seen?
- How do you prepare for your first appointment with a new GP? Is this any different from how you would prepare for a regular appointment?
- How much time are you allotted for appointments? Is this an appropriate amount? Has this changed at all between GPs?
- When you see a doctor who is not familiar with your patient file do you think it’s important to bring him or her ‘up to speed’ on your health history/status? Do you provide this information up-front? Do you offer it only when asked? How do you determine which pieces of information are relevant?
- Do you think there are any particular challenges associated with managing a chronic illness when living in a rural area (or, at least, a non-urban one)? What are they?

Demographics:
- Age?
- Length of time living in [CITY]?
- Children? Spouse? Roommates?
- Home owner or tenant?
- Receiving income assistance/social support?
- Employment status (current and before the onset of chronic illness)
- Ethnic background
Interview Guide for Patients Who Did Not Experience Family Physician Turnover

Health status & history
- Tell me about your chronic illness.
- What is it? What are they?
- When were you diagnosed and by whom (GP, specialist etc.)?
- What are the symptoms you currently experience? How have they changed over time, if at all?
- What do you do to treat it/them? (e.g., Prescription drugs, non-prescription drugs, exercises, CAM, specialists etc.)
- Who are the members of your current healthcare team? Have they changed over time?
- Where/what are the places you regularly visit for healthcare? Are they located close to your home? How do you get there (drive, cab, public transportation etc.)?

Practitioner history:
- For how long do you need to see a particular GP before you would consider him or her to be your ‘regular GP’?
- Do you currently have a regular GP?
  - How long have you been seeing this person for?
  - Does this person practice locally?
- How frequently do you see the GP? What types of things do you normally discuss during appointments?
  - Has this changed over time?
    - If yes, why?
  
- How many GPs have you seen since you developed your chronic illness?
  - If more than one: why?
- Do you foresee needing to change your GP in the near future?
  
- Why?
- Do you have a good working relationship with your GP? Are you satisfied with the care you receive?
- Would you want to switch doctors if more local ones were available? Why?

Implications of discontinuity of care:
- What are your expectations of GPs? Of healthcare services in general?
- Are your expectations currently being met?
  - If no:
    - Was there a time they were?
- Do you think having a regular GP is important?
- What, if any, are the advantages of not seeing the same GP each time you go for an appointment?
- Could you be missing out on something by always seeing the same GP?
- Do you think that developing a long-term relationship with your GP has had an impact on your health (positive or negative)? Your referrals to specialists? Your prescriptions? Your ability to manage your chronic illness?
- How do you currently prepare for appointments with the GP you are seeing?
- How much time are you allotted for appointments? Is this an appropriate amount?
- Have you ever seen a non-regular GP to assist in managing your chronic illness (e.g., a walk-in or weekend clinic)?
  - If yes:
    - When you see a doctor who is not familiar with your patient file do you think it’s important to bring him or her ‘up to speed’ on your health history/status? Do you provide this information up-front? Do you offer it only when asked? How do you determine which pieces of information are relevant?
  
- Do you think there are any particular challenges associated with managing a chronic illness when living in a rural area (or, at least, a non-urban one)? What are they?
Interview Guide – NO GP TURNOVER

Demographics:
- Age?
- Length of time living in [CITY]?
- Children? Spouse? Roommates?
- Home owner or renter?
- Receiving income assistance/social support?
- Employment status (current and before the onset of chronic illness)
- Ethnic background