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ORIGINAL RESEARCH

The effect of rurality on patients' satisfaction with out of hours care provided by a family doctor cooperative

LG Glynn, M Byrne, AW Murphy

Department of General Practice, Clinical Science Institute, National University of Ireland, Galway, Ireland

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ABSTRACT

Introduction: Reacting to demand and supply pressures, European healthcare systems are undergoing significant structural changes to the organisation and delivery of out of hours care. Such pressures are of particular concern to rural practice. Although patient satisfaction with out of hours care has been extensively studied, the effect of rurality on satisfaction levels has not, to our knowledge, been previously examined. Objective: To investigate whether rurality has an influence on patient satisfaction with out of hours care provided by a family doctor co-operative.

Methods: All patients contacting the service over a designated 24-day period were forwarded a postal questionnaire. Patients' satisfaction was measured using a version of the McKinley questionnaire, and rurality, by subjective patient assessment, distance from treatment centre or previous rota cover.

Results: The response rate was 55% (531/966). Overall satisfaction levels were high with 88% of patients rating the service as either good or excellent. 47.8% of respondents perceived themselves as living in a town, 14.6% as living in a village, and 37.6% as living in the countryside. Perceived rurality, distance from treatment centre or previous rota cover did not significantly affect satisfaction levels.

Conclusion: Family doctor co-operatives have significantly altered the way out of hours care is delivered. Patients from rural areas are equally satisfied with the provision of out of hours care by co-operatives, as urban patients. Extension of co-operatives to rural areas need not be constrained by concerns regarding decreased patient satisfaction.

Keywords: out of hours medical care, patient satisfaction, rurality.

Introduction

The organisation and delivery of out of hours care by general practitioners varies enormously between among European countries[1]. Reacting to similar demand and supply pressures, European healthcare systems are undergoing significant structural changes to the provision of out of hours care. These changes have been fuelled both by increasing demands for out of hours care and by increasing reluctance among general practitioners to provide such out of hours care[2].

Chief among the structural changes are the development of general practice out of hours co-operatives. In the United Kingdom, the first general practitioner co-operatives were set up in the early 1980s, but it was not until the late 1990s that social, cultural and health service changes produced a climate which favoured their development[3]. By then, the number of co-operatives had increased from approximately fifteen at the end of 1994, to an estimated figure of 250 by 1997[4]. In Denmark in 1992, major national structural reform resulted in the development of a network of local co-operatives[5]. In the Republic of Ireland, the first co-operative was established in 1999, and by 2002 co-operatives had been initiated in all health board areas in the state.

Rural general practitioners, in comparison to their urban colleagues, are on call more frequently and expected to provide a wider range of medical services, including emergency care[6]. Such expectations are proving increasingly onerous and unsustainable[7-9]. It would be expected, therefore, that the development of co-operatives would be especially welcomed by rural practitioners. Rural patients are often used to a small numbers of doctors, sometimes personally known to them, providing out of hours care. They are also used to accessing care close to their own homes. Co-operatives can significantly change both these attributes[10], potentially causing patient dissatisfaction. The objective of this study was to investigate whether rurality has an influence on patient satisfaction with out of hours care provided by an Irish general practice co-operative.

Methods

Definitions used in the study

Out of hours contact: An 'Out of hours contact' is defined as any request for medical care between 18.00 hours and 08.00 hours on weekdays, from 08.00 hours on Saturdays to 08.00 hours on Monday morning, and includes all public holidays until 08.00 hours the following morning.

General Medical Services (GMS): Free primary care and medications are available to 30% of the population of the Republic of Ireland on a means tested basis; they are described as GMS eligible. The other two-thirds, whose income is above a certain level (in 2002: 138 euro per week for a single person aged up to 65 years who is living alone), are responsible for their own primary health care costs. GMS eligible patients are, therefore, the most economically deprived in the community.

Rurality: Rousseau highlighted how widely differing definitions of rurality are utilised, ranging from population density, indices of rurality, and remoteness to subjective assessment[11]. With such a wide range, it is clear that none captures fully the essence of rurality and that emphasis must, therefore, be placed on 'fitness for purpose'. Within Ireland, there are no standard indices of rurality and in a population-based survey, a pragmatic subjective respondent assessment of rurality was considered to be both feasible and reliable. Patients were, therefore, asked to indicate whether they felt they lived in a town, in a village or in the countryside. To consider remoteness, they were also asked how far from the nearest treatment centre they lived.

