Management of Minor Illness

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Foreword by G A Phalp

King Edward's Hospital Fund for London

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Papers from a seminar

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Foreword

The King's Fund has been supporting a series of seminars as a contribution towards the study of priorities in medical care and the performance of management in relation to medical services.

The series began with the subject of minor illness. The papers originally presented for discussion have been revised by the authors for publication. The Fund is grateful to them and to the other members of the seminar for bringing their expertise and experience to the study of these important issues. In particular, the Fund wishes to pay tribute to Dr Peter Mond for his able contribution to the planning and organisation of the seminar.

We hope that with the publication of this collection discussion will continue on a wider basis throughout the health service. It is published with a companion volume *Management of Chronic Illness* from the same series of seminars.

G A Phalp

1978

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What is minor illness?

MARK McCARTHY

What is minor illness? Who defines it? What services care for it, and what alternatives exist?

Minor illness can be placed along a continuum from full health, through illnesses of increasing gravity, to terminal illness and death; but it is difficult to state where on the continuum minor illness begins or ends. Much of the discussion in this paper, therefore, will be about illness in general and how people and medical services perceive it, so that the particular place of minor illness can be identified.

Two groups of words with overlapping meanings are likely to occur: sickness, illness and disease; and handicap, disability and impairment. Sometimes the word 'condition' can be used to escape these difficulties.

This paper presents three approaches to defining minor illness. In the first part, surveys and administrative statistics are used to illustrate illnesses identified at different levels of care, and changes over time. In the second section, different factors thought to affect illness perception are presented. The third section is a brief review of sociological approaches to illness, and looks at the concept of trivia. Finally, the discussion section brings in some broader issues for debate.

Review of studies and routine statistics

This section looks at some of the studies and routine statistics which illustrate different degrees of illness. Using standard diagnostic groups, one can compare how doctors regard illness in different areas (community, clinic, hospital, and so on) and the trends evolving in illness presentation.

Surveys

In epidemiological surveys of illness by questionnaire, the amount of illness recorded depends upon the depth of questioning. In the study by Wadsworth, Butterfield and Blaney[114] each interview began with the question 'Would you say that your state of health during the last fourteen days was perfect, good, fair or poor?' Just over one-third (35 per cent) of the respondents assessed their state of health as 'perfect', 34 per cent felt in 'good' health, 21 per cent said that their health was 'fair' and 10 per cent felt in 'poor' health. However, after a detailed questionnaire and checklist of complaints had been given to the 2153 respondents, only 105 (4.9 per cent) finished claiming to have been completely healthy within the previous fourteen days.

The 1971 General Household Survey (GHS)[48] asked two very general health questions, and 21 per cent reported 'limitation' due to acute or chronic sickness. It is of note that this figure is very similar to the proportion identified by the introductory questions of the Southwark study.[114] In the GHS, 16 per cent had a long-standing limiting illness and 8 per cent had an acute illness.

In 1972, the GHS question on long-standing illness was rephrased, trying to isolate the component of peer reference, and different responses were obtained (Table 1).

TABLE 1 Preliminary question on health from the General Household Survey[48]

	Persons answering 'yes' %
1971	
Do you suffer from any long-standing illness, disability or infirmity which limits your activity compared with most people of your own age?	16.0
1972	
Do you suffer from any long-standing illness, disability or infirmity?	20.6
If yes	
Does [it] limit your activity compared with most people of your own age?	12.0

Comparison of the two 1972 questions shows how small alterations produce markedly different results. Nevertheless, the two questions may both be 'right' for different purposes. The first question on long-standing illness provides the epidemiologist with a figure which may be close to the prevalence rates of chronic sickness within the private population. On the other hand, the question related to 'people of your own age' may be more useful to administrators and planners, as it is likely to be more closely related to people's motivation to use services.

It is of interest that the reduction in response to the second question in 1972 was found for all ages, since it is often assumed that only elderly people understate the extent of their disability by attributing it to aging. This effect, if it exists at all, seems to be no more important than the perception by younger people of their handicaps in relation to others of similar age.

No English survey has made a close comparison of total health needs, identified by questionnaire, with objective health state, by medical examination, although particular system questionnaires such as Medical Research Council schedules for respiratory, locomotor and mental illnesses have been validated in this way. However, as an indication that these by no means match up simply, the responses of the Southwark survey were compared with the results of a population screening exercise undertaken by the medical officer of health in the same borough a few years later. The screening study was non-random, taking patients who came voluntarily to a mobile clinic, and is over-represented with women and middle classes; but these factors do not completely explain differences between the two groups (Table 2).

In Table 2 the first three health complaints (ascribed to respiratory, mental and skeletal systems) form 67 per cent of complaints but only 19 per cent of disorders found on screening—coughs and colds, headaches and tiredness, and low back pain are common symptoms but difficult to demonstrate medically. On the other hand, digestive, nervous or circulatory disorders were frequently identified on screening but gave rise to far fewer complaints.

The comparison emphasises the different views on health and illness that are held by patients and doctors. This question of definition by perspective is considered in more detail in the section on illness behaviour.

Utilisation

A number of local general practice studies is collected in *Present state and future needs of general practice*[98] and gives a rough guide to the range of severity of presenting complaints. It suggests that about 65 per cent of conditions seen could be called minor (self-limiting, with no risk to life or permanent disability), 15 per cent as major, immediate life-threatening situations and 20 per cent as

TABLE 2 Comparison of interview and screening surveys in Southwark 1963–69

Complaint	*Screening disorders* %	*Complaints reported* %
Respiratory	4.1	27.7
Skeletal	7.0	16.6
Mental	7.6	22.8
Skin	3.3	5.8
Gastrointestinal	23.2	11.7
Sensory	23.5	8.3
Endocrine	0.3	0.1
Circulatory	12.8	4.5
Gynaecological / Genitourinary	17.9	2.4
Total complaints (= 100%)	2171	8643

Note: 6.7% of the people examined were without screening disorders and 4.9% of those interviewed had no complaints.

Source: *Health and sickness: the choice of treatment,* by M E J Wadsworth, W J H Butterfield and R Blaney.[114] Reproduced with the permission of Tavistock Publications Ltd.

chronic conditions with permanent disabilities. This classification reflected the context of current medical practice: thus, acute otitis media is classified as 'minor illness', although the course of this illness is markedly changed by therapeutic intervention with antibiotics and, if not treated promptly, the consequences to the

TABLE 3 Summary of management of the five most common groups of complaints, expressed in each case as a percentage of all complaints in that group

Complaint group	*Visited a doctor* *	*Away from work* *	*Bed rest* *	*Asked non-medical advice* *	*Medically prescribed medication* *	*Non-medically prescribed medication* *	*Who had ever diagnosed Medical*	*Non-medical*
Respiratory	4.1	3.0	1.0	0.6	13.0	21.1	37.0	63.0
Tiredness, worry, etc	3.7	1.7	0.8	0.3	11.1	19.0	19.6	80.4
Rheumatic	5.1	1.6	1.0	0.1	16.4	29.8	39.2	60.8
Digestive	4.2	1.5	1.4	1.4	13.6	36.1	22.7	77.3
Skin	5.0	2.2	1.2	0.8	17.7	50.4	27.3	72.7

* During the previous 14 days.

Source: *Health and sickness: the choice of treatment,* by M E J Wadsworth, W J H Butterfield and R Blaney.[114] Reproduced with the permission of Tavistock Publications Ltd.

patient are serious—for instance, severe earache, possible chronic infection and deafness, or a possible cerebral abscess.

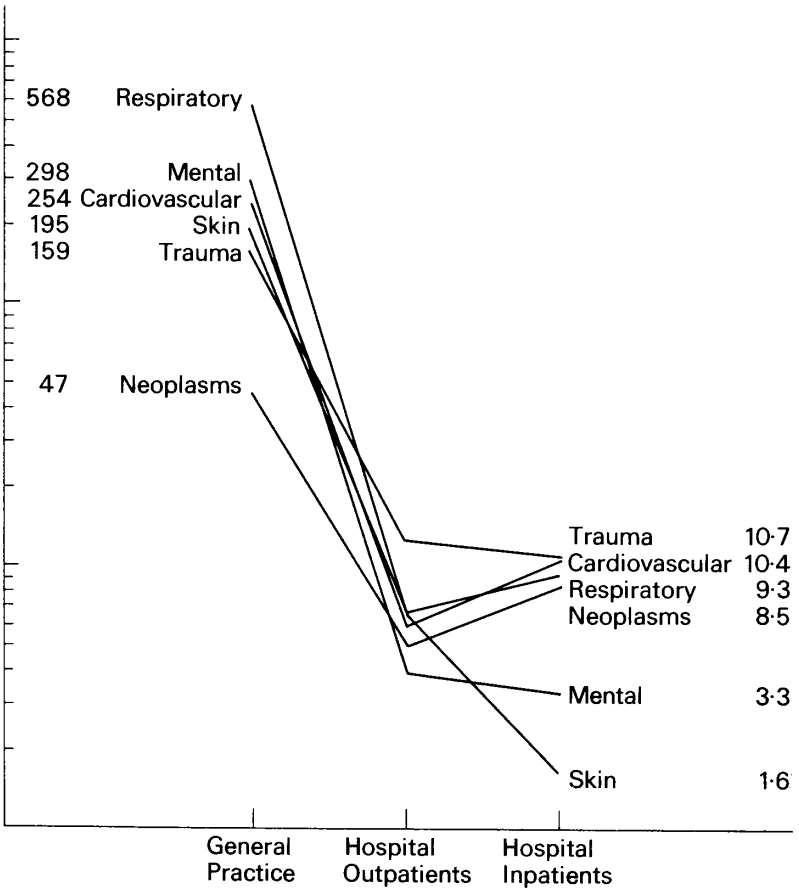
However, not all symptoms perceived as illness are referred for medical attention. The levels of GP consultation recorded by doctors in the second national morbidity survey[49] were similar to those reported by patients in the General Household Survey.[48] But in the latter, less than half of the respondents recalling a limiting acute illness within the previous fortnight had gone to their general practitioner, and this proportion was only 17 per cent for limiting chronic illnesses. So utilisation studies by themselves cannot define the extent of minor illness as perceived by the whole population.

The Southwark survey[114] supports this view. Table 3 gives a summary of the five most common groups of complaints recorded, and shows that the patient took medication (using either medically or self-prescribed drugs)—sometimes on his own initiative—much more frequently than attending a doctor.

The lack of a clear relationship between need and utilisation, particularly for less urgent illnesses, supports the hypothesis that there are thresholds for presentation to medical care which depend upon cultural and demographic factors, and upon the availability or otherwise of appropriate services.

Thresholds to care can be assessed in very rough terms from data of attendances at general practice, outpatient and inpatient levels. Figure 1 demonstrates this in graph form, and shows consultations for selected diagnostic groups per 1000 population per annum. General practice figures come from the national morbidity survey.[49] Outpatient attendances are from a local study at Chesterfield, undertaken by the former Sheffield Regional Hospital Board.[18] The inpatient figures are deaths and discharges from the *Hospital inpatient enquiry* for England and Wales, with mental hospital admissions from the Mental Health Enquiry added.[42]

FIGURE 1 CONTACTS PER 1000 POPULATION PER ANNUM IN THE NATIONAL HEALTH SERVICE BY SELECTED DIAGNOSTIC GROUPS



The main trends are that respiratory and cardiovascular conditions are commonplace in general practice, not so often referred to outpatients, but again become frequent causes of inpatient care. Mental health and skin complaints also are common in general practice, but are seen progressively less often at hospital. On the other hand, neoplasms and trauma form a progressively higher proportion of diagnoses seen at outpatients and on admission. These trends, therefore, give general support to the commonly held categories of minor and major illnesses, the latter being those more frequently 'needing' hospital attention. Taking an individual diagnosis—for example, migraine—the gradient is

	Disease	*Consultations per 1000 population*		
		GP	OP	IP
code 346	Migraine	12.3	2.0	0.18

Morbidity trends

Crombie[21] has reviewed the data available in the first (1955–56) national morbidity survey with those in the second (1970–71) study. The number of illness episodes presenting to general practitioners has increased, but, because reattendances dropped markedly, the overall workload has decreased. Comparison of the rates within the diagnostic categories suggests that it is the minor illnesses which have increased. Table 4 shows that the smallest percentage increases—or, in some cases, reductions—have been for neoplasms, diseases of the blood and blood-forming organs, diseases of the nervous system and sensory organs, diseases of the circulatory system, and accidents, poisoning and violence. In contrast, conditions with the greatest percentage increases include communicable diseases, mental, psychoneurotic and personality disorders, symptoms and ill-defined conditions and prophylactic procedures.

TABLE 4 Patients consulting per 1000 population by diagnostic group in first and second national morbidity studies[49]

	1955–56	*1970–71*
Infections and parasitic	55	71
Neoplasms	11	12
Endocrine, nutritional and metabolic	19	26
Blood and blood-forming organs	14	12
Mental	50	110
Nervous system and sensory organs	115	114
Cardiovascular and respiratory	264	260
Gastrointestinal	107	121
Genitourinary	53	75
Complications of pregnancy	17	22
Skin	113	113
Skeletal	86	91
Congenital	2	2
Perinatal	2	<1
Ill-defined	95	244
Accidents, poisoning and violence	102	85
Prophylaxis	53	139
All conditions	670	671

TABLE 5 Changes in sickness absence diagnosis over 18 years for men in Great Britain

Increase or decrease in days and spells per capita in 1971–72 as percentage of 1953–54

	Days	*Spells*
Sprains and strains	368	343
Nerves, debility and headache	362	335
Displaced vertebral disc	288	327
Diabetes	223	180
Diarrhoea and enteritis	213	283
Arteriosclerotic heart disease	187	187
Psychoneurosis	167	158
Migraine	153	214
Bronchitis	136	95
All causes	123	129
Kidney infection and cystitis	77	101
Eczema and dermatitis	66	82
Gastritis	65	86
Asthma	50	62
Septic skin disease	49	43
Appendicitis	49	50
Pneumonia	38	38
Ulcers: stomach and duodenum	34	39
Respiratory tuberculosis	14	15

Source: *Sickness absence: facts and misconceptions.*[107]

Taylor[107], discussing trends in sickness absence, points to many difficulties of interpretation. About one-third of the total days relate to people who are permanently disabled, will not work again, but are not yet of pensionable age; spells are calculated on a six-day week, but spells of up to three days are not included because they are uncertified; the figures do not include members of the forces, non-industrial civil servants or post office staff; and married women at work are often not insured for sickness benefit.

Nevertheless, these factors have been present for many years, and the trend in the figures is thus of interest. It is clear that, despite rising health expenditure and better material standards, certified sickness absence has risen steadily since the early 1960s. Table 5 shows that more objective diagnoses have tended to fall, whilst the overall increase in sickness absence has been produced by a rise in less precise diagnoses.

Factors affecting the perception of illness

This section identifies some factors which have affected the perception of illness. For convenience, they are grouped under three headings: medical factors include those related to professional definitions of illness; demographic factors are those often identified as partial determinants of behaviour in social surveys; and economic factors relate to aspects of the system of health care.

Medical factors

Historical The practice of medicine, viewed historically, shows changes in conditions which doctors regard as 'sickness'. Before the introduction of the electrocardiogram in the early years of the present century, 'heart attacks' were not distinguishable from other chest pains, and, because of the frequency of respiratory conditions such as phthisis (tuberculosis), consumption (con-

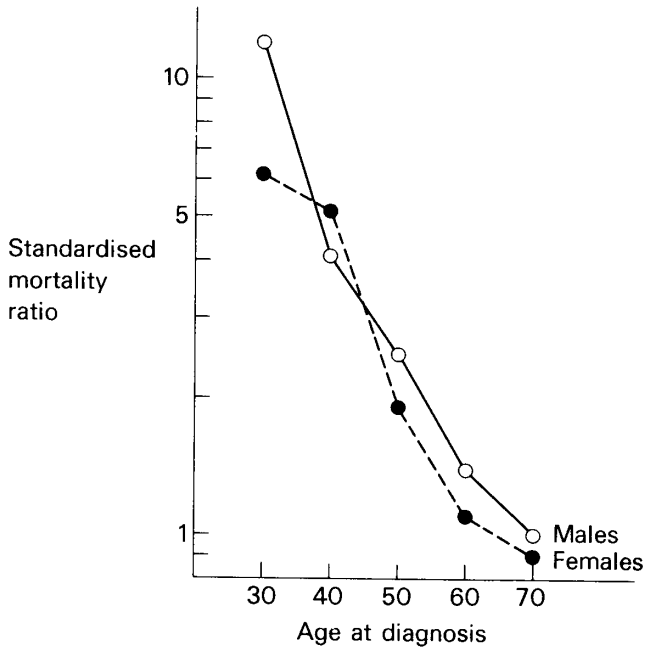
gestive cardiac failure) and pneumonia, the heart attack was not separately distinguished.

