

BJGP OPEN

Patients' experience with German primary care practices during Covid-19: an interview study

Otto, Daniel; Vanderwardt, Veronika

DOI: <https://doi.org/10.3399/BJGPO.2023.0129>

To access the most recent version of this article, please click the DOI URL in the line above.

Received 13 July 2023

Revised 21 September 2023

Accepted 26 October 2023

© 2023 The Author(s). This is an Open Access article distributed under the terms of the Creative Commons Attribution 4.0 License (<http://creativecommons.org/licenses/by/4.0/>). Published by BJGP Open. For editorial process and policies, see: <https://bjgpopen.org/authors/bjgp-open-editorial-process-and-policies>

When citing this article please include the DOI provided above.

Author Accepted Manuscript

This is an 'author accepted manuscript': a manuscript that has been accepted for publication in BJGP Open, but which has not yet undergone subediting, typesetting, or correction. Errors discovered and corrected during this process may materially alter the content of this manuscript, and the latest published version (the Version of Record) should be used in preference to any preceding versions

Patients' experience with German primary care practices during Covid-19: an interview study

Daniel Otto¹ (doctoral student), Veronika van der Wardt¹ (senior research fellow; corresponding author; ORCID ID: 0000-0003-3995-7056)

¹Department of General Practice

University of Marburg

Karl-von-Frisch-Str. 4

35043 Marburg/Germany

Email corresponding author: v.vanderwardt@uni-marburg.de

Telephone (corresponding author): ++49-6241-2825163

Abstract

Background: Due to Covid-19, access and communication with German primary care practices had changed. Patients had to comply with Covid-19 regulations, which included closed waiting rooms and appointment-based consultations. It is unclear how patients experienced these changes and how the pandemic impacted on their primary care attendance.

Aim: The aim of the study was to explore how patients, who frequently attended primary care practices before the pandemic, perceived primary care during the initial phase of Covid-19 in Germany.

Design and setting: Between January and June 2021, we completed 17 semi-structured interviews. Participants included primary care patients from two regions in Germany who frequently attended their physician before the start of the pandemic.

Method: Data were analysed using content analysis.

Results: Four interconnected themes emerged in the analysis: 'fear of Covid-19 infection', 'practice organisation', 'information about Covid-19' and 'telemedicine'. Participants were unconcerned about being infected in their practice and mostly agreed with Covid-19 regulations though waiting outside for their appointment was uncomfortable for some. Participants consulted their primary care physician in relation to different vaccines but felt they were sufficiently informed regarding general information about Covid-19. Views on telemedicine, which was mostly understood as contact via telephone or video call, differed widely, with some participants being very accepting and interested, others dismissing telemedicine categorically.

Conclusion: Participants regarded the new Covid-19 regulations as sensible. Telemedicine using telephone or video call consultations should be further explored under the assumption that this would be acceptable for some but not all patients.

Keywords: Primary health care, patient experience, Covid-19, lockdown

How this fits in:

- In German primary care practices, Covid-19 regulations were mostly perceived as sensible and acceptable.
- Primary care physicians were consulted on vaccines but not for general information regarding Covid-19.
- Participants were divided on telemedicine using video or telephone calls: it was acceptable for some but unwelcome for others.

Introduction

The Covid-19 pandemic had rapidly changed how patients could access primary care practices in Germany. Walk-ins were changed to telephone contacts or appointments, personal contacts with staff were reduced to a minimum, waiting rooms were closed and patients were asked to wait outside leading to long queues and waiting times [1]. During lockdown fewer consultations were completed, consultations reasons changed as well as medication prescribed and services delivered [2]. Up to date, the impact of the pandemic in primary care has been mostly investigated from the physicians' perspective: studies examined the general experience of the pandemic across Europe [1], coping strategies for practices [3], the use of telemedicine and virtual consultations [4], the impact on training and professional identity development [5], financial effects [6] and patient contacts [2]. Some studies also examined the patients' perspective, in particular their attitudes towards remote consultations: a Canadian cross-sectional study with 7532 participants found that primary care patients were comfortable with phone consultations (92%), video consultations (95%) and email or text messaging (91%) [7]. However, 31% of patients delayed care because of the pandemic and patients who were 65 years or older, had lower financial status, had not been born in Canada and/or had less education wanted to use the three digital consultation modalities significantly less beyond the pandemic, compared to other groups [7]. Surveys conducted in the US showed similar high satisfaction rates with telemedicine [8,9] as did a large interview study with 66 participants from eight European countries during the first wave of Covid-19 [10].