Service under study

The family doctor co-operative under study ('Shannondoc') covered a mixed urban and rural population of 85 000 people in the West of Ireland and was funded by the Department of Health and Children. The service began on 25 June 2002, involved 38 family doctors, and responded to approximately 350-450 out of hours calls per week. The Shannondoc receptionist, having received the patient's call, logged the patient's registration details and reason given for calling directly into the 'Adastra' computer system. The details then appeared in a prioritised log that is used by the nurse to identify callers waiting to be assessed and triaged. The triage nurse took the call at the earliest opportunity, using the pre-set protocols to guide and document the process of assessment. The triage nurse either offered advice or organised for the patient to be seen by the doctor on duty. Calls were categorised as either 'emergency', 'urgent' or 'routine', according to agreed guidelines. Call details were then forwarded via mobile telephone and fax to the relevant on-duty general practitioner. The whole process took approximately 5 min. The doctor on duty responded to a patient call by providing telephone advice, undertaking a home visit, or inviting the patient to the designated primary care centre. Every morning general practitioners were faxed a print-out of the calls and associated management received for their own patients during the previous out of hours session.

Shannondoc had fully equipped primary care centres in the general hospital in the geographical centre of Clare and in four surrounding towns. Each primary care centre had a driver and car available at all times and maintained communication via mobile telephone and fax with the Shannondoc call centre.

Design

The study design was comprehensively described in an accompanying paper[12]. In brief, all patients contacting Shannondoc during a designated 24-day period from 20 September to 14 October 2002 were included in the study. This period was chosen to avoid winter epidemics or holiday periods and to allow a sufficient lag period between the inception of the service and the beginning of the study. The questionnaire had been piloted on two occasions with a sample of 12 patients on each occasion. These patients were living in the area under study and the questionnaire was adjusted in response to the pilot participants' feedback. Patients were sent a postal questionnaire with a covering letter and stamped addressed envelope within 7 days of their contact with the out of hours service (Appendix I). Patients received a telephone reminder between 2 and 4 weeks after the initial sending of the questionnaire.

An adaptation of the McKinley questionnaire[13] was used to measure patient satisfaction. As an alternative to the five-point Likert scale used by McKinley, a more simple 'Yes or No' scoring system was utilised. This was the format used in other studies evaluating family doctor co-operatives in the Republic of Ireland[14]. The questionnaire consisted of a total number of 16 questions grouped into four themes, each requiring a 'Yes or No' answer, as well as an overall rating of the service received. No validation of this adaptation, to our knowledge, has been preformed. The themes used in the questionnaire were: access to care, interpersonal aspects of care, quality of care and overall rating of the service. The final section recorded demographic details of the patients using the service. Respondents were also asked to state their preference for the new Shannondoc provision of out of hours care in comparison to previous arrangements. Patients' previous rota cover (eg 1:1) was determined by LG from the name of the respondents' general practitioner.

Patients were excluded if they had died or were seriously ill, had been admitted to hospital under the Mental Health Act, were a nursing home resident, were non-competent in the English language, did not have a permanent address in the area or had an invalid address, or where confidentiality was a concern. Ethical approval was obtained from the research ethics committee of the Irish College of General Practitioners.

Statistical methods

The data were entered into SPSS for Windows (vers. 11.0) (SPSS Inc; Chicago, IL, USA) for analysis, and appropriately double-checked. For respondents and non-respondents, comparisons of mean age were made using independent-samples *t*-test while comparisons of gender and GMS status were made using c^2 analysis. Comparisons of patient satisfaction were made using c^2 analysis. Not all questions were answered by all respondents.

Results

Study population

There were 1203 contacts for the designated study period. A total of 966 questionnaires were forwarded to patients following application of the exclusion criteria. The exclusion rate was 19.7% (237/1203). The largest exclusion category (43.0%) was for those who did not have a permanent address in the area under study. This group was significant because the study area is a popular tourist destination. Other important reasons for exclusion were an invalid address (eg a sports ground) (20.3%), or nursing home resident (17.3%). The overall response rate was 55% (531/966). There was no significant difference between respondents and non-respondents in terms of gender and GMS status. Respondents were older than non-respondents (t (964) = 2.986, p = 0.003).