Better diagnosis has two effects working in opposite directions. When only a few conditions are described, most illnesses will be put into one of a few categories, usually without regard to niceties of coherence. This is still the case in part for psychiatry. On the other hand, as diagnoses become harder and more assured, the unusual case becomes more problematic, and may be labelled minor or trivial because no diagnostic slot is appropriate. Some evidence for this is present in studies of classification in general practice, where the World Health Organization international classification of disease[118] is unsatisfactory for symptoms which are neither 'minor' nor fit easily into a diagnosis.

Screening The 1960s brought a new difficulty in defining minor illness. Population screening may identify patients as having an 'illness' before they ever experience symptoms. Of itself, this may represent only the difference between medical definitions of illness and the patient's subjective assessment. Screening for high blood pressure is a good example. A man with diastolic blood pressure of 120 mmHg found on screening is 'at risk': is he ill? Does illness include a probability factor? Mild hypertension may be a minor illness in its short-term effects, but when identified in young people is it more serious because it is likely to rise as they get older? In Fry's[32] series of untreated hypertensives in general practice, life-expectancy was shorter when hypertension was diagnosed at younger ages (Figure 2).

Another aspect of screening is the differentiation between normal and diseased.[88] Parameters distinguishing healthy from diseased populations may overlap, resulting in an area of uncertainty between two populations, with false negatives and false positives in the two groups. Equally, random screening tests will go beyond 95 per cent confidence limits simply because of the statistical

FIGURE 2 STANDARDISED MORTALITY RATIOS FOR UNTREATED HYPERTENSION IN GENERAL PRACTICE



Source: *Natural history of hypertension.*[32]

definition of 'normal'. Furthermore, not all screening tests use clearly defined criteria. For instance, many questionnaires give a range of positives from minor to major: they do not split the population clearly into diseased and normal. In these situations, the definition of 'minor' is very arbitrary.

Categories Another aspect of professional recognition of disease is that the 'medical' categories can be changed. Sometimes this is

because of new therapeutic opportunities: following the pattern of twentieth century technical medicine, if a condition can be treated in some way, it is more clearly defined as an 'illness'. Obesity is an example. At present, appetite suppressants or stimulants are poor factors in weight control, since a heavy psychological commitment is of underlying importance. It is seen, alongside alcoholism and smoking, as a health-related condition but not an illness. If, however, an effective 'treatment' could be found—especially if it were simple, pleasant and personally controlled—then obesity would be like hypertension. It would be actively sought and treated by doctors. A difference would be that the three conditions mentioned depend on personal behaviour, whereas hypertension is apparently endogenous: nevertheless, it is likely that each condition would be much more acceptable as an illness to doctors.

Until the late nineteenth century, with the advent of a few rational treatments, doctors were not over-concerned about what categories were 'medical': that their advice was asked was sufficient. By the 1950s and 1960s technical medicine could define fairly precisely how much it could benefit any particular condition, so that today's doctor feels he knows much more clearly what 'is medical' and what 'is not'. Patients are concerned with their 'problems', and turn to doctors as one source of help. Doctors are defining only problems they believe they can treat as medical ones. Medical emphasis is on curing, leaving caring to others.

Alternative healers Medical and lay definitions of illness are not the only ones we should consider. Barbara Ehrenreich makes this point at the start of a lively paper on the sexual politics of sickness.

> 'The 19th century was a time of great ferment in American medicine. There were dozens of medical sects, each with its own particular philosophy of healing—homeopaths, eclectics,

> botanists, Thomsonians—to name but a few. One sect is of particular interest, because, unlike most of the others, it was entirely male in composition. This sect had inherited from colonial times a somewhat mystical philosophy of healing called "allopathy" and an approach to healing that has been termed "heroic"—probably because of the heroism required of their patients. Bleeding (until the patient fainted or until the pulse ceased), blistering, and massive doses of calomel (a mercury-based laxative) were their principal techniques until the latter part of the 19th century, when surgery and opium were added. This particular sect held the messianic belief that they were the only true healers, a belief which they publicized through various verbal devices. They styled themselves as "regular" doctors, all others being termed "irregular", or, less politely, "quacks". And when they formed their first national organization, in 1847, they named it *the* American Medical Association.'[26]

Alternative approaches to allopathic medical care continue to flourish in the west as well as in developing countries.[74, 85] Where they exist side by side, it suggests that lay people as consumers can make personal choices between the different definitions of illness and care.[6] Here is one answer to critics who have claimed health care as 'too important to be left to doctors'.

Demographic factors

Regional variations Several health service characteristics show regional variations which cannot easily be explained on grounds of morbidity alone. Hospital admissions[42], general practice consultations[49], sickness absence[38] and prescriptions[40] are all higher in Wales and the north of England than in the south. Urban–rural differences have also been noted, although they are not of marked effect. Hart[57] has pointed out how resource provision is, in

general, inversely related to the health care needs demonstrated by utilisation. This may lead to regional differences in perception of health. For example, a survey of children's teeth[110] showed that 50 per cent of 14-year-old children in Wales had had some permanent teeth extracted, compared with only 18 per cent in London and south-east England. Yet this does not correlate with caries morbidity as, for instance, fluoridation does. It relates to the lack of conservative dentistry—loss of teeth seems to be more acceptable in regions with fewer dentists.

Class Differences in social class perspectives on disease have been described extensively (for example by Cartwright[14] and by Kosa and Zola[71]). Among the points made are that differences of work needs may lead to different estimates of incapacity (for example, backache is more disabling for a manual worker than an office worker); working class people undertake less action for disease prevention, perhaps because of attitudes which do not encourage action for deferred rewards, perhaps because of sociolinguistic problems in the communication of preventive concepts by health professionals; working class people define a wider range of behaviour as normal rather than mentally unbalanced, but are more definite in their differentiation of the normal from the unbalanced; middle class people seem to be more likely to ascribe psychological causes to symptoms than are working class people; and unemployment occurs frequently before and after psychiatric hospitalisation.[30]

Nevertheless, compared with the social anthropology literature, there is a relative paucity of descriptive and analytic studies on health attitudes and perceptions in England. For example, McKinlay[75] has suggested that there is a connection between the under-utilisation of professional help found in working class communities with the lay consultation and referral system of close-knit family networks described by Bott.[7] This is a fascinating but unestablished hypothesis. McKinlay also suggests that

different somatic conceptions exist which influence the treatment that is acceptable.

> 'The poor do appear to entertain a conception of the body as a kind of elaborate plumbing system, to be occasionally "flushed out", "unblocked" or "cleansed" as the need arises. This conception is probably reflected in the use of patent laxatives, liver and kidney tablets, and the so-called "blood cleaners".'[75]

Ethnic groups Studies of English social attitudes will help also in explaining comparative studies in those immigrant people now assuming English habits. We know, for instance, that many Indians in England have both National Health Service and private doctors, both primarily practising 'western' medicine.[19] We do not know how much their perspectives, transformed into British social class ways, will create new patterns of health-related behaviour and utilisation of services. Ethnic variations have been found in rates of hospitalisation for mental illness in South London.[2]

In the USA it seems that differences may remain after apparent cultural assimilation. For example, in a study of 63 Italian and 81 Irish patients at a hospital general outpatient clinic, Zola[120] found that the Irish patients complained of symptoms relating to the eye, ear, nose and throat eight times as frequently as Italians, whereas the latter identified pain as part of their presenting symptoms twice as often as the Irish.

Age Age is very much a function of health as well as of illness. Child health practice is concerned with developmental surveillance and prophylactic measures. In young adulthood, physical fitness is encouraged by popular sports and probably contributes to the low levels of morbidity of these ages: good nutrition and home environment have diminished the chronic infective and respiratory

illness of former years, so that mortality now relates to accidents, cancer and genetically determined conditions. By middle age the effects of self-neglect appear in disease patterns—lung cancer, cirrhosis, osteoarthritis of obesity—and progressively degenerative conditions become prevalent. Yet it is not clear why only some members of the population are affected by these conditions, or to what extent they may be preventable.

The degree to which people assess their health within peer strata by age is unknown: the answers to the GHS questions[48] indicated that a proportion of people at all ages feel their ill-health to be no different (or no more limiting) than others of their age. There may be generational effects: those who are now elderly in the UK lived their youth before the antibiotic era—and before the NHS. People today are more aware of science and its impact on medical care. Will the next generation of senior citizens be more vocal in demanding better health services for the elderly? They have seen open-heart surgery and renal dialysis used for the middle-aged: will they demand that these be extended to the elderly (their generation grown older)?

Age therefore has two effects on the seriousness of illness. In a biological sense, the probability of serious illness (from a medical perspective) rises with increasing age; for instance, a fall at the age of 85 is far more likely to result in a fractured hip than at 35. Yet, at the same time, is there less perception of the intensity of a specific illness with increasing age: is the younger patient with a broken hip more likely to complain of pain (sensory perception higher) and to be impaired in mobility because of greater activity (social perception higher)?

Economic

International comparisons of health care utilisation help identify system aspects of illness behaviour. The relationship to financing

is complicated because most countries with developed services have a mixture of insurance and private payment mechanisms, sometimes both operating together for one illness episode. Equally, since there is evidence that utilisation increases with availability of services, comparative studies must try to balance out differing levels of provision.

Evidence for financial effects on medical practice comes from Lichtner and Pflanz's study in Germany[73], where appendicectomy rates are four times as high as in England. Since this is a condition likely to have a similar incidence throughout Europe, and for which the indications for surgery can be specified with some clarity, the inference may be drawn that some financial advantages in Germany lead to the higher operation rate. With less urgent conditions, such comparisons are less meaningful, since doctors will differ in their views on the need for surgery. Varicose veins and hernias are treated surgically but, because the private market provides—to some extent—a consumer-dominated cosmetic service, the variations in practice are not so easily established or their causes assigned.

Access to care is determined by the organisation of services, and one component of illness behaviour is availability of a doctor. Countries with capitation systems of remuneration (Denmark and Britain) have retained a tiered system of general practitioner and consultant referral. There is rough equality of utilisation by all social groups, since the resources of care depend upon open access (GP list) and medical referral rather than self-referral. Where there is a 'single tier' practice, a doctor seeing his patient both at his office and potentially also in hospital, with greater remuneration for the latter, then hospitalisation is more likely for the more well off. In such countries, the illnesses seen at different thresholds of the spectrum of care will be less likely to represent differences between minor and major illnesses.

Illness behaviour

Studies of the process of becoming a patient have been reviewed by Mechanic[78], and by Kasl and Cobb[67,68]. These authors identify the various social groups which are more likely to use medical services, and the social and cultural values which mediate the process. Tuckett summarises the features as follows: 'For symptoms, which are recognized by the medical profession as signs of disease, to be taken to the doctor they must first be perceived as a problem, then defined as something to be taken to the doctor, and then actually taken there.'[111] He terms these components recognition, definition and action. Descriptive studies using social categories alone do not explain the *reasons* for consultations at a particular time—thus, various studies suggest that the decision to seek medical aid is based upon a break in accommodation to symptoms rather than on a worsening of symptoms. Mechanic states that one of the more consistent findings in illness behaviour literature is that people are more likely to take action for their symptoms that in some fashion disrupt usual functioning than in other circumstances, and that concepts of health are affected as much by total functioning as by the nature of symptoms experienced.[79]

Some components of recognition and definition are related to professional estimates of the seriousness of an illness. Major symptoms such as a fractured leg or high fever, or which are seen to be life-threatening, have a process of illness behaviour most closely in line with medical assumptions of rational behaviour. However, for the large majority of symptoms which are less serious, the perceived threat of the disease and the perceived probability that action will produce results are both lower. Many courses of action are open—ignoring the symptoms, self-medication, going to the doctor or quasimedical agencies, religious advice and so on. In going to the doctor, the patient balances the 'benefits' of relieving symptoms such as pain and the threat of the

disease against the 'costs' of money, time and the stigma of the patient role.

Various ways of looking at and analysing patient behaviour are held in medical sociology. Parsons' conception of the sick role was specified in four characteristics. The patient

1 is exempt from normal social responsibilities

2 is unable to 'help' being ill

3 has an obligation 'to get well'

4 must cooperate with his physician to do so.[89]

But this ideal type excludes many patients who attend doctors (alcoholics, for example), and Robinson has suggested an interactional definition, that 'socially a person is sick only when one or more significant others identify and treat him as sick'.[95] The process of definition becomes more important than simple presentation to medical care.

Others have followed Balint[4] in broadening the range of possible reasons for consultation. For example, they may want company, want advice from the doctor on how to obtain a council house, or get on better with their husband, or wish to reduce pressure that is being put on them by friends.[111] If these are the underlying reasons, then the actual symptoms present are irrelevant—as indeed is the quality of medical treatment provided, as long as it is not positively harmful. Some general practitioners believe that, in a moderate proportion of consultations, the presenting symptom may not be the 'real' reason for attendance, and in some formulations the 'real' reason may not even be present in the patient's consciousness. Stimson and Webb comment somewhat cynically 'In this view, the doctor knows his patient better than the patient knows himself. The popularity of this approach is

not surprising because (1) amateur psychoanalysis appears to be easy, (2) the doctor's interpretation is irrefutable, (3) it does not threaten the relationship from the point of view of the doctor because the power (interpreting) is in the doctor's hands. His control is thus extended.'[105]

The problem of why patients present in general practice was neatly contrasted by Kessel and Shepherd[69], who interviewed the non-attenders (for over two years) of a single practice and compared them with more frequent attenders. Perhaps surprisingly they found a rather similar range of perceived illnesses in the two groups, but the non-attenders denied the need for as much professional help and tended to use self-medication more. The fact that social class, employment status, marital status and household size were similar in the two groups suggests that these demographic characteristics do not themselves contribute much to illness behaviour.

Trivia

Discussion of medical consultation from the patient's view emphasises the many alternative paths of action open to someone who recognises 'symptoms', and consultation with a doctor is but one of these. From a professional view, however, it is 'natural' for a person with symptoms to consult and receive treatment. The doctor, whether or not he acknowledges that filtering has occurred before patients 'present', expects his patient to conform to Parsons' strict conception of the sick role[89], and to be ill. General practitioners are more likely to accept social reasons for presentation than hospital doctors; nevertheless, trivial consultations are an important cause of irritation for both groups.

In her study, *Patients and their doctors*[14], Cartwright found that general practitioners considered about a quarter of their con-

sultations to be trivial.* In this group, about half the consultations 'were attributed to minor illnesses which the doctors did not feel needed medical care. Conditions recorded included colds, coughs, catarrh, headaches, morning sickness, small boils, hair falling out, minimal wax in ears, obesity, dandruff, constipation, dysmenorrhoea, indigestion, teething, cuts, bruises . . .'[14] Other consultations mentioned were for certificates and forms to be signed (18 per cent) and repeat prescriptions (11 per cent). Certain attributes of the doctors were associated with their level of perception of trivia. Of particular note was that those who claimed a special interest in psychiatry recorded trivia relatively infrequently. But they all seemed to exercise some control over the amount of trivial consultation they undertook: doctors who frequently perceived trivia did not have any difference in the overall number of patients attending them but their patients had less *frequency* of attendance.