A wider range of patient experiences was investigated in two interview studies: Homburg et al. [11] showed that for Dutch patients, remote care was viewed as positive by some

patients as it lowered the threshold for contacting the GP, but as negative by others as it increased the fear of missing a diagnosis and was experienced as less personal. The study also indicated mixed feelings about personal protective equipment (feeling of safety, less personal feeling), showed reduced accessibility to the GP but more time for scheduled visits and a quieter practice, and suggested that some postponed their check-ups for chronic conditions and were stressed about not being able to bring a relative to the consultation [11].

Another interview study with patients, pharmacists and a primary care physician [12] investigated the experience of Covid-19 regulations in Irish primary care practices. The findings indicated that many patients were reluctant to enter GP practices for fear of getting Covid-19, and other patients had difficulties getting appointments. Electronic prescriptions directly delivered to pharmacies were seen as useful and medication safety was not considered an issue by patients. Some of these aspects were reflected in a Scottish qualitative survey [13], which also showed frustrations about the difficulties to get an appointment and worries about catching Covid-19. Remote consultations by telephone or video were a positive experience by some, others lacked confidence in remote appointments [13].

To date, it remains unclear how patients perceived Covid-19-related changes in Germany. Therefore, we explored how patients, who frequently attended primary care practices before the pandemic, perceived and used primary care during the first year of Covid-19.

Method

A qualitative study based on semi-structured interviews with primary care patients. The study was approved by the Faculty of Medicine/University of Marburg Ethics Committee (reference number 196/20).

Participants

We recruited primary care patients who were 18 years or older and had at least nine contacts with the primary care physician (in person, by telephone or video) within the twelve months before recruitment. It was decided to include those who frequently attended the GP practice as it was assumed that these patients would be particularly affected by pandemic related changes. The definition of frequent attender was based on a systematic review by Gill & Shape [14]. Participants needed to be able to provide informed consent and have sufficient German language skills to understand the study information and complete the interview. Covid-19 infections were recorded but not an eligibility criterion. Participants were recruited from primary care practices who were willing to support the study in the German states of Hesse (North and Middle Hesse) and East Frisia. These states were initially chosen to include areas with different Covid-19 rates but over the course of the study rates changed substantially, and a comparison of differently affected areas was no longer possible. We first recruited the practices via telephone to ask if they would be willing to support the recruitment of the study. If the leading GP agreed, we supplied them with information letters, consent forms and the short questionnaire for the participants. Practices supporting the study displayed a poster outlining the study with contact details of the study team. Interested patients would first talk to their GP who would provide further information about the study, and, optionally, the study information and consent form. Then,

if patients were still interested, they would contact the research team (DO) who introduced himself as the person who would also complete the interviews. We aimed for maximum variation sampling to include a diverse sample in terms of gender, age and exposure to Covid-19.

Data collection

Data was collected from January to June 2021. Interested primary care patients who called the study team and were eligible, received the study information, the consent form (if they had not received it yet from the GP) and a short questionnaire by mail. The questionnaire asked about participants' gender, age, living situation, if they or their relatives/friends had Covid-19 infections and how often they visited their primary care physician within the last 12 months. Interested candidates could discuss the study and/or ask questions either in person or by telephone. Both the signed consent form and the completed questionnaire were then sent back to the study team. All interviews were completed by the first author (DO) by telephone using a semi-structured interview guideline, which was developed by the research group based on the research aims and discussed in the department's qualitative research method advisory group. The final version is available as Supplement 1. The interviewer (DO, male) was a medical student with interest in primary care who completed the project for his dissertation and had personal experience with Covid-19 during his placement in a GP practice. Guidance and training to complete the interviews was provided by VvdW who is an experienced qualitative researcher. With the permission of participants, interviews were audio-recorded. Field notes were created during and after the interviews.

Data analysis

Audio-recordings were transcribed verbatim using the transcription protocol by Dresing and Pehl [15]. Transcriptions were analysed in combination with audio-recordings and field notes using a qualitative content analysis based on Kuckartz [16]. Analysis started parallel to conducting further interviews. Translations of quotes were completed by VvdW who is bilingual. A preliminary coding frame and potential themes were developed continuously, deductively guided by interview questions as well as inductively based on data. Once all interviews were completed data was analysed by VvdW and DO independently. Subsequently the coding frames and themes were discussed within the research team and a qualitative study working group within the department of General Practice/Family Medicine. Going back to the data, themes were adapted, and the process repeated. Preliminary results were presented to the qualitative study group of the Department of General/Family Medicine at the University of Marburg who provided feedback, which led to a final round of data-led refinement. The analysis was supported using the data management software MaxQDA [17].