Respondents

Patients over 65 years of age made up 13.4% (71/531) of the respondents, while 56.5% (300/531) were aged 15 to 64 years with the remainder (29.9% [159/531]) aged less than 15 years. Of the respondents, 39.2% (208/531) were male; 43.3% (229/531) were GMS eligible. Of those who responded, 17.7% (94/531) had received a house call, 67.4% (358/531) were seen at the treatment centre, and the remaining 14.9% (79/531) were managed with telephone advice.

Overall satisfaction with out of hours service

Among the respondents to the questionnaire, 62.0% (328/531) rated the service as excellent; 26.1% (138/531) rated the service as good, and 8.1% (43/531) rated the service as satisfactory. The out of hours service was rated poor by 3.8% (20/531) of patients. Differences of gender and GMS status did not significantly affect overall satisfaction (Table 1). In regard to age grouping, patients 65 years or more had the lowest levels of overall satisfaction followed by adults, with children and their parents or guardians expressing the highest levels of overall satisfaction, but these differences were not statistically significant (p = 0.09).

Rurality and remoteness

47.8% (249/521) of respondents, perceived themselves as living in a town, 14.6% (76/521) perceived themselves as living in a village, and 37.6% (196/521) perceived themselves as living in the countryside. For the purposes of analysis, respondents were divided into urban (those who perceived themselves as living in a town) and rural (those who perceived themselves as living in a village or the countryside). Rurality did not affect overall patient satisfaction (Table 1).

Respondents lived between one and 25 miles from their nearest treatment centre. 62.6% (321/514) lived 5 miles or less from their nearest treatment centre, 25.9% (133/514) lived between 6 and 10 miles from their nearest treatment centre, and 11.5% (59/514) lived greater than 10 miles from their nearest treatment centre. As outlined, distance from the nearest Shannondoc treatment centre did not appear to affect overall patient satisfaction levels (Table 1). Additionally, distance from the nearest Shannondoc treatment centre did not appear to affect the likelihood of receiving a house call. For patients who lived within 5 miles of a treatment centre, 18.3% (59/322) received a house call. For those who lived between 6 and 10 miles of a treatment centre, 19.5% (26/133) received a house call; of those who lived more than 10 miles from the treatment centre, 10.2% (6/59) received a house call.

Table 1: Relationship between patient satisfaction and age, sex, GMS status, distance from nearest Shannondoc centre, rurality status, and previous out of hours care

Variable	Excellent/Good *n* (%)	Satisfactory/Poor *n* (%)	*p* value
Age			
Child (0–14 years)	143/155 (92.2)	12/155 (7.8)	.133
Adult (15–64years)	257/295 (87.1)	38/295 (12.9)	
Pensioner (≥ 65years)	57/68 (83.8)	11/68 (16.2)	
Sex			
Male	182/204 (89.2)	22/204 (10.8)	.599
Female	278/317 (87.7)	39/317 (12.3)	
GMS status			
Medical card	205/228 (89.9)	23/228 (10.1)	.243
No medical card	258/298 (86.6)	40/298 (13.4)	
Rurality status			
Urban	219/248 (88.3)	29/248 (11.7)	.980
Rural	240/272 (88.2)	32/272 (11.8)	
Distance from centre			
0–5 miles	287/321 (89.4)	34/321 (10.6)	.496
6–10 miles	114/133 (85.7)	19/133 (14.3)	
≥ 11 miles	51/59 (86.4)	8/59 (13.6)	
Previous out-of-hours care			
1:1	55/62 (88.7)	7/62 (11.3)	.786
1:3, 1:4, 1:5	225/252 (89.3)	27/252 (10.7)	
1:7, 1:8	170/195 (87.2)	25/195 (12.8)	

GMS, General medical services.

Table 2: Perception of quality of care of Shannondoc, in comparison with previous arrangements, according to rurality status and previous rota cover

	Rurality status *n (%)*		Previous rota cover *n (%)*		
	Urban	**Rural**	**1:1**	**1:3, 1:4, 1:5**	**1:7, 1:8**
Better	152/244 (62.3)	158/268 (59.0)	33/61 (54.1)	148/251 (59.0)	124/188 (66.0)
Worse	11/244 (4.5)	9/268 (3.3)	2/61 (3.3)	13/251 (5.2)	5/188 (2.7)
No difference	46/244 (18.9)	52/268 (19.4)	14/61 (22.9)	50/251 (19.9)	30/188 (15.9)
Don't know	35/244 (14.3)	49/268 (18.3)	12/61 (19.7)	40/251 (15.9)	29/188 (15.4)
Significance	$p = 0.594$		$p = 0.510$		

60.7% (315/518) of respondents considered Shannondoc service to be an improvement on their previous out of hours care, 3.9% (20/518) a disimprovement, 18.9% (98/518) no difference, and 16.4% (85/518) did not have an opinion. The perception of quality of care of Shannondoc, in comparison with previous arrangements is illustrated, according to rurality status and previous rota cover (Table 2). There were no differences in preferences according to rurality status or previous rota cover.