If the conditions which doctors considered trivial were simply very minor illnesses, it would be possible for health education to overcome some of the frustrations general practitioners feel by raising the threshold for consultation up to suitable important illnesses. But in fact the situations which frustrate doctors, and are thus often dismissed as trivial, include those where the doctor is not able to affect the course of the complaint. Thus two further categories of trivia may include conditions presenting medically but in which a rather large social component exists (for example, lesser symptoms of alcoholism) and those in which there are repetitive minor symptoms for which there is no physical treatment (for example, minor strokes or arthritis). For these groups of patients a greater acceptance of social definitions of disease, without demand for therapy, may reduce the frustration experienced by doctors.

*In a re-survey of a group of the same GPs two years later this level had fallen somewhat, perhaps because of the progressive introduction of receptionists and appointment systems which might 'protect' the doctor.

Another group of symptoms frequently commented on are those that are minor in themselves but may perhaps presage serious illness. Here is the major dilemma of those who believe a clear threshold exists between self-care and medical consultation. In the large majority of people, a nose-bleed is innocent and does not need professional attention unless it is intractable. But, in a small proportion, the bleeding may herald leukaemia. Other non-specific symptoms—tiredness, weakness, vague limb pains, slight bruising—also form the initial symptoms of a variety of life-threatening conditions. Considered together, several minor complaints may indicate to the doctor a particular condition, but their very generality makes a patient unlikely to proffer them as symptoms unless prompted. The public thus receives two messages from the medical profession. In the context of cancer 'come early with your symptoms', and in the context of resources 'don't bother your doctor unless it is important'. Without a medical degree (and not always then), a person cannot reconcile these two commands. Perhaps better, more specific health education will help: for instance, postmenstrual or rectal bleeding demand immediate attention, nasal bleeding rarely does; pain within the eye is rarely important, pain in the ear often is—but there will be many conditions not covered by these general rules. People will continue to 'make sense' of their bodily experiences according to cultural norms, their desire for consultation being fashioned by the many factors already considered.

Summary

This paper has looked at the concept of minor illness in three ways. First, by linking various statistics of health care use to demonstrate, very broadly, how certain illnesses are selected for increasing medical attention. One definition of minor illness could be 'those illnesses which use the least medical resources, some not reaching medical attention at all, some requiring only brief assistance by general practitioners'. The second perspective

considered various attributes which affect whether illness is acknowledged or treated. The attributes are not mutually exclusive, nor do they fully describe illness behaviour, but there are particular variables which have been isolated to gain some insight. Third, sociological analyses of the presentation of illness were reviewed, sketching some of the theory which might in future be used to explain features identified in the first two sections.

Underlying much discussion on medical care is the view held by many professionals that there is some abstract measure of need for health care, to which planning should aim. In such a scheme there is a continuous graduation from health, through minimal abnormalities, 'trivia', minor illness, major illness to life-threatening illness. The parts of this continuum are arbitrary but, because they are ranked, it is possible to make statements such as 'illness A is less minor than illness B'.

This approach has been used by economists and statisticians in constructing 'health indices'. For example, Grogono and Woodgate[55] used ten measures of patient welfare to construct a scale which could be used to determine the effect of treatment on patients admitted to hospital. The score sheet used is shown in Figure 3 and the results for several different diagnoses are given in Table 6.

As an aid to evaluating the cost effectiveness of providing various kinds or quantities of health care, such an index, or group of indices, would be extremely welcome.

An alternative approach to scaling would be to use Thurstone's method. Various illness states would be placed in order by a series of 'judges' and the resulting series, averaged, would be held to represent a social ordering of disease severity. It will be interesting when comparisons of health indices and Thurstone scales can be made against the present practice of threshold referral across the spectrum of medical care.

FIGURE 3 EXAMPLE OF A HEALTH INDEX SCORE SHEET

Date		Observer	
Patient	Age	Sex	Hosp no

Diagnosis	Score 1, ½ or 0 (ie, normal scores 1)

	Date							
1 Work: normal, impaired or reduced, prevented								
2 Hobbies and recreation: normal, impaired or reduced, prevented								
3 Is patient free from malaise, pain or suffering?								
4 Is patient free from worry or unhappiness?								
5 Does patient communicate satisfactorily?								
6 Does patient sleep satisfactorily?								
7 Is patient independent of others for acts of daily living (eg, washing, feeding, dressing and moving)?								
8 Does patient eat and enjoy his food?								
9 Are micturition and defaecation normal?								
10 Has patient's state of health altered his sex life?								
Total (÷ 10)								

Notes and comments:
The following notes apply to individual questions.
(1) Medical advice leading to light duty or absence from work (eg, hospitalisation) will result in a score of ½ or 0, even if the patient feels he has a greater capacity. Someone able to work while in hospital (eg, an author) may score normally. When retirement is compulsory due to age, the maximum score is still 1. This score is to be awarded on the basis of ability to do tasks associated with everyday life.
(5) Language barrier alone should not produce a reduced score.
(7) The score should be reduced when the assistance of others is required on medical grounds or on medical advice.
(8) Patients on a diet may have a reduced score if they dislike it.
(9) If there is *major* abnormality of either micturition or defaecation the appropriate score is 0.
(10) Infants, children and the celibate would normally score 1 on the basis that their behaviour is regarded as normal and not as requiring therapy. In these groups this score will normally remain as 1 even during disease, since no deprivation occurs. However, enforced celibacy (eg, hospitalisation) which causes a feeling of deprivation may result in a reduced score.

Source: *Index for measuring health.*[55]

TABLE 6 Diagnoses of patients placed in rank order according to health index scored

Score	*Diagnosis*
1.00	Benign tongue papilloma
0.95	Varicose veins
	Vaginal prolapse
	Vulval warts
0.90	Controlled diabetes
	Varicose veins
	Infertility for investigation
0.75	Fistula-in-ano
	Pregnancy for termination
0.70	Hernia
	Carpal-tunnel syndrome
	Hodgkin's disease
0.65	Carcinoma of stomach
	Myocardial infarction
	Lumbar pain for investigation
0.55	Hiatus hernia
0.45	Gout in a patient with coarctation and alcoholic neuropathy
	Diabetic neuropathy
0.35	Heart failure
0.30	Acute cholecystitis
0.25	Status asthmaticus

Source: *Index for measuring health.*[55]
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If acceptable groupings of minor and major illnesses can be achieved, questions of resource allocation will still arise. Although in broad terms the aim of the NHS may be said to be to treat all major illness and as much minor illness as there are resources for, this may not be achieved in practice. Thus, whilst it has been clear for decades that certain regions were relatively well endowed with resources and could provide a full range of hospital services whereas other regions were deficient in some acute ('major illness') facilities, only within the last few years have major steps been taken to redress this imbalance. Similarly, within a health district the allocation of resources between primary and secondary care remains split since family practitioner committees are directly funded by the Department of Health and Social Security. Variations in GP referral patterns are insufficiently understood, and an integrated study of GP–hospital interaction, on the basis of disease severity and outcome, would be valuable.

Three wider issues arise in considering the allocation of resources. First, Britain cannot isolate herself from the rest of the world. At present, much medical expertise is following oil money to the Arab States and is being spent on initiating high-technology medical care on a western model. Yet, with minor illness, many complaints to a British general practitioner are trivial indeed when considered against the parasitic and infectious diseases in other countries of the world. Leprosy, schistosomiasis, enteric fever, filariasis are crippling diseases rife throughout many tropical countries, and might be felt to command more attention than backache, allergic rhinitis or eczema. Western diseases of affluence—obesity, coronary heart disease, lung cancer—might compare unfavourably with marasmus and kwashiokor if they could both be overcome by redistribution of resources from rich countries to poor. A definition of minor illness which fails to embrace these problems may seem parochial.

Second, Illich[62] has set a challenge to modern medical care in the degree that it takes from individuals their personal responsibility

for health and health care. Self-care is discussed more fully in Chapter 6 but the persistent increase in medication for illness in a population which, objectively, becomes progressively more healthy throws up many questions about the relationships between capitalism (the pharmaceutical industry), power elites (the medical profession) and sick people ('health consumers').

New initiatives are needed—by governments to control profit-seeking by drug companies, surgical equipment manufacturers and tobacco corporations; by doctors to investigate newer forms of medical training and alternative therapies such as chiropractice, acupuncture or radionics; and by patients to take greater responsibility for self-limiting illnesses, and those in which personal behaviour is important aetiologically such as alcoholism, lung cancer and obesity.

Third, in Britain more thought could be given to funding alternative resource inputs which might improve the present medical care system. What is the balance between sheltered housing and geriatric care? Between adoption and abortion? Between community development projects and mental hospitalisation? Between unemployment and sickness benefits? Between central heating and hypothermia? These questions, often outside the control of health authorities themselves, may need to be tackled by multidisciplinary research in pilot areas, and the answers returned for decision-making and resource reallocation at central levels.

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Who deals with it now?

2

The general practitioner

ERIC GAMBRILL

In order to discuss the vexed subject of 'minor illness', it is necessary first to define what we mean when using this term, since inevitably our response will depend on our concept of it. As a working definition of 'minor illness' I have accepted that of the Royal College of General Practitioners' report, *Present state and future needs of general practice*

> 'self-limiting, with no risk to life or permanent disability.'[98]

So defined, this category of disease accounts for over 50 per cent of all doctor–patient contact in general practice in the UK. Does this imply that at least half the work carried out in general practice is unnecessary? Does it imply that the public is misusing the family doctor service on a monumental scale? Does it imply that, as a nation, we have become soft, spoiled, unable or unwilling to tolerate even minor inconvenience without rushing for professional help? Is it all the fault of socialist featherbedding, the welfare state, the National Health Service or television? Perhaps we can go some way towards answering these questions if we look more closely at the conditions concerned (Table 7).

Although all of the conditions listed in Table 7 comply with the definition, it would be unfair to dismiss them as trivia, since they may well occasion the patient or parent considerable discomfort, inconvenience and anxiety, in addition to requiring a considerable degree of diagnostic sophistication in order to separate out the

TABLE 7 Persons consulting for minor illness in a year in a hypothetical average practice of 2500

Conditions	*Consultations per 2500 patients*
General	
Upper respiratory tract infections (URTI)	500
Emotional disorders	300
Genitourinary disorders	250
Skin disorders	225
Special	
Acute tonsillitis	100
Acute otitis media	75
Cerumen	50
Acute urinary infections	50
'Acute back' syndrome	50
Migraine	30
Hay fever	25

Source: *Present state and future needs of general practice.*[98]

early signs of serious illness which are often almost indistinguishable from those of minor illness.[31, 59, 76]

Varieties of minor illness

If we look more closely at the list in the table it is immediately apparent that these conditions do not form a homogeneous mass and that separate subgroups may be found within the whole.

There are, for instance, the acute conditions for which specific treatment is available. Acute tonsillitis and otitis media will usually respond to antibiotics, thus shortening the illness and reducing the risk of complications such as acute nephritis, rheumatic fever and a chronic discharging ear with subsequent deafness. It is also usual to treat the acute urinary infections with antibiotics although there is some doubt as to their efficacy in relieving the acute symptoms. Indeed, the members of self-help groups, such as the U & I club, complain that doctors as a whole neglect to advise their patients on immediate, simple, first-aid measures which may relieve their misery much more effectively. The 'acute back' requires rest and analgesia, and wax in the ears is one condition for which we have a swift, sure and guaranteed treatment—would that all patients were so grateful!

We have something to offer patients suffering from long-term 'minor' disorders such as migraine, hay fever, dyspepsia, irritable colon and some chronic skin disorders. Since management usually includes rather detailed advice and the exhibition of some powerful and potentially dangerous drugs, it would seem that these conditions fall properly within the overall province of the doctor.

What of those acute self-limiting disorders for which, as yet, we have no specific remedies? Most of these conditions occur in two systems: the upper respiratory tract and the gastrointestinal tract. In other words, they comprise the sniffles, sneezes and coughs and the diarrhoea and/or vomiting syndromes which are usually self-limiting, whose course is relatively unaffected by any treatment and which are very often managed without recourse to professional help.

The other group of conditions which, perhaps more than any other, provokes argument and dissension regarding the general practitioner's role and responsibility are the emotional disorders. These conditions, representing as they do a mixture of personality problems, social stress, marital problems, financial, cultural and

emotional deprivation, may present as anxiety or depression or with a host of physical symptoms. The doctor often feels ill-equipped to understand and help these people and consequently resents the pressure they put upon him. He may bemoan the demise of the extended family, of the vicar or even the witch-doctor, to whose province he may consider these problems most properly belong or he may gleefully seize the opportunity to off-load these problems on to the health visitor, the social worker, the community psychiatric nurse, the Samaritans or anyone else who may be available.

Since the latter types of disorder account for such a large proportion of 'minor' illness seen in general practice, it may help if we look more closely at the factors which determine the patient's behaviour and the doctor's response to that behaviour.

Reasons for consultation

It has been shown in a number of community studies[27, 114] that, in spite of the large number of symptoms presented to the general practitioner, they represent less than a quarter of all the symptoms experienced by the population at large. Whilst most of those not presented are of an insignificant nature, there are nevertheless a considerable number of potentially serious symptoms which are ignored. What determines the threshold at which a given patient chooses to seek professional advice? Why does one patient choose to consult a chemist, one a nurse and another a doctor? Most people, if they take any action at all, will treat themselves initially. If so, will they do this with or without guidance? Will the medicine(s) they consume be an appropriate symptomatic remedy? Will it be safe for that individual?

If we accept that the presentation of certain trivial symptoms to a general practitioner is not, in fact, the normal behaviour of the majority of the population, why then do such patients who

present with these symptoms do so? I suggest that there are at least six possible reasons.

First, there is no doubt that a considerable number of patients who would not otherwise attend the doctor does so because of some administrative need, predominantly certification of absence from work. Any observer of the medical press cannot fail to note the rancour which this frequently occasions, and indeed it is not uncommon for patients to apologise to the doctor for having to trouble him for this reason.

Second, some patients have an unrealistic expectation of the doctor's therapeutic powers. It is not uncommon to be consulted by a patient with a cold who apologises for troubling the doctor, but explains that on this occasion he is going away on holiday, taking an examination or undertaking some important business engagement. The implication here, of course, is that we have the cure but not the time to purvey it. Similarly, the 'catarrhal' child is often presented in the vain hope that the doctor has some specific and magic cure. The mass media must bear some of the responsibility with their stress on wonder drugs and dramatic cures, together with unrealistic expectations engendered by the advertising industry.

A third factor is that certain patients have an exaggerated fear of the implications of a given symptom from which they are suffering. Thus, a middle-aged man who has seen two or three of his workmates die of a myocardial infarction may well be very conscious of any minor discomfort around the chest, and sensational publicity has driven to their doctors thousands of anxious women who take the contraceptive pill and provoked much unnecessary stress. Similarly, a tragedy affecting a friend or relative will heighten a patient's awareness of some symptoms which he or she would normally dismiss.

Fourth, certain types of patients who may be labelled as chronically inadequate, psychopathic, hysterical or hypochondriacal ('no-hopers' in the antipodean parlance), are well recognised as being dependent, either on their doctors or on their families and, increasingly, on the social services. This group usually has unrealistic fears and excessive expectations of therapy as well, but essentially such people are vulnerable and need someone to lean upon.

The fifth point is that certain families have a tradition of being doctor-oriented.[69] In my experience this does not seem to correlate with any of the other factors mentioned above or with social class.

The sixth reason I suggest for consultation about an apparently trivial problem has been well defined and elaborated in recent years, largely by the groups of general practitioners who met under the guidance of Michael Balint. The notion of the 'passport' symptom—the complaint of a minor problem when the patient is unable or unwilling to formulate the real and major problem—is now accepted as a not infrequent aspect of human behaviour in general practice.[4]

Significance of minor illness

At this stage one might reasonably ask the question 'Does the behaviour of patients in respect of minor illness matter?' My answer would be in the affirmative and for the following reasons.

First, the neglect by patients of early symptoms of potentially serious conditions may jeopardise the chances of effective treatment.