Results

In total, 17 primary care patients (7 women) participated in the study with an age range between 20 and 88 years. Participants were recruited until a reasonably diverse sample in terms of age, gender and exposure to Covid-19 was achieved and coding did not generate new information that was considered relevant. Interviews took between 18 and 48 minutes. Pseudonyms and details are presented in table 1.

[table 1 about here]

Four interconnected main themes emerged in the analysis: 'fear of Covid-19 infection', 'practice organisation', 'information about Covid-19' and 'telemedicine'.

Fear of Covid-19 Infection

Fear of a Covid-19 infection was discussed independently but also in the context of Covid-19 regulations in the primary care practice, which therefore became a sub-theme ('Covid-19 regulations'). Another sub-theme of fear was 'it's not my personality'.

While fear of infection was discussed by all participants, their level of fear differed widely.

'No, I had never any concerns when I went to the doctor' (SP4)

'No, [I experienced fear] more in supermarkets or public transport, not in the primary care practice.' (ST 8)

'...I had twisted my ankle. Usually, I would have gone to the doctor to have a look at it. But I didn't. I didn't want to go.' (ST6)

Reluctance to go to the physician was only partly due to fear; the sometimes difficult organization of appointments also factored into the decision for some participants. Fear of Covid-19 in the PCP was more common in the beginning of the pandemic, and had often passed at the point when participant was interviewed.

'But then, no, then [I was not afraid] not anymore. Now I would go anytime' (ST3)

Familiarity with the primary care practice and trust were important. One participant regarded trust as a value for the primary care practice, which, in return, would create a responsibility to uphold the trust.

'And so there is trust. And in return, I'd say, the responsibility to maintain this trust.'

Therefore, I have no worries [regarding the risk of infection].' (ST8)

The busy environment of the practice did not increase the fear of contagion but was perceived as assurance that practice staff would be very careful as they were in danger of infections themselves.

Sub-theme 'It's not my personality'

When participants considered their response to Covid-19 in the context of their primary care contacts, personality was used to explain their attitudes.

'I'm rather optimistic. I don't have a pessimistic outlook on the world and always think it will be well. And I had no problems going into the primary care practice.'

(ST1)

'I really had no fear; I'm not an overly fearful type.' (ST7)

Sub-theme 'Covid-19 regulations'

Strict implementation of adherence to Covid-19 regulations, such as mask, use of disinfection dispensers, separate consultation hours for people with symptoms and distancing rules mostly reassured patients and eased their worries about infections in the practice.

'...yes, so, I am very happy with how the PCP deals with the situation. They [PCP staff] try to preferably eliminate the risk [of infection]...' (ST4)

'So that [the regulations] showed me: ok, I am safe, and can regularly visit the doctor'

(ST15)

Practice organization

Sub-theme 'appointments'

For some people, getting appointments was easy, others had difficulties just getting into contact with the practice.

'it was difficult [to get an appointment], by phone, for example' (ST9)

One person did not appreciate that she could not just walk in but had to make an appointment, which could not be changed with a quick chat to the receptionist. However, one person also mentioned that making an appointment was much easier during the pandemic. The participant suspected that less people tried to contact the practice.

Sub-theme 'waiting outside'

The 'waiting outside' rule, which many practices implemented to ensure distancing, was remarked on by many participants and not always approved of.

'...and that was very uncomfortable for someone of my age, when you had to stand outside for long' (ST6)

'...when it rained...then it was not so good, that you had to stand outside' (ST1)

On the other hand, there were participants who felt okay or safer waiting outside, and even some who preferred waiting outside already prior to the pandemic.

'...even before Covid-19 I did not like that, when you had to sit in the waiting room during flu season, you saw all the dripping eyes around you.' (SP 11)

'I hate full waiting rooms. Also, in the PCP when we did not have a pandemic, I registered, and, when the weather was nice, said: "I'll sit outside!"' (ST9)

Information about Covid-19

Most participants got their information about the pandemic from newspapers, television and the internet. For many participants there was too much information, which people experienced as overload and confusing.