Discussion

The findings provide reassurance to rural general practitioners concerned about the impact on patient satisfaction of out of hours care provided by a co-operative. In the present study, patient satisfaction was consistent for patients categorised by perceived rurality, distance from treatment centre or type of previous rota. Such concerns may be felt acutely by rural practitioners because they often live in the communities within which they practice. The negative impact on rural practitioner recruitment and retention of the demands in the provision of out of hours care is well recognised. For example, in Ireland less than 10% of a national sample of general practice registrars wished to work in rural practice with the demands of out of hours care perceived as the single biggest barrier[15]. In Australia, in a qualitative study of medical practitioners who had left rural practice, the most common 'pushing' factor was excessive on-call coverage[16]. Opposition to the extension of co-operatives to rural areas has sometimes centred around the perceived negative effects on patient satisfaction. The present study suggests that such concerns are unfounded.

An important effect of co-operative care is the increase in the numbers of patients managed by advice alone, and the decrease in those visited at home. It was of interest, therefore, that distance from the nearest treatment centre did not appear to affect the likelihood of receiving a house call. Regular review of such data could act as quality assurance to ensure that rural patients receive an equitable service. It is also noteworthy that the proportion of patients who received advice alone, while higher than that reported when care is reported by 'own general practitioner'[17], is still less than that reported by co-operatives in the UK. In reports from Irish co-operatives[14,18] generally the proportion of patients seen in treatment centres is much higher than that reported in the UK. Explanation of such process differences is beyond the scope of this paper.

The generalisability of rural research may be problematical. Many European countries do have similar health policy, organisation of general practice and geographical features to that of Ireland[19]. Extrapolation to countries with more remote rural communities such as Australia should be performed cautiously[20]. In any event, further confirmation of these findings in different settings would be welcome.

Study limitations

The patient satisfaction measurement instrument used in this study is adapted from McKinley's questionnaire[13] on measuring patient satisfaction with out of hours care. Although, this will facilitate comparison with studies carried out in the Republic of Ireland where there is a dearth of published data in relation to out of hours care, it may limit comparison with results from studies that use the Likert scoring system.

Non-response bias is an important potential source of bias which we sought to minimise through careful planning of questionnaire design, sample selection, data collection and a reminder strategy[21]. The overall response rate for the study was 55% which is comparable with other similar studies.

Defining rurality in terms of perception alone presents some problems. Such an approach is clearly subjective. People's views are coloured by their past and current experiences. Someone who lives or has previously lived in an inner city may have a very different perception of what is rural from someone who has lived in a small farming community their entire life. Thus, two people from the same community may define that community in very different ways. Nonetheless,

subjective assessment in the context of the geographical area being studied was pragmatically considered to hold a high degree of validity and reliability, and so this form of assessment was adopted for the current study.

Conclusion

Based on the results of this study, we conclude that patients from rural areas are as equally satisfied with the provision of out of hours care by co-operatives, as urban patients. Extension of co-operatives to rural areas need not be constrained by concerns regarding decreased patient satisfaction.

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Appendix I

Questionnaire

SECTION A: Your Experience with SHANNONDOC

Please tick the boxes that best summarise your feelings about the way your call to SHANNONDOC was handled.

