MEDICAL CARE AS A COMMODITY:
AN EXPLORATION OF THE SHOPPING BEHAVIOR OF PATIENTS

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ABSTRACT: A 10% household sample of high- and low-income census tracts was interviewed to assess the extent of doctor shopping. In 632 households studied, 53% of high socioeconomic status and 51% of low socioeconomic status families had shopped for or changed doctors of their own volition. During the previous year, 4% of each socioeconomic group had consulted more than one doctor without referral for the same episode of illness. Shoppers could be distinguished from non-shoppers—shoppers were younger, were better informed about medical specialties, were less self-reliant, more hypochondriacal, expressed less hostility toward physicians, and had less positive attitudes toward the medical care system. The differences between shoppers and non-shoppers were generally similar for both high and low socioeconomic status groups. In addition, 52% of the families studied had been forced to change doctors because of circumstances beyond their control, i.e., the patient moved or the doctor moved, retired, or died.

Although physicians frequently express frustration over the phenomenon of doctor shopping, there is little information in the professional literature that documents this aspect of patient behavior. The Opinion Research Corporation reported in 1962 that three out of ten persons interviewed had changed their physician during the previous five years; only 8% changed because of dissatisfaction. In an even older study of National Health Service patients in England and Wales, changes because of dissatisfaction (as opposed to movement of either the doctor or the patient) amounted to only 7 per 1,000 adult patients per year. More recently, Finnish investigators found three quarters of the patients interviewed willing to return to the same physician.

Although almost every physician perceives that he is victimized to some extent by doctor shopping, to our knowledge there are no studies of the frequency with which it actually occurs or the factors that may be associated with shopping. Therefore, we sought to determine what proportion of a population actually engaged in doctor shopping and to what extent others would like to shop should the opportunity arise. Some reasons for shopping were also obtained. Personal characteristics, attitudes, and knowledge of medical specialties were also gathered so that we might describe some of the characteristics of shoppers.

By examining these aspects of doctor shopping, it may be possible to gain some insight into the behavior of these patients and to move closer to

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an understanding of why and where the medical system has failed to meet their needs. In light of the rising cost of medical care, multiple visits to different providers for the same episode of illness are certainly not cost effective.

METHODS

Population

In July-August 1974, a 10% random sample (746 households) from four urban census tracts in Salt Lake County was selected for household interview. This is a metropolitan area in the Intermountain West, with a population of about a half million. To evaluate the importance of possible economic and social factors, the samples were chosen from two low and two upper-middle socioeconomic neighborhoods. Of those contacted, 5% refused to participate, 6% were not home after repeated calls, and 4% were unavailable for other reasons, such as vacant dwellings, away for extended periods, or unable to speak English. Thus, the study includes data from 364 high socioeconomic status (high-SES) households and 268 low socioeconomic status (low-SES) households, comprised of 2,135 individuals.

Procedure

The adult principal respondent (husband or wife) was interviewed in the home; the interview lasted approximately one-half hour and followed a standardized questionnaire form. In addition, the principal respondent was asked about the episodes of illness for each member of the family during the previous year. For each episode, the names of all physicians or other practitioners consulted were recorded, as well as the respondent’s identification of the physician’s specialty. If the respondent was unable to answer, other members of the household were consulted. Practical knowledge of the medical specialties was computed by comparing the reported specialty of each physician named to his actual specialty as recorded by the AMA directory. The respondents were also asked to match a series of brief descriptions of various medical specialties with their appropriate titles, to evaluate the respondent’s theoretical knowledge of medical specialties.

The questionnaire included attitudinal measures drawn from previously validated scales and a series of questions specifically designed to examine the principal respondent’s doctor-shopping behavior. The attitudinal scales included hypochondriasis, patient hostility to physicians, attitudes toward aspects of the medical care system (cost and convenience, providers’ personal qualities, and professional competence), tendency to adopt a sick role, self-reliance, and a number of individual questions about