Second, we are regularly, and rightly, reminded that the proportion of national resources available for health care is finite and

that it behoves us to make maximal use of it. There is the constant cry that we are short of doctors, when it is more likely that our need is to make more effective use of the doctors we already have. What is the optimum size of a GP's list? What is the optimum size and constitution of the primary health care team? How many home visits are really necessary? We know that each GP burdens the NHS more per annum in terms of his prescribing costs than he does in his income, but we have very little idea how much of this prescribing is rational or makes any significant difference to the patient's health or comfort. How much of our prescribing, especially for minor illness, is ineffective and expensive—if not downright dangerous? The presentation of a prescription is the traditional way to end a consultation; it is the easy and quick way out for the doctor and it makes the patient feel the visit was worthwhile. This habit reinforces the patient's belief that the consultation was necessary and may well encourage him to present again with the same condition. It may be noted in passing that the capitation fee system of payment does at least remove some of the doctor's interest in producing dependent patients.

Third, we have to consider the effect of the patient's behaviour on the job satisfaction experienced by the doctor and, indirectly, the recruitment of doctors into primary care, which seems to be a world-wide problem. In Ann Cartwright's classic study of patients and their doctors[14], unnecessary consultation about trivial conditions was by far the most common cause of frustration expressed by the participating doctors. However, since the proportion of consultations considered by the doctors to be for trivial reasons varied from less than 10 per cent to more than 90 per cent, and since it appeared that the doctors who were better trained and more likely to carry out procedures and investigations themselves generally tended to consider a smaller proportion of consultations trivial, it may be that this aspect of the study revealed more about the doctor's attitudes than about the patient's behaviour.

Indeed, it has been said that perhaps the general practitioner should not complain that he is not able to practise the skills for which he has been trained, but rather he should complain that he has not been taught the skills required to perform his role in society. Let us hope that the new generation of vocationally trained GPs will be better prepared and better equipped to carry out their role and respond to the needs of their patients. However, no matter how well trained and sympathetic the doctor may be, his time is inevitably limited, and if a large proportion of it is spent in dealing with minor conditions this must reduce his availability for the performance of more complex tasks. It may also lead to a situation where the patients' *demands* are being met but where their needs or the needs of other patients on his list may remain unfilled. It is only too easy for preventive and educational work to be subordinated to symptom management. Doctors may also retreat behind barriers in what they see as self-defence; the use of appointment systems as a barrier rather than as a gateway, with the familiar dragon at the door, is too well known to need elucidation.

Management of minor illness

In what ways might we look towards improving the management of minor illness within our community?

The first area in which I see considerable room for improvement is that of health education. This is a topic which is currently receiving a considerable amount of attention and the Royal College of General Practitioners has a study group working on it. Health education should be positive rather than negative wherever possible, with the emphasis on the promotion of health, on the prevention and management of disease with special emphasis on self-care and self-medication, and on the use of the medical services. In an increasingly complex world it is easy for the public

to become confused about the nature and function of the many services available.

Where should this education take place? In the home via TV and radio, in the schools, in clinics or hospitals, or in general practice? There is obviously room for the use of all available methods, but the potential of the primary care team in this field has been greatly under-used up to now. As I have indicated, the GP has a unique opportunity in the course of his daily work to influence his patients' behaviour, and the use of models, diagrams and written instructions has been little developed and evaluated. Similarly, attempts to provide information and advice to receptive groups within the community have rarely developed beyond the stage of parentcraft classes for expectant parents. Health visitors have special responsibilities and training in this work, and closer cooperation with GPs would enable their services to be expanded. Other members of the team, including midwives, nurses and receptionists, have opportunities for health education; the GP should be aware of the advice which they offer and, if necessary, discuss with them the contributions they are able to make.

I have already touched on the role of other members of the practice team with regard to health education, but they already play an important part in dealing with minor illness within the community. Health visitors cope with most of the feeding problems, nappy rashes, teething troubles and sniffles of young children in addition to their educational and developmental surveillance roles. The practice nurse deals with many of the problems of minor trauma in addition to helping with injections, ear syringing and investigations, and the district nurses cope with many of the day-to-day minor problems in the home, especially those of elderly patients. It is significant that nurses working in primary care stress the extent to which they also function as a 'listening ear' and help with various minor emotional and social problems within the family. Whether they have sufficient aptitude and

training to perform this type of role is a subject which requires further research.

The community psychiatric nurse—a relatively new type of worker—and the social worker are eminently qualified to deal with the more major psychological and social problems in the community. Indeed, few general practitioners can match their expertise in these areas even if they have the interest and the time available.

There is as yet little experience in the UK of the types of worker found in North America such as nurse-practitioners and physician's assistants[93], who have a good deal of autonomy in diagnosis and treatment. What evidence we have suggests that they can be at least as competent as a doctor in most aspects of primary care, although carrying a smaller caseload. If our nursing colleagues are to be given greater autonomy, then detailed consideration will need to be given to their training needs and requirements.

I have already alluded to the effects of certification requirements in increasing consultation rates for minor illness. Recent changes in NHS requirements, introduced in 1976, have improved the situation but I remain unconvinced of the validity of any need for a doctor's signature to legitimise short-term absence. In many respects it seems to me that government and industry use the doctor instead of their personnel department in trying to discipline their staff. Most employees could be given the opportunity to certify their own short-term absence from work and those who appeared to have an excessive amount of absence be investigated and a medical report obtained if indicated. The present 'private certificate' is, in many cases, not worth the paper on which it is written!

Would there be any value in increasing the deterrents to consultation with the general practitioner? What about increasing the prescription charge, introducing a charge for consultations, for home visits, or for out-of-hours contact? In general, I feel that

these are blunt and ineffective weapons. Either the charge is so small as to be ineffective as a barrier and a nuisance to collect, or it is so high that the wrong people may be deterred unless complex exemption arrangements are made. I know of no evidence that patients in the UK consult their doctors more frequently than in comparable countries abroad. Indeed, if anything, the consultation rates here are rather low by international standards. I also know of no evidence to show that the proportion of trivial conditions seen in British general practice is unduly high by world standards. However, I believe that doctors find it more irritating to cope with trivia when they do not have the consolation of a direct and tangible reward in the form of a fee!

It would be a retrograde step to restrict direct access to the doctor, possibly delaying the reporting of potentially serious symptoms, denying the patient with genuine fears—whether or not these are rational—and obstructing the patient with 'passport' symptoms or a general sense of not functioning normally. We must be careful that the development of the team approach does not appear to deny access to the doctor, although I fear we are generally more easily dispensable than we fondly imagine!

Conclusions and questions

In conclusion, I see the presentation of minor illnesses as an inevitable problem of any system of health care. The question is, how best should we cope with the problem?

If we are to have barriers—either administrative or financial—at the point of entry to the health care system, how should they be operated and how can we monitor their effects?

If more health education is required, how should it be carried out and who should do it? Are we in a position to evaluate any educational efforts which we might make?

Do we need more ancillary staff in primary care and, if so, what are their requirements in terms of training and facilities?

Is certification of short-term absence from work really necessary and, if so, whose responsibility should it be?

Do patients who treat themselves for minor conditions do so effectively and safely? Do doctors prescribe rationally, safely, effectively and economically?

Clearly we have many questions to answer and a relative dearth of hard evidence with which to answer them.

3

The nurse

ANNE DAWAR

What is minor illness?

In the perspective of world health the aches and pains, coughs and colds of a self-indulgent affluent society appear grotesque against a background of nations whose many millions lack the most basic elements of health care provision. Studies and surveys indicate that the infant mortality rates in some populations may be as high as 300 per 1000, and in some subgroups even higher.

The officially reported life-expectancy figures range from 74.5 years in Sweden to 35 years and less in some African countries.[117] This is not to suggest that minor illness in the UK ceases to be a matter for concern. Rather, it becomes more urgent that health care resources be deployed in such a way that maximum economy and efficiency ensue—allowing for a rational redeployment in international health care planning.

In global terms, not enough medical expertise has been generated to contemplate the control of endemic and health-destructive problems. A redistribution of medical manpower resources (undergraduate, graduate and postgraduate) is necessary now to prevent an escalation of world problems which will defy the continuing development of a humane society on this planet.

It is necessary to examine the background to minor illness to understand why that which has always prevailed has lately become

a matter of such concern—and a costly item on the UK National Health Service budget.

Sociological changes in Britain were perhaps precipitated by the industrial revolution but, in some respects, have gained momentum since. The social and geographical mobility of the population witnessed this century has not only devolved the support nexus of the extended family, it has finally demolished the word of mouth folklore on the diagnosis and treatment of minor illness—the authority of the family and the family remedy.

In the control of fatal and disfiguring disease, medical science has contributed to the notion that pain and discomfort are not only dysfunctional but are also symptomatic of disease which must be treated by a doctor.

It can be supposed that experience of physical pain as a fact of life is generally on so much lower a plane that to the sufferer it is indeed dysfunctional and not to be borne. The confusion still lingering on the optimum use of antibiotics (available only on medical prescription) must have added considerably to the numbers of patients presenting with minor illness. It would be interesting to have on record the numbers of people (particularly parents with young children) who have visited their GP on the erroneous assumption that their malady required antibiotic therapy.

Finally, it appears that the magnificent concept of the National Health Service had a vital flaw in failing to provide for education in its use. A 'free' health service was a new toy with which the public had not been taught to play. In some respects they now threaten to break it.

If it can be accepted that demand for the treatment of minor illness represents the need of the individual rather than society, what is the justification for regarding minor illness as a matter for national concern?

The justification lies in that it reflects, in a number of ways, national wellbeing. In the appropriate management of minor illness certain desirable objectives should be achieved.

The maintenance of a stable, optimally fit, work force.

The protection of a life-style acceptable and rewarding to the population at large.

The limitation, at an economic cost, of major diseases of which minor illness may be symptomatic.

Is it possible to define the term 'minor illness'? The presentation of minor illness for medical treatment could be ascribed to four root causes.

A failure to achieve or maintain emotional wellbeing.

Symptomatic of major disease.

Symptomatic of a failure to understand or practise a life-style conducive to health.

A dysfunction not amenable to self-help.

It is recognised that people suffering from anxiety, dissatisfaction, depression and a host of other emotional imbalances will present to a general practitioner—sometimes frequently—with real or perceived minor illness. Some will genuinely believe themselves physically ill, whilst others will offer physical symptoms as an acceptable route to the supportive, counselling interview; this deception is compounded by the need of the patient to obtain a prescription 'for cure' and, in many cases, the need of the doctor to provide one.

In no way can one under-estimate the genuine health needs of this group. The dilemma lies in

accurate diagnosis

who the diagnostician should be

who should apply the therapy.

Whilst some GPs believe this to be an important element of their work, others regard it as an abuse of their skills and fail to meet the implicit needs. This is borne out by the current level of prescribing of psychotropic drugs.

The ever-present possibility that minor illness may be a precursor to or symptomatic of a major disease undoubtedly accounts for the vigorous attention it usually claims from our medical services. It is one of the more critical aspects which must be examined before any alteration in the present practice is envisaged. It must also be questioned—if minor illness is symptomatic of major disease—whether early diagnosis is desirable when knowledge and resources may not be sufficient to treat it. Does early diagnosis raise unrealistic expectations of health care and cure? Would self-prescribed palliation be more appropriate?

Alternatively, does early diagnosis provide the only material for research and improvement?

When minor illness occurs as a result of an unhealthy life-style (smoking, obesity, alcohol), the remit for prevention and cure becomes very wide indeed. Is secondary health education effective? Who amongst health care workers is most able and effective in conveying principles of health education? Who is to carry the responsibility for deducing that a given minor illness relates solely to unhealthy habits and is not symptomatic of major disease or has not degenerated into major disease? Perhaps the

only true minor illness is that which is dysfunctional and is not amenable to self-help. It implies that the person affected is not able to carry out normal functions of living or is disabled for work. It has been shown that people's perception of 'illness' is clearly affected by its relationship to their capacity to work. It is thus of economic importance that such illness receives prompt and effective treatment.

Who should deal with it?

It is known that minor illness as an incapacitating condition presents most frequently in the primary health care setting. It will also present in occupational health units and in accident and emergency departments. General practitioners—because of their paternalistic role, their accessibility and their obligation to provide certification of unfitness for work—are most frequently involved in the treatment of minor illness and it is to the rationalisation of their activities that our attention should be directed.

It could mean that, in the diagnosis and treatment of minor illness, we must find an acceptable provision of therapy whose cost-effective element is a major factor.

Alternative solutions

There are four basic alternatives.

1 Restriction of services.

2 Compulsion on general and specialist medical services to contain the problem.

3 Education of the community and of health service personnel.

4 Alternative therapists.

The belief behind the concept of a free health service was that if payment of medical fees were no longer a factor, the provision of medical care would accurately reflect scientifically defined medical need. Much evidence has pointed to the fallacy of this assumption.[87] A solution, therefore, might lie in the reintroduction of a fee for service or in severely restricting the availability of medical advice. (If the present trends in care are allowed to continue, this solution may be imposed perforce.) However, these propositions are unacceptable in that they would inevitably result in the failure of many people in real need to seek or receive appropriate help—creating once more an inequable distribution of care.

A second solution might be the compulsion on general medical services to continue to deal with all forms of minor illness, whatever their cause or effect.

We have already witnessed the failure of this system—few doctors practising in primary health care would acknowledge that their training has prepared them to deal competently and realistically with the range of emotional, social and psychological problems presented to them in the guise of minor illness.

Probably fewer still would accept that the financial resource and personal attributes required to produce a qualified medical practitioner are well spent in this direction if alternative, more readily attained, personnel could perform equally well.

Discussion on the demand for the treatment of minor illness and the provision made for it shows both to be inappropriate. Reeducation must, of necessity, be the foundation of change. It is an urgent requirement for those conveying the service and those receiving it. If it is agreed that medical manpower and resources

should be directed away from the initial diagnosis and treatment of minor illness, alternative therapists must be found.

We may see a re-emergence of 'lay' advisers. Alternatively, it might be more acceptable for workers with a high level of training in health care, but who are more numerous and less expensive than doctors, to be equipped to provide a service for the treatment or referral of minor illness within the primary care system.

Health education

The national 'health' service has been a misnomer. Professional education has been notable for a 'disease' orientation, which must be changed to that of health. Undergraduate courses for nurses are demonstrating the efficacy of education programmes based on the 'total person' in his natural setting. The graduates of these programmes show a marked appreciation of health-oriented nursing roles.

Given a transformation of attitudes within the health service, how can this be applied to public education? The aim should be to instil the principles of personal health maintenance in all UK citizens—no less logically or pragmatically than we attempt to instil the 'three Rs', through our state school curricula. Public education appears to have neglected to teach individuals and groups an appreciation of national provision for health care and how best to use it. Similarly, there has been a failure to prepare people for what might be described as 'expected' life crises, telling them how these can be ridden with minimal disorder and with least resort to curative services.

There has been little attempt to inculcate a knowledge of minor health problems and how they may be contained. Who should provide this education? It can be agreed that it is the responsibility of every citizen[43] but that teachers and health workers must take

a dynamic role. Primary health care teams, including social workers, occupational health workers, staff of accident and emergency departments, community psychiatric services and personnel workers are all in a strategic position to apply this education.

Health visitors are particularly identified as first line workers in preventive health care, and their training must constantly be appraised in this direction.[44] Not least in their function is the provision of support to families to enable them to find their own solution to health care problems.

The use of public media for health education has not yet been exploited systematically and intelligently. Ironically, independent radio's 'phone-in' programmes which are well used by lonely and anxious people may have come nearer to providing an accessible health support mechanism than government sponsored channels.

The nurse as alternative therapist

The nursing service has expanded in recent years. With this expansion, many tasks traditionally performed by nurses have devolved upon increasing numbers of ancillary workers such as clerks, domestics and technicians.

The paradox is that there is little evidence that the quality of nursing care in the NHS has improved.

To what causes can this unhappy trend be ascribed?

Undoubtedly, a growing proportion of trained nursing skills is now directed to supporting medicotechnological advances—without obvious direct nursing benefit to the patient.