'Covid-Extra, Covid-Special, Covid front, Covid sideways. It was all too much, ..because of the know-it-alls...also the virologists. That leads sometimes to uncertainty.' (ST9)

'I feel quite well informed. Partly over-informed' (ST11)

Information and assurance were also sought from online support groups. Primary care physicians were primarily consulted about questions relating to vaccines; participants partly assumed the physician would not now more than they did themselves.

'Which primary care physician would be able to answer these questions? He basically asks the same questions.' (ST 8)

Telemedicine

Telemedicine was a topic raised by the interviewer, and therefore discussed in most interviews. Views on telemedicine focused on consultations via telephone or video calls and ranged from welcoming to opposing.

'But I think this [video consultations] is actually a good idea' (ST3)

'...it could become normality, I could very well imagine that' (ST8)

'As long as it is not absolutely necessary, I'd rather not' (ST6)

'No, that is not for me.' (ST11)

Several participants also wondered how telemedicine would work. However, while several people felt they would not like it for themselves, none of them was against it as a matter of principle for health care in primary care.

Discussion

The findings from interviews during the second and third wave of the pandemic reflect the initial worries and confusion as well as their decline over the following year. In German primary care practices, the Covid-19 regulations were accepted and perceived as a shield against the risk of an infection providing safety for the patients and staff. Getting appointments was difficult for some but not for all. Even waiting outside was accepted; for some it was uncomfortable, in particular in bad weather and if they had to stand for longer periods of time. Others, who already disliked waiting rooms before the pandemic, viewed it as a welcome escape. The participant's own personality and general attitude was used to explain why they did not worry about Covid-19 infections. Given the quantity of information about Covid-19 from television, newspapers and internet sources, participants rarely consulted their primary care physician even if they perceived the information as contradictory and confusing. Participants approached the physician only when they needed information regarding the range of vaccines. Telemedicine was understood as consultation via telephone or video call. Participants' views differed widely, with some being very accepting and others dismissing it categorically.

Compared to Gleeson et al., 2022 [12], our study findings showed similar anxiousness in some patients to visit the primary care practice. Some patients were reluctant to go to their GP during the initial phases of Covid-19, which is reflected in the results of an observational study that showed a reduction of GP visits of 49% during the first months of lockdown in Germany [2]. Similar to the results of Brown et al. [13] and Homburg et al. [11], our findings indicated that getting an appointment was an issue for some of our participants. In addition, waiting outside was experienced as undesirable and uncomfortable for some, though not for everyone. It became evident in our study, that independent of the pandemic some people would rather avoid sitting in a waiting room and were quite content waiting outside or going for a walk to pass the time until their appointment. Receiving live notifications for wait times, for example using pagers or texts, has been indicated to facilitate empathic care in a hospital setting [18]. Similar systems using apps have shown to be useful and acceptable in a primary care setting [19]. In line with general population data, our study reflected declining fear of Covid-19 over time and the acceptance of regulations [20],

Participants trusted their primary care physician, with trust having been identified as an important factor for compliance with Covid-19 preventive behaviours [21]. This might explain the acceptance of Covid-19 regulations in the practices. The participants' perceptions regarding information reflect evidence from a British survey assessing Covid-19 information overload [4], which indicated that the frequency of receiving information about the pandemic was associated with higher levels of fear and confusion. While clear Covid-19 information messages from primary care practices might have helped patients who attended the practice regularly, it would require a well-organized dissemination of knowledge to the GP practices as a German survey showed that GPs themselves felt that they lacked information [22]. Telemedicine, which has received high levels of satisfaction by both physicians and patients

[9], has demonstrated to convey clinical empathy [23] and is considered to be feasible for primary care [24], was generally regarded more cautiously by the participants of this study. Some people supported it, some were unsure about it, and others did not consider it an alternative to face-to-face consultations. A recent literature review [25], reflected the mixed perception of telemedicine: some considered the remote consultations as convenient and a sensible measure to avoid Covid-19 infections, others had concerns about privacy, felt they lacked technical skills, worried about additional costs if the patient had to subsequently have a face-to-face appointment, and expressed barriers due to communication issues, loss of physical assessments, loss of non-verbal communication and shorter, or missed consultations. Considering the range of issues and the reluctance of some German patients to use telemedicine, remote consultations should be introduced gradually and with appropriate support. Patients could be provided with information on how to participate in a remote consultation and, if needed, shown how to use a mobile phone, tablet or computer for that purpose in the practice.