(Please answer only one of the questions 'A1', 'A2' or 'A3' as appropriate)

A1) If you were advised over the telephone without seeing a duty doctor:

	Yes	**No**
1.	Was your call returned without unreasonable delay?	
	(__)	(__)
2.	Did you feel the doctor/nurse established your condition in sufficient detail?	
	(__)	(__)
3.	Was the doctor's/nurses advice clear and easy to follow?	
	(__)	(__)

4. Did you feel that the doctor's/nurses advice was appropriate and helpful?
   (__) (__)
5. Were you invited to call again later if still concerned?
   (__) (__)

A2) If you were seen by a doctor at home:

6. Were you satisfied at the length of time it took the doctor to arrive?
   (__) (__)
7. Were you satisfied generally with the way the doctor talked to you and established the history of the problem?
   (__) (__)
8. Were you satisfied with the way the doctor examined you?
   (__) (__)
   Were you satisfied with the way the doctor explained his/her findings and treatment?
   (__) (__)

A3) If you were seen by a doctor at a treatment centre:

9. Do you feel that that you were well enough to travel to the treatment centre?
   (__) (__)
10. Were you seen promptly once you arrived at the treatment centre?
    (__) (__)
11. Were you satisfied generally with the way the doctor talked to you and established the history of the problem?
    (__) (__)
12. Were you satisfied with the way the doctor examined you?
    (__) (__)
13. Were you satisfied with the way the doctor explained his/her findings and treatment?
    (__) (__)

(Please answer both questions 'A4' and 'A5')

A4) When you telephoned us:

14. Was your telephone call answered promptly?
    (__) (__)

Did you find the telephone receptionist courteous and efficient?
(__) (__)

A5) In summary: please tick whichever term below best summarises your feelings about the service provided on this occasion. If you wish to comment further, please write below.

Excellent	Good	Satisfactory	Poor

SECTION B: Your General Health

B1. In general, would you say your health is:

(Please tick the appropriate box)

Excellent	Very Good	Good	Fair	Poor

B2. The following questions are about activities you might do during a typical day. Does your **health** now limit you in these activities? If so, how much?

(Please tick the appropriate box)

	Activities	Limits me a lot	Limits me a little	Doesn't limit me at all
a.	**Moderate activities**, such as moving a table, doing vacuum cleaning, bowling, or playing golf			
b.	Climbing **several** flights of stairs			

B3. During the **past 4 weeks** have you had any of the following problems with your normal day-to-day activities or your work **as a result of your physical health**?

(Please tick the appropriate box)

		Yes	No
a.	I have **accomplished less** than I would like		
b.	I was limited in my work or other day-to-day activities		

B4. During the **past 4 weeks**, have you had any of the following problems with your work or other regular daily activities **as a result of any emotional problems** (such as feeling depressed or anxious)?

(Please tick the appropriate box)

		Yes	No
a.	I **accomplished less** than I would like		
b.	I didn't do work or other activities as **carefully** as usual		

B5. During the **past 4 weeks**, how much did **pain** interfere with your normal day-to-day activities or work?

(Please tick the appropriate box)

Not at all	A little bit	Moderate	Quite a bit	Extremely

B6. These questions are about how you feel and how things have been with you **during the past 4 weeks**. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the **past 4 weeks**.....

(Please tick the appropriate box)

		All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	All of the time
a.	Have you felt calm and peaceful?						
b.	Did you have a lot of energy						
c.	Have you felt downhearted and low?						

B7. During the **past 4 weeks**, how much of the time has your **physical health or emotional problems** interfered with your social activities (like visiting with friends, relatives, etc.)?

(Please tick the appropriate box)

All of the Time	Most of the time	Some of the time	A little of the time	None of the time

SECTION C: Some Details about Yourself

C1. **Age:** _____years

C2. **Sex:** Male (__) Female (__)

C3. Which SHANNONDOC treatment centre do you live closest to:

(Please tick the appropriate box)

Ennis	Kilrush	Ennistymon	Shannon

C4. How many miles do you live from your closest SHANNONDOC treatment centre?

_____miles

C5. How would you describe where you live?

(Please tick the appropriate box)

Town(>1000 population)	Village(<1000 population)	Countryside

C6. What is the name of your own Family Doctor?_____

(Please tick the appropriate box**)**

		Yes	**No**
C7.	Do you currently hold a medical card?	(__)	(__)
	If 'No', have you ever held a medical card	(__)	(__)

C8. How does the new SHANNONDOC service compare with your previous Family Doctor Out-of-Hour arrangements?

(Please tick the appropriate box)

Better	Worse	No Difference	Don't Know

Thank you very much for your help

Please put the questionnaire in the free post envelope provided and return it as soon as possible. You do not need to put a stamp on the envelope.

If you have lost the return envelope, please post the questionnaire to:

Dr. Liam Glynn (Research Co-ordinator)
The Department of General Practice
Clinical Science Institute
National University of Ireland
Galway

Call Number	