Similarly, the provision of a career structure, with early advancement to managerial grades (especially of the more highly educated nurse), drains the fountain of young talent in qualified nurses.

A clue may lie in the words of Christine Chapman, director of advanced nursing studies, Welsh National School of Nursing. She has stated* that money is being wasted on 'inefficient educational practices and the high cost of the 30 per cent who leave before qualifying'. Nurses left because the bedside nursing which attracted them to the profession in the first place was regarded as low status. Promotion came only to those who were prepared to leave clinical nursing.

This suggests, first, that we are creating an over-educated, excessively numerous, nursing force and, second, that a proportion of this force would prefer to maintain and develop a clinical role which offers job satisfaction allied to independence and acceptable status.

If one accepts, therefore, that a considerable number of nurses is available to undertake a role compatible with that of a diagnostician and therapist in minor illness, how does the profession view such a move? Undeniably, with reservation. Leaders in nursing have for some time questioned the objectives of nurse training and manpower planning. There are many advocates for a return to the basic care of patients as an objective of the skilled nurse at whatever educational level. At the same time, it must be accepted that many nurses seek an extension of their role which, while it may not be 'nursing', is a legitimate development of nursing skills and offers a clinical satisfaction not readily available in recognised nursing practice above a basic level. These nurses are frequently to be found in primary health care.[99] Against an awareness of shortcomings in the provision of care and of professional standards, must be set the fact that both medicine and nursing could

* In an address to the Royal Society of Health Congress, Eastbourne, 1976.

be said to have over-educated themselves or, at best, to be using their education inappropriately. Nursing needs to set its own objectives in the prevention and treatment of minor illness. While it rests on other responsible persons, it will lack the dynamism to be effective in the situation. To be fair, nurses are already engaged to an extent in this activity—health visitors, home nurses, practice nurses, nurses in occupational health and in accident and emergency departments are constantly required to advise on prevention and treatment. The weakness lies in the function being ill-recognised, ill-supervised and totally dependent on variants of skill and opportunity.

This is not a new situation. Before the NHS, home nurses and health visitors were commonly required by the lower income groups to provide an opinion on whether or not the expensive advice of a doctor was necessary. This 'alternative advice' probably provoked some of the traditional friction between GPs and local authority health staff—which group practice attachment has, to a great extent, alleviated. This informal system pertains in areas of the world where poor people can obtain medical advice only in return for a fee. In Britain it persists where the general practitioner service remains inadequate in quantity or quality. In effect, the spontaneous solution to a problem sometimes proves to be the logical one: where the profession leaves off, the entrepreneur takes on. The individual family doctor has recognised the virtue of enrolling skilled nurses in minor illness, to free himself for those tasks demanding his skills as a medical practitioner.

In 1974 the British Medical Association board of science and education report on primary care teams[9] pointed out that it is responsible and practical for nurses in primary health care teams to undertake assessment and counselling of patients and, indeed, in certain circumstances, to initiate therapy.

M F Moore and his colleagues[81], writing on first contact decisions in general practice, showed a strong correlation between those

decisions taken by doctors and those of a hospital staff nurse. They postulated that some specific training for the nurse would have eliminated most differences in decision-making and concluded that when the reasons for the disagreements between the decisions of the nurse and those of the doctor are identified, training programmes can be developed for the nurse, aimed at eliminating specific risks. With her continuing experience in her new, more demanding role, the nurse would play an important part in the redistribution of resources and skills which is necessary if the standards of medical care are to improve.

In the USA the insufficiency of primary medical service in some regions has precipitated an emergence of the nurse practitioner at an earlier stage than in the UK and has resulted in a clearer documentation of definition and practice.

The activity of nurses as medical deputies has also increased in the Third World and in parts of Scandinavia where medical practitioners are thinly distributed, but it is the American pattern which is most closely allied to possible developments of nursing in the UK in the diagnosis and treatment of minor illness.

If, then, it can be argued that the American experience could usefully be applied in the UK, time should be taken to examine it.

In the late 1960s some prominent members of the medical and nursing professions in Colorado recognised the need for improvement in health care and the elimination of fragmentation of the services offered in the primary setting. Similarly, both disciplines were anxious to utilise the nurse to her full potential and enable her to contribute dynamically to the evolution of health care. In January 1972 a preparatory programme was funded by the Colorado–Wyoming Regional Medical Profession. The participants were drawn from occupational health, outpatient and community nursing.

Ten weeks of the preparation was spent in the university; the time was divided into two phases, between which participants returned to practice in order to implement and try out their newly acquired skills. They were then monitored for a year at work, finalising in an evaluation on their success in meeting the course objectives. It was found essential for each participant to have a preceptor for one-to-one guidance and development.

It was noted that some participants, on return to work, were expected to resume their traditional responsibilities whilst implementing a new role; this was an impediment to change and a source of dissatisfaction. As a result of this observation, the sponsoring authority was required to make written commitment to support the nurse in her practitioner role, as was the physician who had agreed to serve as preceptor during the practice period and the year under supervision. The only criterion for admission to the course was that the participant be a registered nurse, because it was recognised that background experience was more critical than education.

The content of their programme included 300 hours of theoretical and clinical experience. It was based on the theory and technique of physical assessment, history-taking and interviewing. Problem-oriented medical recording was integrated throughout.

Other aspects studied are advanced concepts in symptomatology, patient management, drugs, x-rays and laboratory data significant in chronic illness and common acute complaints. It is of considerable importance that role reorientation is emphasised throughout the curriculum. This development requires support from physicians, nurses and other co-workers in the clinical situation.

The outpatient clinics of the Colorado General Hospital provided the main source of clinical experience. One feels that, in the UK health centres, GPs and the primary care setting would be more appropriate.

A sophisticated evaluation procedure is built into this course. In addition to a sense of commitment by both service and educational staff

> the preceptors must be committed to assist participants on a one-to-one basis during part of their learning
>
> planning and implementation must be carried out on an inter-disciplinary basis
>
> functional demonstration areas must be available to implement and teach the practitioner role
>
> faculty must have time to practise to maintain their skills and keep in touch with the realities of the delivery system.

In the American experience there is no attempt to minimise the difficulties and hazards in developing this new role for nurses. Nor is there an attempt to aggrandise the nurse at the expense of the physician. What emerges is an attempt to rationalise the provision of primary health care—which, coincidentally, provides an alternative source of satisfaction for the 'clinical' nurse. Reedy has traced the development of the 'new health practitioner' in the USA and compares this with the British experience.[93]

In the search for a solution to 'minor illness' as a health care problem in the UK, we might do worse than follow the American example. The evidence indicates a need for a nursing role complementary to the general practitioner, which can encompass the prevention, diagnosis and treatment (or referral) of minor illness. There is a work force available, less costly than medicine but as effective; it is derived from nursing and requires specific preparation, organisation, recognition and supervision. (The report of the joint working party on nursing in general practice in the reorganised health service 1974[99] concurs with this view although

not concerned with nurse practitioners as a separate entity from nurses employed in general practice.)

Summary

Minor illness exists and requires treatment. The present NHS remedies are costly and not always effective.

It is in the national interest to provide an acceptable, less expensive solution. An expansion of the educational process in health and the preparation of alternative therapists are practicable solutions.

Implementation requires a change of philosophy in basic health care education, and recognised post-basic education for nurses who may act as therapists.

4

The pharmacist

DAVID SHARPE

In a report on the present state and future needs of general practice, the Royal College of General Practitioners defined minor illness as 'self-limiting, with no risk to life or permanent disability'.[98] Whatever definition of 'minor illness' is accepted, I submit that the treatment of this state is most conveniently and most efficiently carried out for the public at large by the pharmacist in his community pharmacy.

Prior to the 'chemotherapeutic revolution', pharmacists were mainly concerned with the elegant preparation of medicines. The 'active' ingredients of these preparations were often therapeutically ineffective and also quite harmless. With the development of specific and potent synthetic drugs, the emphasis of the pharmacist's responsibility has moved substantially towards the utilisation of his scientific knowledge in the proper use of modern medicines and the protection of the public against the dangers which are inherent in their use.

There are many roles of the general practice pharmacist, amongst which are supervising the dispensing of all preparations; making contact with the prescriber to discuss any unusual doses or any other matters arising from a prescription; giving advice to patients about precautions to be observed when taking or using a prescribed medicine; giving information and advice to medical practitioners on pharmaceutical matters; giving advice to members of the public on pharmaceutical matters or any question raised

relating to general health care, hygiene and the prevention of disease; and the supervision and the sale of medicines and advice to the public on self-medication.

With regard to the last point, the pharmacist's proven ability to advise on self-medication is legally embodied in the 1968 Medicines Act, in a section which exempts from the product license requirements, *inter alia,* 'Preparing or dispensing a medicinal product for administration to a person where the pharmacist is requested by or on behalf of that person to do so in accordance with the pharmacist's own judgment as to the treatment required, and that person is present in the pharmacy at the time of the request. . . '[52] But can we really completely dispense with the GPs in the treatment of minor illness?

Surveys of effectiveness

Northampton survey

Several surveys have been carried out to determine the pattern of self-medication by the general public. In 1973 Dr Elliott-Binns[27] carried out a survey on 1000 patients attending a surgery in Northampton. Only patients complaining of new symptoms were included and they were asked if they had received any previous advice or treatment for the symptoms concerned and, if so, from whom. It was found that 96 per cent of the sample had done so. Most had consulted a friend or relative, but 10.8 per cent had consulted a pharmacist. The soundness of each piece of advice was assessed and it was found that the pharmacists not only gave the best advice but also the lowest percentage of harmful advice. Nurses did rather less well, since, when giving casual advice, they were liable to frighten the patient by suggesting a serious diagnosis for trivial conditions. By far the worst advice came from impersonal sources such as women's magazines, home doctor books and television.

There was a significant amount of statistical evidence to show that the advice of pharmacists was more often accepted by the patient, presumably because of their professional standing. As would be expected, pharmacists usually recommended medicines as a form of treatment although 13.9 per cent gave no treatment but told the patient to go to the doctor because the pharmacist was unable to assess the condition accurately enough or because the symptoms had been suffered for more than four or five days.

What was not established was why the patient had initially gone to the pharmacy rather than going to the surgery. If the prime reason was a self-diagnosis of 'minor illness', other factors influencing the decision could have been the barrier of a doctor's receptionist, the problem of fitting in with an appointment system or the apparent triviality of the ailment. Factors indicating a visit to the pharmacy could have been its ready availability near home or work, its 'shop hours' and the lack of formality involved in a consultation with a pharmacist. The public does not have such ready access to any other professional person.

No other professional view can be obtained as easily and without cost as that of the pharmacist. He is available for long hours at a fixed point in one locality, and his university training—covering in great depth the field of pharmacology—enables him to act in a consultative capacity on the actions and uses of all drugs and medicines, and he is trained to convey this information across a very wide spectrum of the population from the consultant physician to the old age pensioner. His additional training and knowledge in the chemical and biological sciences allow him to discuss authoritatively all aspects of drug therapy in fields as diverse as the use of radioisotopes and the prescribing of 'over the counter' medicines.

The types of symptoms described by patients visiting pharmacies include

cold	head lice
constipation	indigestion
cough	mouth ulcers
cystitis	sickness
diarrhoea	skin complaints
ear and eye complaints	sore throat
haemorrhoids	various pains

Devon survey

Dr R V H Jones[66], in a survey carried out in Devon in 1976, indicated a chemist's success rate at 90 per cent, expressed as a weighted mean average in three of the groups mentioned—coughs/colds, indigestion, diarrhoea/sickness.

The future

What of the future? The increasing number of health centres is going to affect both the medical and the pharmaceutical services. Members of the public will probably find access to their general practitioner more difficult and certainly the distance they will have to travel to the surgery will be greater. This grouping together of medical services will possibly make the provision of primary health care more cost-effective, but will the patient benefit?

There is pressure to provide pharmaceutical services in all these health centres, and there would be unquestionably a closer doctor-pharmacist relationship. With the inevitable centralisation of prescriptions, peripheral community pharmacies could very easily be adversely affected economically with a resultant continuing closure of pharmacies. Sections of the public, including the old age pensioner and the young mother with children, would thus be deprived of a much used service on which they depend for advice and treatment of minor illness.

It is in everyone's interest for the pharmaceutical service to be planned on a national basis so that *all* the needs of the patient are adequately provided within the National Health Service.

5

The accident and emergency department

M S CHRISTIAN

Most people working in accident and emergency departments complain of the amount of trivia and cases of minor illness that present there. This is largely the result of the past history of such departments and failure to educate the public in the correct use of the new facilities.

Forerunners of the present accident and emergency departments were the old hospital casualty departments and such charitable institutions as sick people's dispensaries where the sick poor were able to obtain free treatment. Thus a very wide range of illnesses and injuries was presented, varying from the trivial to the severely injured. With the development of the modern accident and emergency departments, there has been a failure on the part of the service in general and hospitals in particular to project the new image successfully and to get across to the public the real functions of such departments.

The present

The modern accident and emergency department exists for the reception, resuscitation and stabilisation of the seriously ill and injured and also for those who require specialised care but not necessarily life-saving measures. Both categories of patient will invariably require multispecialty management, full laboratory facilities and specialised and, very often, sophisticated techniques for their wellbeing and indeed their survival. In other words, they

require all the resources and expertise of the modern district hospital. Minor injuries, on the other hand, can be somewhat loosely defined as those cases which could, and should, be treated without reference to this level of expertise. Exactly where they are dealt with depends to some extent on local circumstances. Almost invariably, their management demands some hospital investigations such as x-rays or blood tests but, in most areas, general practitioners already have access to such facilities without having to send the patient through the accident and emergency department.

Why do cases of minor illness come to the accident and emergency department?

One could give a long list of possible reasons, but the main reasons are as follows.

Patients often say that it is easier to go to an accident and emergency department than to visit their GP. Whether this attitude is the result of the widely adopted appointment system is debatable.

Patients may have no GP. This is particularly noticeable in the London area. Fifty per cent of patients attending the accident and emergency department in one teaching hospital were either overseas tourists or people working in London but living outside.

Dislike of one's particular GP.

Patients feel that they would like a second opinion and regard the department as the easiest source.

Patients feel that it is pointless to visit their GP since he would, in any case, only refer them to the department.

Problems

Although conditions naturally vary in different parts of the country, the present situation has, by and large, considerably increased the workload of accident and emergency departments. They are overloaded with minor illnesses which should never have reached them and staff spend far too much time trying to explain to patients why they really should not be there at all.

As a safeguard, virtually all departments adopt the policy that every patient must at least be seen and spoken to by a doctor, though not necessarily treated by him. Some patients think that they have an inalienable right to use the NHS—and particularly hospitals—as they think fit and refuse to accept that the correct approach is through their own family doctor who, after all, is probably the most important member of the primary care team.

Solutions

The main solution is one of communication. The general public and the industrial health services—sometimes even general practitioners themselves—must be clearly told of the real purpose of the accident and emergency department and of the correct procedures for its use. This can be time-consuming and also demands considerable toughness in the approach to the problem. Patients do not always appreciate being told plainly that the department is not the place for them. Departments are often inclined to err on the safe side by spending too much time on non-urgent cases, giving the reason that it is easier to see and treat a patient than to refer him to his GP.

Those points may seem to be a little hard and inhuman. They may seem less so to an observer seeing the results of an accident in which gravely injured casualties arrive in a department already overflowing with cases of minor illness and injuries which are

eminently suitable for self-treatment or management by the family practitioner.

6

Education for self-care

KATE DANAHER

A theoretical perspective

The concept of 'self-care' is now arousing a good deal of interest. But why? People have always cared for themselves, preventing and treating disease. 'Lay medicine' is a ubiquitous phenomenon: it has always existed alongside a variety of medical expertise, though there has frequently been a third, intermediate, level of 'lay expert', as for example, the 'wise woman' of medieval times.