Strengths and limitations

The findings of this interview study are novel as perceptions of Covid-19 in primary care have mostly been investigated from physicians' but not patients' perspective. The study included a diverse sample in terms of gender, age, living situation and experience of Covid-19 among family and friends but only one participant has had a Covid-19 infection herself. Having experienced a Covid-19 infection might change the patient's perception of the GP practice. For example, the fear of getting a new infection might de- or increase worries about future infections and attitudes towards protection regulations. Furthermore, interviews were

conducted during the start and height of the third wave of the pandemic in Germany. Therefore, recall bias might have influenced the reporting of perceptions participants held during the earlier phases of the pandemic.

Conclusion

While fear and worries declined during the course of the pandemic and acceptance of Covid-19 regulations in the primary care practice was high, information overload was a large contributor to worries and confusion. Clear and distinct health information from primary care practices might have helped to ease the feeling of information overload and confusion. Waiting rooms, which have been standard in primary care practices before the pandemic, should be re-examined, as some people would rather avoid them. Using digital technology to provide live notifications (texts, pager) when appointments are starting would support those patients who do not want to use the waiting room. Remote consultations should be introduced gradually and with support from the primary care practice, in particular for those who are not confident using digital technology. To increase preparedness for pandemic outbreaks, research should explore how and by whom patients who are not confident in using digital technology, could be supported to participate in remote consultations.

Funding: The study did not receive funding.

Ethical approval: Ethical approval was granted by the Faculty of Medicine/University of Marburg Ethics Committee (reference number 196/20).

Data availability: Data is not available as this has not been included in the consent form.

Disclosure of interest: The authors report no conflict of interest.

References

- [1] Wanat M, Hoste M, Gobat N, et al. Transformation of primary care during the COVID-19 pandemic: experiences of healthcare professionals in eight European countries. *Br J Gen Pract.* 2021;71:e634–e642.
- [2] Schäfer I, Hansen H, Menzel A, et al. The effect of COVID-19 pandemic and lockdown on consultation numbers, consultation reasons and performed services in primary care: results of a longitudinal observational study. *BMC Fam Pract.* 2021;22:125.
- [3] Eisele M, Pohontsch NJ, Scherer M. Strategies in Primary Care to Face the SARS-CoV-2 / COVID-19 Pandemic: An Online Survey. *Front Med.* 2021;8:613537.
- [4] Mohammed HT, Hyseni L, Bui V, et al. Exploring the use and challenges of implementing virtual visits during COVID-19 in primary care and lessons for sustained use. *PLOS ONE.* 2021;16:e0253665.
- [5] Cullum RJ, Shaughnessy A, Mayat NY, et al. Identity in lockdown: supporting primary care professional identity development in the COVID-19 generation. *Educ Prim Care.* 2020;31:200–204.
- [6] Filippi MK, Callen E, Wade A, et al. COVID-19's Financial Impact on Primary Care Clinicians and Practices. *J Am Board Fam Med.* 2021;34:489–497.
- [7] Agarwal P, Wang R, Meaney C, et al. Sociodemographic differences in patient experience with primary care during COVID-19: results from a cross-sectional survey in Ontario, Canada. *BMJ Open.* 2022;12:e056868.
- [8] Holtz BE. Patients Perceptions of Telemedicine Visits Before and After the Coronavirus Disease 2019 Pandemic. *Telemed E-Health.* 2021;27:107–112.
- [9] Vosburg RW, Robinson KA. Telemedicine in Primary Care During the COVID-19 Pandemic: Provider and Patient Satisfaction Examined. *Telemed E-Health.* 2022;28:167–175.
- [10] Wanat M, Hoste ME, Gobat NH, et al. Patients' and clinicians' perspectives on the primary care consultations for acute respiratory infections during the first wave of the COVID-19 pandemic: an eight-country qualitative study in Europe. *BJGP Open [Internet].* 2022 [cited 2023 Aug 31];6. Available from: <https://bjgpopen.org/content/6/2/BJGPO.2021.0172>.
- [11] Homburg M, Brandenburg D, Hartman T olde, et al. Patient experiences during the COVID-19 pandemic: a qualitative study in Dutch primary care. *BJGP Open [Internet].*