It is easy to forget that in Europe these levels can still be recognised. In Dublin, current research is looking at the efficacy of folk remedies, still used in the countryside, in terms of modern medical criteria.* Dr Elliott-Binns' work shows also that a very active 'lay referral system' exists in Northampton, but that the advice given nowadays is 'go to the doctor'.[27]

Self-care, then, is associated with 'non-professional' care, but conveys much more than 'lay care'. Its origin is extremely complex but has two quite separate strands: that within the medical profession and that outside it. I will look first at the latter.

'Self-care' is a term employed by various types of self-help groups: in London, for example, there are several community groups of a self-help ethic introducing self-care elements into community projects; women's groups have been doing this for years, based on

* Personal communication with the Department of Folk Studies, University College, Dublin.

a similar ethic. Self-care, directed now at health, can be seen as a natural outflow of self-help.[115]

Steinman and Traunstein, in their discussion of the self-help movement, suggest that the origin of this movement can be seen in the elitism and exclusivity of the professions.[104] They describe the self-help movement as having demonstrated the therapeutic potency of the process whereby people with similar stigmata find each other, strengthen each other through mutual consciousness, training and support, and express anger about and reject prevailing modes of professional (and societal) response to their condition.

This description seems apt for the 'self-help in health' movement. The rejection of prevalent current medical practice is the result of three broad trends. First is the perceived stigmatising of women by the medical profession, which has led many women's groups to attempt identity reconstruction outside the medical paradigm. The second reason is rooted in the essence of medical practice today: it is disease oriented, and has little to offer apart from the diagnosis and treatment of disease. The self-care movement focuses on health maintenance and views this in social, as well as physical, terms. Lastly, the profession operates a monopoly of information relating to treatment of disease, and this perception has in no way been altered by such institutions as the Health Education Council. This factor keeps the patient dependent on the doctor for a definition of the illness and for knowledge as to its treatment. The self-care movement has come to reject both the exclusive definitional ability of doctors and also their treatments, the latter frequently seen as potentially iatrogenic. The goals of the self-care movement may be loosely summed up as 'autonomy and health'. These are often seen as synonymous, but pose a problem which will crop up later in the discussion: activity directed towards 'autonomy' may, in orthodox medical terms, be dysfunctional for health; in this case, a choice of priorities must be made.

The authors cited above place the origin of the self-help movement in the 1930s with the formation of such groups as Alcoholics Anonymous. Self-care is very much a product of the 1960s and 1970s and I think the reasons for this can be seen under the separate headings of 'medical' and 'professional' explanations. The earlier part of this century saw types of disease processes not amenable to self-care; for example, the infectious variety. We also know now that the basis for much disease was poverty; neither medical nor self-care could alleviate this. The professional response to ignorance and impotence was mystification and induction of dependency—the 'doctor knows best' phenomenon—and the advances in scientific medicine lent enormous credibility to the claims of doctors. The 1960s, however, was the era of 'participation'; the poverty programme in the USA brought this concept to its renewed recognition of deprivation in many communities. One part of the tremendous flux of ideas in this decade was the resentment borne against professions—medical, legal and planning—for their elitist position in society and their exclusion of clients in the decision-making process. Alternatives were suggested: on a theoretical side, Richard Korn in 1964[70], described prevailing models of the social expert as either prescription *for* the elite producing dependency, or operation *upon* the client producing passivity. He suggested an alternative model of 'learning' *with* the client, producing interdependency. This breakdown of hierarchical role-structures has been echoed and advocated many times since. Practically, these models have been attempted. 'Community lawyers' and 'community planners', though less common in the UK than in the USA, do exist: the paucity perhaps underlines the power of each professional group in sustaining its own definitions.

I said earlier that 'self-care' was a term used also within the medical profession. It was indeed the subject of a report of interested people in 1972* in which the term appears to represent 'self-

*The panel on self-care. *Self-care: its place in the total health care system. A report by an independent working party.* Chairman: Dr John Fry. Mimeographed by the Chairman, 1973. pp. 13. (Copies available on application to J. Wells, Proprietary Association of Great Britain, 519 Victoria House, Southampton Row, London, WC1. 01-242 8331. Copy held in King's Fund Centre library.)

medication' by and large. This tendency can be seen in the majority of references to the subject, and it can certainly be no coincidence that foremost in the minds of those advocating research in this area are the pharmaceutical companies. Other voices raised in this debate point out that medical care costs are rising and suggest either greater emphasis on self-care or greater delegation to lower-paid paramedical staff in order to bring down costs. The general practitioner, a victim of an apparently infinite demand for primary care, also looks to self-care for a release from trivial ailments to allow more time for situations which demand his expertise.

These, then, represent some of the interests of 'self-care'.

The Guy's project

Much medicosociological literature has been devoted to studies of the consultation process, but studies of 'illness' without consulting a doctor are few. The report by the panel on self-care* summarised the available literature, showing for example that the experience of symptoms is a normal condition of life—and that this experience does not interfere with a perception of oneself as healthy.[25, 114] Different surveys agree that the majority of those experiencing symptoms self-treats and that only a small proportion consults a general practitioner for these symptoms. This consultation is frequently a last resort.[27] The report called for more research into the area of self-care: the Guy's project, started in 1972, was a response to this.

The project has not been fully completed or written up, but I shall describe its methods and some results in order to raise some questions which may be of continued relevance.

* See footnote on page 71.

For the purpose of our study, self-care was conceptualised in terms of five components: health maintenance and disease prevention; symptom recognition and simple diagnosis; self-treatment; use of appropriate medical services; participation in the organisation and delivery of health care.

We saw the designation 'self' as somewhat ambiguous here since the term could have several different connotations: individual care; care by significant others (for example, family); or care by lay community groups.

We defined our level of study as that of primary health care, and decided to focus on two interrelated aspects of self-care: self-treatment and the use of appropriate medical services. For our purposes, the latter was seen as the use of general practitioner services; the former was defined as any activity undertaken by the person for the relief or cure of an ailment. The largest area of self-treatment is self-medication, but the remainder is composed of various therapeutic activities such as diet, rest and exercise.

The project was two-pronged: the self-treatment survey was designed to elicit the lay person's view of self-treatment and appropriate consultation; the second part tried to obtain information from doctors about appropriate self-treatment, and when and for what ailment to visit a general practitioner. Ultimately, the project was seen as an exercise in two-way communication between the lay public and the medical profession.

The second part of this project is dealt with more easily: it consisted of activities surrounding the construction of guidelines for people about *which* symptoms or conditions are amenable to self-treatment; *how* they should be self-treated; and *when* a doctor should be consulted, if at all. A group of six eminent general practitioners was convened by Professor Carol Buck to discuss these issues, and copious notes were kept by myself over a series of meetings. Sadly, no agreement was reached by the group on

any of these points. It is perhaps unrealistic to expect *the* correct answer to any of these questions; indeed, our focus changed to *ranges* of correct answers. However, the disagreement among the participants was often fundamental even within a given range, and this project eventually foundered.

Another minor exercise of a similar nature involved asking a group of 15 general practitioners to specify, for 68 symptoms or conditions, when it was desirable to see a doctor. This was a crude exercise, but was useful in terms of its broad implications. There were certain symptoms of a potentially harmful nature which elicited the least disagreement amongst doctors: for example, 'haematuria' was given a range of one day to two weeks but with one day as the median. Similarly, 'chest pain' had a range of one day to one week, and again the most common was one day. The more 'trivial' the ailments became, the less the agreement: for example, 'acne' ranged from two weeks to 'never' (three doctors felt consultation to be unnecessary). A similar ambiguity—though possibly not for the same reasons—was seen in 'depression', which achieved a range of necessary consultation of one day to three months; one GP felt it to be unnecessary.

Without exaggerating the importance of either of these exercises, the self-treatment survey was started with a greater knowledge of the difficulties involved in recognising the 'correct' self-treatment or the 'right' time to see a doctor.

Those aims of the survey relevant to this discussion were

> to assess the extent of self-treatment amongst a group of people consulting their general practitioners and to compare this with the extent of self-treatment amongst those in a control group registered with, but not attending, their GPs as frequently
>
> to look at the adequacy of self-treatments in the two groups

to try to evaluate the appropriateness of the use made by our respondents of their GPs' services.

The group studied was comprised of 375 adult patients: they were selected from the surgery lists of nine practices, using a simple binary code, and were then matched for age and sex with people who had not consulted a doctor for at least the previous 12 months—our control group. However, only 302 of the latter were interviewed owing mainly to the well documented inaccuracy of general practice records.

A standardised questionnaire was used by trained personnel during the interview to ascertain symptoms experienced over the preceding two weeks, particularly with regard to forms of self-treatment used, and the reasons for, or for not, consulting a GP. Since there was no precedent for objective evaluation of self-treatment, we were forced to adopt a series of relatively crude measures, described below.

From the entire sample we excluded those symptoms or conditions which were under routine care of the doctor, since we felt that such a settled relationship would strongly influence the patient against self-treatment and would at any rate create a situation not comparable with other types of consultation. This left us with 1254 symptoms, of which 821 were self-treated.

For each reported symptom the following information was abstracted and sent separately to three general practitioners who were acting as referees.

the respondent's serial number for purposes of confidentiality

the symptom or condition, and its severity as rated by the respondent in terms of his own normal functioning

the duration of the symptoms

the periodicity of the symptom (if recurrent)

methods of self-treatment attempted, if any, and their perceived results

whether or not a doctor was consulted, and, if so, when.

From this information, the general practitioners were asked to make two separate judgments.

Was the self-treatment (either medication or other activity, or both) adequate?

Was the use made of the GP appropriate?

Each of these judgments was graded, as described below.

Evaluation of self-treatment

The cooperating referees were asked to evaluate self-treatments bearing in mind two factors: first, the duration—did the treatment exceed a safety limit, given the particular symptoms; second, was the self-treatment itself safe and efficacious? Adequacy was graded into four categories: 'completely adequate' represented a treatment as good as a doctor could have advised; 'partially adequate'—giving symptomatic relief; 'harmless' and 'harmful'. Each self-treatment was given one of these four gradings by the three general practitioners. A *majority decision* was taken as the final result, except in the case of a fundamental disagreement about the appropriateness of a treatment, in which case classification was not attempted. An example of the latter case would be two decisions of 'completely adequate' and one of 'harmful'.

Table 8 shows the results of this evaluation. There was no difference between the two groups in the number of 'unclassifiable'

TABLE 8 General practitioners' evaluation of self-treatments

Judgment	*Completely adequate**	*Partially adequate**	*Harmless*	*Harmful*	*?*	*Total*
Study group's symptoms	98	266	53	24	40	481
Control group's symptoms	102	153	38	15	32	340
Total	200	419	91	39	72	821
	χ^2 11.86; 3 df ($p < 0.01$)					

* The difference between the two groups was significant at 98% level.

Source: *Self-care: its place in the total health care system* (see footnote on page 71).

judgments; however, the difference for the remainder is significant ($p < 0.01$). The members of the control group had approximately 32 per cent of their self-treatments designated 'completely adequate' compared with the study group's 22 per cent; however, when the two categories of 'completely' and 'partially' adequate are amalgamated, approximately 80 per cent of both groups are represented here. There is no significant difference between the two groups in the category 'harmful' self-treatment. The 39 symptoms represent 37 people—approximately 5 per cent of the total sample.

Table 9 shows that women were almost twice as likely to have self-treated symptoms compared with men. The male members of the study group indulged in the *least* self-treatment (31 per cent); their counterparts in the control group indulged in significantly more than expected. The *most* self-treatment was undertaken by female study group members—68 per cent of their symptoms were self-treated.

TABLE 9 Self-treated symptoms by sex

	Male	*Female*	*Total*
Study group's symptoms	152	329	481
Control group's symptoms	141	199	340
Total	293	528	821
	$\chi^2 = 8.15$; 1 df ($p < 0.01$)		

Source: *Self-care: its place in the total health care system* (see footnote on page 71).

No other significant differences were found between the two groups.

Table 10 summarises the adequacy of self-treatment for both groups together by symptom category. The least self-treated category of symptom is that of 'psychological disorders'; the most, not surprisingly, is used for headaches, upper respiratory tract infections, stomach problems, injuries and skin trouble. This appears to reflect the availability of accepted methods of treatment. 'Harmful' treatments were clustered around three categories: stomach and skin problems, and psychological disorders (28 out of 39). A closer look at these harmful treatments revealed the following

For psychological disorders (4 in all)

2 cases of chronic insomnia with depression treated with 'extra rest'

TABLE 10 Categories for all self-treated symptoms

	Completely adequate %	*Partially adequate* %	*Harmless* %	*Harmful* %	*?* %	*Total no* (100%)	*All symptoms* %
URTI	17	58	11	4	10	149	(77)
Gastro-intestinal	24	48	9	9	10	185	(82)
Musculo-skeletal	8	71	16	0	5	75	(55)
Psychological disorders	0	50	15	13	22	32	(33)
Skin	18	48	16	9	9	79	(69)
Headaches	65	33	0	1	1	120	(92)
Allergic/ metabolic	46	42	4	0	8	24	(51)
Injuries	18	64	12	0	6	33	(71)
Nervous system	6	63	14	3	14	29	(44)
Genito-urinary	29	55	3	3	10	31	(57)
Cerebro-vascular	5	56	24	4	11	55	(48)
Miscellaneous	11	22	44	0	22	9	(27)

Note: The number in parentheses following the total number of symptoms is the percentage of all symptoms in that category which were self-treated.

Source: *Self-care: its place in the total health care system* (see footnote on page 71).

2 cases of acute depression (lasting more than one month) treated with alcohol

For gastrointestinal trouble (14 in all)

7 cases of constipation: examples of treatment are

Boots Senna Laxative taken twice a week for seven years

Senokot three tablets taken every three days for two years

7 cases of indigestion: examples of treatment are

two Boots Indigestion Tablets taken four times a day for 14 years

two Disprin tablets twice per day for one day.

For skin disorders (7 in all)

examples are

for a rash lasting one day, Savlon as necessary

for a skin irritation of 21 days' duration, Germolene used as necessary.

In attempting to assess the influence of self-treatment on consultation, it was necessary to look at pairs of study–control group respondents who reported the same ailment at the same degree of severity. Sixty such pairs were found who, in addition to the previously mentioned factors, were also of the same sex, age group and practice of origin.

The study group respondents all consulted (for the symptom for which they were matched); their opposites did not.

No one factor was found to account for this difference in behaviour. Self-treatment was significant—the control group used this more often than those who had attended (Table 11). However, amongst those who used self-treatment, there was no significant difference in the adequacy of self-treatment.

TABLE 11 Self-treated symptoms for 60 matched pairs

Self-treated by	*Number of pairs*
Both members of pair	20
Study group member only	5
Control group member only	23

Source: *Self-care: its place in the total health care system* (see footnote on page 71).

Table 12 sets out the measure of agreement between our referees in the evaluation of self-treatment. The picture is ambiguous, and it is interesting to speculate whether this table would look similar if medical treatments were the subject of evaluation.

TABLE 12 Agreement amongst general practitioner referees in evaluating self-treatments

	%
Total agreement	21
Marginal disagreement	60
Substantial disagreement	8
No agreement	11

Source: *Self-care: its place in the total health care system* (see footnote on page 71).

Evaluation of the use of the GP

Using the same information as for the first evaluation, the referees were asked to judge the respondent's behaviour *vis-à-vis* his GP as 'appropriate' or 'inappropriate'. A judgment of 'appropriate' was made either where the referee thought the ailment did not merit consultation and no doctor was involved, or where the ailment was brought to the doctor in what was considered to be a suitable context. Contrariwise, a judgment of 'inappropriate' could relate either to a consultation which did not need formal medical treatment or which took place too late to be of maximum benefit to the patient, or to ignoring the GP's recommendations for indicated ailments.

In the sample over all, no difference between the study and control groups was found in this respect.

Table 13 sets out the figures for both sexes: different categories can be distinguished above and beyond our criteria of selection. The control group had, by definition, not consulted for 12 months previously, but between their selection for the study and the interview, 23 had done so—hence two categories in a 'non-attending group'. Of the study group, those symptoms causing consultations are compared: those which were only 'mentioned to the doctor' while consulting for something else, and those for which no consultation took place. The *only* significant relationship is that between sex and the 'while I'm here, doctor' category of symptom: here males are more likely to present appropriate, and females inappropriate, symptoms.

In the 60 matched pairs of the same symptom, where the study group member consulted and the control did not, no significant difference was found between the two groups in their use of the GP.

The 227 'inappropriate' managements of symptoms refer to 185 people (27 per cent of the total sample).

TABLE 13 Appropriateness of utilisation behaviour by sex

Patients	*Appropriate behaviour*			*Inappropriate behaviour*		
	M	*F*	*Total*	*M*	*F*	*Total*
Study group						
no consultation	96	225	321	21	44	65
symptom chief reason for consultation	93	148	241	18	28	46
symptom mentioned while consulting for other reasons*	35	59	94	4	18	22
Control group						
no consultation	146	206	352	41	49	90
consultation	14	5	19	0	4	4
Total	384	643	1027	84	143	227

* $p = 0.04$ (Fisher's test) M : F/Appropriate : Inappropriate.

Source: *Self-care: its place in the total health care system* (see footnote on page 71).

In relation to eight symptom categories out of eleven, 'inappropriate' use of the general practitioner is shown to be fairly constant in the range of 11–16 per cent of symptoms. However, for the other three symptom categories (excluding 'miscellaneous') 'inappropriateness' is substantially higher

upper respiratory tract infections 24 per cent

psychological disorders 30 per cent

cardiovascular and cerebrovascular complaints 34 per cent.

An analysis of one part of the data suggests that in the first case people consulted unnecessarily; in the second and third, people did not consult when this was thought to be necessary.

In summary, we found that

approximately two-thirds of our sample were self-treating

approximately 80 per cent of these were self-treated 'completely' or 'partially' adequately

about 5 per cent of the sample were self-treating harmfully

27 per cent were judged to be using their GP 'inappropriately', but there was no difference in the direction of this misuse

self-treatment was found to be a significant factor in non-consultation.

Implications for self-care education

How far has our survey helped us to answer the three original questions: what to self-treat and how, and when to see a doctor?

The 'how to self-treat' seems to have been answered indirectly, in that 80 per cent of those self-treating were deemed to be doing so reasonably appropriately. However, this result must be viewed in the light of the overall degree of agreement *amongst* our judges (see Table 12) and also in the light of the avowed difficulties experienced by them in doing this: in fact, many acknowledged to me the help of their receptionists in recognising the treatments used. This is not surprising since general practitioners are—almost by definition—unfamiliar with lay treatments. Surely this leads us to conclude that a doctor's role in this question is one of 'adviser' to non-professionals, rather than 'teacher'. Instead of panels of

doctors deciding the 'correct' self-treatment, perhaps this job entails guiding people away from harmful or ineffective measures, and building up confidence in the use of self-treatment for suitable ailments.

This latter discussion hinges largely on the answers to the other two questions. Where health and safety are involved, the first decisions must always be 'what to self-treat' and 'how long for'. If the lay person answers both of these correctly, the 'how' is of less importance. Here our work showed that there was no consensus amongst our participating doctors on these points. On the contrary, there was a good deal of confusion about what could be offered by doctors at the level of 'minor' ailments. Until doctors know what they can offer for these conditions, it is impossible to submit authoritative judgments to lay people about self-treatment.

It would seem that a more participative model might represent the most hopeful approach to 'informed self-treatment'. Discussion with medical professionals could be arranged in different ways with a view to arriving at generally acceptable treatments and, more important, at ways of maximising 'appropriate' use of the general practitioner's services. The safety of self-treatment could be checked by the doctor for those who consult. For the chronic non-attender who self-treats harmfully the potential source of advice could more easily be the pharmacist.

An ideal model of health care is composed of two separate but interlocking parts: the medical care system, run by medical professionals; and the self-care system, the activities of non-professionals. The efficient pursuit of health presupposes that both sides of the team can integrate their separate activities: this, in turn, presupposes a knowledge on both sides of the other's activities and of the appropriate setting for a meeting point of the two sides. It also implies that both sides are motivated to do this. It suggests that ignorance and knowledge may be accepted and communicated effectively by each side to the other. Such a

system would operate in a non-hierarchical sphere: it would resemble Korn's 'co-learning'[70], producing interdependency.

This model is far away from the one we have. I suggest that we need to move in the direction of this more participative model in order to solve the biggest problem in implementing self-care: that of motivation for both the professional and the lay person.

Perhaps it is appropriate to pursue these possibilities on an economic note. Self-care may come to mean self-medication—particularly if left to doctors, who are accustomed to treating almost entirely with drugs.

Finally, a climate of economic stringency is ideal for the acceptance of cheap, low-quality care. Is this what self-care may turn out to be?

7

The use of mass media in health education

WILLIAM T JONES

Improved education, aspirations to a better way of life and a better distribution of information through a multiplicity of sources have created in the general public a greater awareness of health and disease. The opportunity to direct and educate this interest through the press, radio and television appears to many to offer the single greatest hope of success in health education. Indeed, the possibilities of informing and persuading vast numbers of people, through the communications media generally and through television in particular, are commonly seen by health educators as the principal solution to the problems of inducing behaviour change.[28]

There is a conviction in some quarters that failure to take adequate advantage of the communications media, particularly television, has been responsible for under-achievement by health education. This is widely, indeed almost unanimously, believed by health educators and is so at variance with the views of those working within the media that a more objective assessment is needed.

Health educators' expectations of the contribution which can be made by the media are clouded by

inadequate knowledge of the mechanisms involved

failure to appreciate the economic and social goals of press and broadcasting

poor understanding of the types of education which they can most effectively undertake.

Probably the most prevalent misconception is that the media have a voracious and unsatisfied appetite for health education material. In fact, the converse is true. Health education is only acceptable to the media when it has immediate news value, or when some elements provide the media with the basis for an audience-catching issue.[101] There is considerable resistance to health education among many communicators who believe that, while the public have an insatiable curiosity about disease, it is demonstrably disinterested in the promotion of health. Some journalists resent the suggestion that they have a duty to provide information on health subjects simply because doctors and other health personnel believe this to be a responsibility of the media. Other journalists and programme makers have doubts about the moral and ethical issues involved in attempting to effect behaviour change.[119]

All the media have paramount need to capture audiences, and entertainment and news value are usually the dominant criteria. Even given the good will of journalists, the exigencies of editorial policy or more urgent news items frequently take priority. The extent of coverage accorded to any health education issue is unpredictable and bewildering. This is due in part to the inability of health education professionals to assess the news value of a particular item or give adequate emphasis to those aspects which are newsworthy, and in part to faulty understanding of the very real limitations of space and time. There are countless cases where these factors were responsible for the apparent capriciousness of media coverage, but two examples will serve to illustrate the point. In the first example a substantial and long-awaited enquiry into the knowledge, attitude and practice of birth control, carried out for the Department of Health and Social Security[47], was virtually

ignored because its publication coincided with particularly sensational proceedings against a general practitioner accused of adultery. In the other example, evidence of the relationships between smoking and pregnancy and infant mortality, which had received scant attention when published in the medical journals 15 months earlier, received massive coverage through television, radio and press because of the dearth of 'hard news' on the day it was reprinted in a shortened form in a specialist, small-circulation journal.*

The provision of information alone is unlikely to overcome the many barriers to the use of the mass media. It is essential to identify and emphasise such aspects of an issue which are newsworthy, to identify the most appropriate medium and to stimulate the interest and enlist the cooperation of professional communicators.

The press

Newspapers afford health education a valuable means of communication with many millions of readers each day[90]; in contrast to radio and television, they have the singular advantage of providing readily assimilable information in written form, allowing the reader time to absorb or re-read and the opportunity to retain items for future reference. All newspapers give considerable space to health and medical issues, but only a few national newspapers today have a regular column offering solely medical, that is clinical, advice. Where these exist, they appear to have a circumscribed role; one doctor who has written the regular medical column of a mass circulation national paper for more than 15 years has a remit which precludes him from writing about any ailment occurring between the waist and knees!† Such columns

*H Goldstein, 1973, personal communication.
†D Abse, 1973, personal communication.

are of restricted value since they command limited space and have to cover a number of easily recognisable symptoms or fears, but they do at least help the reader to recognise which common illnesses require medical attention and which are amenable to self-management.

Conflicts and misapprehensions

Long-standing conflicts of attitude between the medical profession and the media have served to restrict effective communication with the public on health education.[112] While few doctors question the value of newspapers in reducing ignorance and promoting knowledge of health and disease, many doubt the ability of journalists to present responsible and balanced information. These doubts are deeply resented by medical correspondents,* who regard it as their duty to readers to check the accuracy of information with leading medical authorities and present it in simple, intelligible and memorable form. There certainly seems little justification, at a time when there is so much vocalised anxiety about doctors' inability to communicate effectively, for the view that medical qualifications are essential for all who write on medical matters in the daily press—and scant evidence that this would impair standards of accuracy. Medical correspondents are, with rare exceptions, well informed and highly responsible 'specialists', but they are repeatedly held to blame either for sensational reporting which creates unnecessary alarm[28] or for failure to exercise sufficient caution. All too often when such accusations are investigated it becomes apparent that doctors themselves are to blame through lack of judgment in making alarmist statements at meetings open to the press.[113] One striking example was the assertion at the 1973 annual meeting of the

*A Brown, 1973, personal communication.

British Medical Association that excessive tea drinking in pregnancy is harmful to the unborn child. In this particular instance the national press did much to quieten anxiety by questioning the reliability of the data, but it must be acknowledged that such premature pronouncements in public cause personal distress and are counterproductive for health education generally because of the doubts they cast on the credibility of other, better substantiated, issues. Many doctors express concern about the way the media handle medical matters, and equal anxiety is expressed by journalists and broadcasters about the medical profession's attempts to restrict public discussion to those matters doctors think desirable and capable of interpretation by laymen. All this is hardly conducive to fruitful cooperation in an area of preventive medicine as uncertain as health education.

It is against this background of mutual suspicion[80] that realistic assessments of the role of the press must be made. Many health education and other campaigns have been considerably helped by newspapers—the uptake of vaccination against poliomyelitis, the promotion of the Corneal Graft Act[28], the acceptance of birth control. Others have made little apparent impact despite the energetic cooperation of journalists. For example, the almost evangelical efforts of medical correspondents achieved little progress in improving the response rate to poliomyelitis vaccination until the death of an international footballer drew dramatic attention to the protection of vaccination.[46] The notable attempts of most newspapers to convince the public that the risks associated with cigarette smoking warrant control are other examples. It is difficult to estimate the impact of much that is written on medical or health matters, but there is some evidence that readers store away information from newspapers and follow it up months or even years later in a search for advice or help.* Some journalists believe that those who seek to use the press for health education purposes expect too much too quickly and that expectations of a

*R Bedford, 1973, personal communication.

dramatic and immediate response are a major factor in the disappointment of health educators with the mass media approach.*

While the press is blamed—frequently unjustly—for creating public fears, it is also held responsible when extensive press coverage fails to persuade the public to adopt healthier modes of behaviour. In the words of one senior medical journalist, 'too many people in Government and the medical profession expect the press to be some magic wand that will make ordinary people do what others think they ought to do simply because someone else says it will be good for them'.†

Personal columns and women's journals

Much of the most effective and under-valued health education imparted through newspapers is the advice given at a simple level through the personal problem pages of newspapers and women's magazines.[90] These provide basic information in an easily intelligible form on a variety of health topics—unwanted pregnancy, lumps in the breast, venereal diseases, intermenstrual bleeding, and so on. The *Daily Mirror,* for example, reaches a readership of 13 million with such a column, and a similar feature in the weekly magazine, *Woman's Own,* has an estimated readership of six million. It is evident from readers' responses that many millions of women accord the advice given by 'agony' columnists the same respect and deference they give to advice from family and close friends. In addition, agony columnists are called upon every day of their working lives to give personal health advice to readers. Marjorie Proops, of the *Daily Mirror,* receives 50 000 letters a year asking for the kind of advice readers might be expected to get from their doctors[80], and calculates that for every letter she receives there are 1000 readers who need the same information.

*P Vaughan, 1973, personal communication.
†R Bedford, 1973, personal communication.

Questions about the menopause, sex, cancer, venereal disease and diabetes predominate.* This is a salutory comment on the barriers—real or perceived—between patients and their doctors, and an alarming reflection of the failure of health education to meet demands for information and sources of help.

The potential contribution of women's magazines and the women's pages of the national press in almost all areas of concern to health education has received little attention. Scant use has been made by health educators of these valuable opportunities by involving women journalists in specific campaigns, by keeping them up to date with new information or by providing guidance on emerging problems of interest. The occasional meetings with groups of influential women journalists which some national voluntary societies organise have created an opportunity for the exchange of ideas, for a better understanding of the contributions expected from each side and a greater volume of informed and sympathetic publicity. This is a practice which could be productively employed by others.

Since this meets a measurable demand for information about health, the valuable contribution made by 'agony' columnists is worth some further consideration. An analysis of their correspondence reveals many of the gaps in communication which causes concern and contributes to under-use or misuse of the health services. It also identifies issues which frighten or embarrass people and deter them from seeking help from doctors and are thus of considerable importance to health education. Anxieties about the physical and psychological problems of middle age, apprehension of VD clinics, inability to comprehend printed information circulated by the DHSS and by voluntary organisations, acute fears of mutilation which prevent women from seeking treatment for lumps in the breast—all these and more stimulate letters to agony columnists and have important

*M Proops, 1973, personal communication.

implications for health education. Moreover, readers' letters frequently identify emerging problems of wide application, such as agarophobia, to which little attention may yet have been paid. It is in this last area that health educators could benefit from a close liaison with columnists. Health education must catch the tide of opportunity provided by such developing trends in public concern, if it is to plan realistically for the future. It is no coincidence that when the Chief Medical Officer of the DHSS set up a working party to study the relationship between patients and their GP in 1973[39], he sought the views of Mrs Proops and the *Daily Mirror* readers.

Other channels

Medical and nursing journals and newspapers and specialist periodicals for other members of the caring professions such as *Physiotherapy, Health Visitor* and *Social Work Today* are also conspicuously under-used as channels for health education. This is particularly true of the many reputable small-circulation journals published by voluntary societies with health education for their workers and their supporters, such as *Multiple Sclerosis News, Care in the Home* and *Family Planning.* Like the professional journals, these provide a forum for discussion as well as a much used source of news and information for national newspapers. They also attract a wider non-professional readership and, moreover, most are on the constant alert for new material and offer opportunities for the publication of many experimental studies which would otherwise go unrecorded. Systematic exploration of their potential, closer liaison with editors and consistent effort to provide them with special articles and information about aspects of health education relevant to their own activities are long overdue.

Radio

Enchantment with television as the white hope of health education appears[102] to have diminished the significance of radio for many workers in health education. Failure to appreciate the continuing, and even the developing, importance of broadcasting is as unrealistic as the high expectations of television and could be even more misguided if it led to the neglect of current and future opportunities. Public devotion to television viewing during evenings and weekends is probably responsible for the comparatively low regard for radio as a communications medium today, but the dependence on radio during daytime hours of many target groups such as housewives, motorists, the blind, the elderly and some sections of the working population must be recognised.

Most of the common misapprehensions about the potential of the communications media generally are applicable to sound broadcasting also. Doubts about health education are as common amongst workers in sound radio as they are in other mass communications media. These concern the morality of interfering with personal liberty by persuading people to modify pleasurable habits inimical to health and the increasing need, in a highly competitive situation, to concentrate on programmes which attract large audiences. Health education programmes, with rare exceptions, are not noted for their popular appeal and are described by both radio and television producers as 'the great switch off'. Again, there is marked disparity of views between health educators and broadcasters in the concept of what is newsworthy.