- 2022 [cited 2023 Aug 31];6. Available from:
<https://bjgpopen.org/content/6/4/BJGPO.2022.0038>.
- [12] Gleeson LL, Ludlow A, Clyne B, et al. Pharmacist and patient experiences of primary care during the COVID-19 pandemic: An interview study. *Explor Res Clin Soc Pharm.* 2022;8:100193.
- [13] Brown LR, Williams AJ, Shaw K, et al. Information-seeking behaviours and uncertainty around accessing primary care in the changing landscape of the COVID-19 pandemic: a qualitative study. *BJGP Open [Internet]*. 2022 [cited 2023 Sep 21];6. Available from: <https://bjgpopen.org/content/6/1/BJGPO.2021.0151>.
- [14] Gill D, Sharpe M. Frequent consulters in general practice: A systematic review of studies of prevalence, associations and outcome. *J Psychosom Res.* 1999;47:115–130.
- [15] Dresing T, Pehl T. Transkription. In: Mey G, Mruck K, editors. *Handb Qual Forsch Psychol Band 2 Des Verfahr [Internet]*. Wiesbaden: Springer Fachmedien; 2020 [cited 2022 Jun 7]. p. 835–854. Available from: https://doi.org/10.1007/978-3-658-26887-9_56.
- [16] Kuckartz U. *Qualitative Text Analysis: A Guide to Methods, Practice and Using Software*. SAGE; 2014.
- [17] Verbi. MAXQDA [Internet]. 2022 [cited 2022 Jul 4]. Available from: <https://www.maxqda.de/software-inhaltsanalyse>.
- [18] Kang ES, Di Genova T, Howick J, et al. Adding a dose of empathy to healthcare: What can healthcare systems do? *J Eval Clin Pract.* 2022;28:475–482.
- [19] Angermeier DK. *Digitale Unterstützung für Hausarztpraxen: Konzeption und Design einer nutzerzentrierten Anwendung zur Prozessoptimierung bei Arztbesuchen*. Technische Hochschule Ingolstadt; 2021.
- [20] BfR. *BfR Corona Monitor [Internet]*. 2020 [cited 2022 Jul 4]. Available from: <https://www.bfr.bund.de/cm/349/200414-bfr-corona-monitor-en.pdf>.
- [21] Ayalon L. Trust and Compliance with COVID-19 Preventive Behaviors during the Pandemic. *Int J Environ Res Public Health.* 2021;18:2643.
- [22] Doepfmer S, Akdenizli K, Dashti H, et al. Changes to utilization and provision of health care in German GP practices during the COVID 19-pandemic: Protocol for a mixed methods study on the viewpoint of GPs, medical practice assistants, and patients. *PLOS ONE.* 2023;18:e0279413.
- [23] Vennik J, Hughes S, Lyness E, et al. Patient perceptions of empathy in primary care telephone consultations: A mixed methods study. *Patient Educ Couns.* 2023;113:107748.

- [24] Garattini L, Badinella Martini M, Zanetti M. More room for telemedicine after COVID-19: lessons for primary care? *Eur J Health Econ.* 2021;22:183–186.
- [25] Verma P, Kerrison R. Patients' and physicians' experiences with remote consultations in primary care during the COVID-19 pandemic: a multi-method rapid review of the literature. *BJGP Open* [Internet]. 2022 [cited 2023 Sep 21];6. Available from: <https://bjgpopen.org/content/6/2/BJGPO.2021.0192>.

Accepted Manuscript - BJGP Open - BJGPO.2025.0129

Table 1: Study participants

	Gender	Age	Living situation	Covid-19 infection	Infections among family and friends	Primary care visits during the last year
ST1	man	78	living alone	no	yes	5-9x
ST2	woman	20	with partner	no	no	more than 10x
ST3	woman	45	living alone	yes	no	5-9x
ST4	man	59	with partner	no	yes	more than 10x
ST5	man	58	with partner	no	no	more than 10x
ST6	woman	88	living alone	no	no	5-9x
ST7	woman	65	with partner	no	no	5-9x
ST8	man	73	with partner	no	no	more than 10x
ST9	man	67	with partner	no	no	more than 10x
ST10	woman	62	with partner	no	yes	more than 10x
ST11	man	67	with partner	no	no	more than 10x
ST12	man	77	with partner	no	yes	more than 10x
ST13	man	83	with partner	no	no	5-9x
ST14	man	64	with partner	no	yes	5-9x
ST15	woman	61	with partner	no	no	more than 10x
ST16	man	82	with partner (ST17)	no	yes	more than 10x
ST17	woman	76	with partner (ST16)	no	yes	more than 10x