However, practical opportunities for securing air time for health education appear to be relatively easier on radio than on television. Although no programme at present sets out to deal specifically with health education, there are a number of regular programmes which include health education items at frequent intervals and there is a good deal of incidental health education in the course of many other programmes. Magazine programmes, programmes

for schools and some in further education series make a particularly well informed and responsible contribution, often featuring leading authorities and allowing time for the discussion of listeners' questions and comments at a later date.

The wide variety of health topics they cover ranges from child health and behaviour to the general care of eyes, teeth and feet, and from sex education to the special problems of handicapped groups such as autistic children, epileptics and the blind. Many of these programmes make a practice of bringing listeners up to date with research findings and new developments in areas of popular concern. They also seize topical or seasonal opportunities to return to health education issues—advice to the elderly on the avoidance of hypothermia in the winter months, diet and slimming in the spring, protection of young children against sunburn in mid-summer, and so on.

Public participation

Possibilities are emerging in other types of programmes such as those which deal with consumer problems or the participatory 'phone-in' programmes. The consumer programmes include such subjects as education about food hygiene, home accidents and aids for the disabled, and provide information on the use of the health and welfare services or specific guidance on the sources of specialist advice and help. Even greater opportunities are present in the 'phone-in' programmes which have become a regular feature of radio broadcasting, permitting listeners to ask questions or discuss personal problems with one or more experts. These programmes have already dealt with the subjects such as cancer, agarophobia, contraception and smoking and health, and have a particular value in allowing listeners to express anxieties and identify failures of understanding.

This type of programme has become especially popular with local and commercial radio stations and offers useful opportunities for discussion of regional problems and reference to local services. Indeed, one Radio London programme earned special commendation in *The Times* for its temerity in offering the address and telephone number of an abortion referral charity during a discussion on unwanted pregnancy. From their early performance, there is every reason to believe that the network of commercial stations will continue to rely heavily on these types of participatory programmes which engage considerable interest and are relatively inexpensive to produce. With the energetic exercise of initiative, health education professionals have here a variety of fresh opportunities for involving audiences in national and local campaigns and for the promotion of health in the broadest sense.

Local radio

While these programmes continue to attract large audiences, health educators must exploit their potential, especially at local level. Regional radio stations frequently include health education items; these could well be prepared by local health personnel and based on issues of particular concern to the local community—for example, fluoridation, cervical cytology services or a cancer education programme. Alternatively, a series of health education items of short duration prerecorded and taped by the Health Education Council could be made available to local radio stations, both public and commercial, on a nationwide basis.

Disc jockeys

Interesting contributions are made by disc jockeys to health education. Virtually every daily disc jockey programme deals with one or more health education problem; road safety, exercise, alcoholism and slimming appeared to be the most popular subjects,

with road safety receiving the greatest attention during the week reviewed. It is not unusual for health problems to take up 30 minutes of a two-hour programme in this way. The value of disc jockeys as 'educators' lies not only in the size of their audiences, but also in their ability to communicate in language listeners can comprehend and in their authority as opinion formers. An example of their influence occurred in 1974 when a disc jockey mentioned the name of a new drug and caused a flood of requests to family doctors. In a leading article discussing the propriety of giving publicity to new treatments, *The Lancet* commented on the 'large audiences which so many of its [BBC] unrehearsed light entertainment programmes attract'.[86] The audiences these programmes command suggest that the means by which topics are selected for inclusion warrant some further exploration. From enquiries it would seem that items about health and the management of disease are known to be popular with listeners; of the 5000 letters a well known disc jockey receives, many ask for information on particular diseases or health topics and comment on the value of this informal but well informed help. Programme researchers and producers select topics by careful scrutiny of the national press for items of topical interest. Many take the opportunity to publicise a 'cause' with which a disc jockey has become publicly identified. Thus one disc jockey will always give prominence to drinking and driving, another to exercise and yet another to the dangers of cigarette smoking (though it must be acknowledged that they personally rarely have any specialised knowledge of the subject). So far, health educators have so poorly understood the potential of disc jockeys as important channels of communication with large and disparate audiences that efforts to solicit their cooperation cannot fail to be rewarding. At the least, their role is as important as that of the dramatised soap operas so valued by health educators.

Educators and the media

Several experienced broadcasters have suggested that those seeking to use the media to provide information on preventive medicine should develop personal contacts in programme companies whom they would regularly brief and who would in turn alert interested colleagues; such approaches would be particularly effective with local radio stations. Equally, producers comment that educators fail to understand the value of a press and information or public relations function. In their view it is the initiative, expertise and access to sources of information provided by a press or public relations officer which can effectively gain an issue air time. These comments confirm the need to maximise opportunities for publicity by the regular and ready supply of information about research findings, developments and current activities relevant to health education. They also emphasise the importance of lively, active press and information services accessible at all times of the day, capable of furnishing background material on request and nominating authoritative and experienced speakers. It must be accepted that broadcasters often prefer 'unprejudiced' or 'balanced' contributions on their programmes from an outside authority rather than from a spokesman from within a national organisation such as the Royal Society for the Prevention of Accidents or the HEC. In initiating any form of media publicity, close consideration should therefore be given by such organisations to the preselection of experts with known interests and communications skills prepared to devote time to advise and participate in radio or television programmes.

'Experts'

Neither the BBC nor the Independent Broadcasting Authority has official panels of medical advisers, though both have educational advisory committees. The IBA has a medical advisory panel but this is concerned solely with monitoring the advertising of

medicines, products or services to which health claims are attached. Both the IBA and the BBC consult doctors widely on an *ad hoc* basis when they need guidance, but strenuously oppose the employment of specialist medical committees with powers to direct the health content of programmes. Robert Reid, formerly BBC head of science and features, television, has said that the answer to ensuring responsible attitudes in programmes, and to seeing that responsibility is ensured, does not lie in permanent committees of specialists who have pre-emptive rights over programmes. The results of such systems in operation could be, perhaps, not so spectacular, but certainly as insidious and dangerous as those we see in countries not very far from our own shores, where state control is the salutory example of a pre-emptive committee in operation.[94] The right to editorial control of programme content is guarded as jealously by broadcasters as it is by newspaper editors.

While the programme makers we interviewed are agreed on the need for the advice and cooperation of members of the medical profession, they believe that the most productive efforts on health education would be effected through close personal contacts.* Such contacts permit discussion and agreement on the broad outlines of the topics to be covered but leave communicators free to introduce them into appropriate programmes. It is obviously preferable to include health education issues in a number of programmes aimed at differing audiences to ensure wider coverage and a useful variety of approaches. In this way a larger number of listeners will be reached and will have the opportunity to make their own assessment of the issues concerned and to absorb the information given in the course of several broadcasts.

* K Yeomans, 1973, personal communication.

Television

In television there is little effective health education activity which can be recorded. Health educators' high hopes of achievement through television are matched frequently by their disappointment when programmes fail to give adequate coverage, understanding or emphasis to a particular subject—or indeed mishandle it. Their enthusiasm for the medium is not always shared by individual doctors or their professional organisations. Moreover, there is still considerable unease about the public presentation and discussion of treatment of disease, which occasional misjudgments by the most experienced of medical communicators on television have done little to relieve.[24]

The opportunity to engage the attention of millions of viewers on a single occasion is so exhilarating that it tends to obscure understanding of the limitations of the medium and the barriers to its use. Television is primarily an instrument of entertainment, a convenient alternative to the social custom of going to the cinema. Though the BBC Charter[53] and the 1964 Television Act[54] require broadcasters to educate and inform the public as well as entertain it, the common view of television is that it is a form of relaxation at the end of a day's work when efforts to educate are inappropriate. In fact, television has become the largest medium of popular information, without sacrificing its role as entertainment, but it is still far from effective at an educational level. Some of its deficiencies in this area are due to conventions at policy level (especially the convention of neutrality) or at programme level where trivialising formats diminish educational effort.

Attitudes

Our interviews with production staff reveal that many reject an obligation to present health problems as part of their function

as servants of the general public. For example, by the end of 1973 neither BBC nor IBA television had dealt with major issues of the reorganisation of the NHS, which were first outlined in 1971, although the changes proposed had been much criticised in the press and professional journals.[33] This neglect stems in part from difficulties in translating the issues involved into acceptable visual programmes and the needs of more urgent and newsworthy items, but also in part from a manifest disinterest in the subject. Many producers believe that problems of health or health education rarely offer opportunities for dramatic audience-retaining presentation.[29] A common expression of the approach of television to health education (and many other important issues) is, 'if it is dramatic, report it; if it is not dramatic, make it so; if that cannot be done, then it is not important'. Robin Day has described television's dependence on the moving picture as a dangerous concentration on action rather than thought, on happenings rather than issues, on shock rather than explanation and on personalities rather than ideas.[23] This no doubt explains producers' beliefs that audiences are only interested in health topics which can be treated in a dramatic or sensational manner—drug dependence, abortion or venereal disease.

A further concern is the relegation of programmes with a health education content to the television channel which attracts a minority audience or to transmission times well beyond normal viewing hours. One well intended series of programmes on birth control was transmitted around midnight, a viewing time hardly likely to capture the attention of the groups for whom the information was primarily intended! The difficulties of transmitting information of any kind at peak viewing hours for a mass audience which requires entertainment from the medium have been persuasively argued and there seems little likelihood that health education programmes can command peak hour transmission on popular channels.

Difficulties

There are no formal mechanisms in television for consultation in programme planning with health and welfare professionals. Unlike newspapers, programme companies do not employ medical advisers or health and social service correspondents with specialised knowledge and experience. It is not surprising that when health educators do become involved in programme making, they are sometimes affronted by

suspicions of their vested interest

the absence of specialised research

producers' fears that detailed attention to one problem group will open the floodgates to demands for attention from numerous other groups with equally worthy specific interests

what appears to be an unreasonable effort to maintain 'programme balance' by the presentation of opposing points of view.

The concept of editorial neutrality—which is specifically enjoined on broadcasters through the 1964 Television Act[54] and the BBC Charter[53]—is particularly irritating to health educators who aim to change health behaviour.[56] The obligation of television to retain neutrality reduces impact, restricts interventionist opportunities and often causes important, if controversial, issues to be handled by spokesmen of established opposing interests in a boring manner. It must be recognised, therefore, that health education programmes with an educative or missionary purpose need to be prepared with considerable care. The viewer has become highly sophisticated and is unlikely to accept overt efforts to change his behaviour unless he is persuaded that both sides of the argument have been presented fairly.[94]

It must also be understood that television is an extraordinarily expensive resource. One episode in a drama series could cost £25 000 (estimates at 1974 prices) if taped, and £35 000 if filmed; an episode of popular mid-Atlantic comedy thriller series like 'The Persuaders' could cost around £100000.[56] The budgets available for documentaries are usually much more limited and financial stringency adds to the hesitation of production staff about investment in health education programmes which may appeal only to minority audiences, many of whom could already be considered to be the 'converted'.

This is doubtless why it is frequently suggested that health education problems can be introduced more effectively in a fictional setting. It may well be that dramatised presentations such as 'Dr Finlay's Casebook', 'General Hospital' and 'The Doctors' are more effective, though there is no real evidence to suggest that this is so. Indeed, 'General Hospital' has been described as presenting a picture of clinical curiosities few doctors would recognise.[8] The practical difficulties of introducing a contrived health education content into a drama series are virtually insurmountable because script editors rarely countenance interference with a planned story line or provide health educators with access to individual writers and dramatists during the creative phase of programme development.

Achievements

With so little effective health education activity to record in television, it must be mentioned that there have been occasional notable programmes; one of the most remarkable was concerned with a particularly difficult area of health education—sex education. This involved an unusual degree of consultation and collaboration with other groups, outside agencies and media. This programme, the international prizewinning Grampian TV series 'Living and Growing', provides a useful model because of the detailed care with which it was prepared.[22] Groups of parents, teachers, clergy-

men, educational administrators and medical advisers defined the purpose of the series, its content and its target audience. At a second stage, pilot programmes were shown to parents and teachers, and evaluated. By the time the programmes were screened, the producers knew precisely what was wanted, what problems to deal with, which varieties of language and illustrative material to use. To help teachers make the best of the programme, Grampian TV published a booklet summarising each programme, with suggestions for following up individual programmes and advice about the place of this series in the school curriculum. The unique success of this series demonstrates the way in which close collaboration and advice at many levels can produce effective television, relevant to the specific educational needs to a clearly defined target audience.

The 'access' programmes—in which voluntary organisations are invited to present their subject in their own way, be it a self-selected combination lecture, studio discussion and answers to viewers' questions—offer singular opportunities for examining problems in some depth and inviting a response from the audience. One particularly effective programme in the 'access' series on BBC television enabled a group of teachers of preventive dentistry to present an account of the nation's dental health, make the case for preventive dentistry in the NHS and outline the ways in which members of the public could press for better services.

Disappointments

An investigation of the total output of commercial television programmes in 1972 showed that little attention was paid to health education apart from news bulletins and news magazine programmes. Only two series for schools and one adult education programme dealt with medical problems in 1972. In the detailed analysis of the subject content of every documentary and science programme listed in the IBA's report for that year[63], health was

not even mentioned though it was claimed that one fiction series included an item on health education.

In spite of some notable efforts by the BBC's further education programmes, this is the depressing reality of television at the present time as a channel for health education. There are, however, some indications of a small but growing awareness among professional broadcasters that television could play a more important role in educating the community about health. Our interviews suggested an emerging concern that the medium is not fulfilling this role and a willingness to try to close the gap between those who make programmes and the needs of the audiences who receive them. This could well give health education a singular opportunity to seize the initiative. A specific effort is needed to improve mutual understanding and to secure closer cooperation between television authorities and those responsible for health education. A worthwhile contribution could be made to the promotion of health education programmes by an exchange of ideas and experience between representatives for health education and the television companies, with the objective of exploring the problems and potential of the medium as an outlet. Participants could outline the methods of fruitful cooperation and provide some guidance on priority subjects, audiences and presentations, and the contributions expected by all the parties concerned. Projects to involve the communications media in practical health education strategies would provide a means by which fresh insights into the objectives, nature and timing of health education issues or campaigns could be gained. They would also help to clarify the communications needs of the media; the advantages and limitations of each medium; the applicability and adequacy of the information available; the additional intelligence data required and the necessity for adaptation to local situations. Efforts such as these would have the additional and important value of improving understanding of the roles of the various professionals involved and would go some way towards resolving many of the present conflicts between medicine and the mass media.

8

What leads up to the consultation?

DAVID C MORRELL

This paper describes the factors which influence the individual who perceives a symptom of illness to seek medical care. It draws on facts of three kinds: there are those derived from ten years' research in general practice; those derived from 20 years' experience in general practice, starting in semi-rural Hertfordshire, hesitating for three years in Edinburgh and finally settling in Lambeth; and those derived from a fairly extensive literature on this subject. It would be dull did it not contain some conjecture and were it not coloured by the prejudice engendered by a comfortable middle class upbringing and a large happy family.

Individuals perceive some symptoms of illness on about one day in three.[5, 25, 96] Only a minority of these leads to a request for general practitioner care. In one study[5] it was demonstrated that only one symptom in 37 experienced by women aged 20–44 years led to a consultation. Over one-half led to some form of self-medication and slightly under one-fifth interfered with normal activities or caused the patient to rest in bed. All the individuals who took part in this study were asked to complete two questionnaires: one designed to measure anxiety and the other designed to measure not only their social status but also their satisfaction with the environment in which they lived. It was demonstrated in this study that 'anxious' individuals recorded more symptoms and, independent of this, presented more symptoms to the general practitioner. They were also more likely to go to bed in response

to their symptoms and to self-medicate. A number of other studies has demonstrated the effect of personality on the propensity to seek medical care. High neuroticism scores on the Maudsley personality inventory are associated with frequent demands for general practitioner care[65], and persons who record high scores on the Cornell Medical Index make high demands on their doctors.[91]

In the study of women aged from 20 to 44 years, no relationship was demonstrated between demands for medical care and a variety of social variables. Short duration of residence in the neighbourhood, dissatisfaction with the neighbourhood and housing, lack of amenities and expressed difficulty in running the home were associated with high demands for care. Other workers have demonstrated a relationship between sickness reporting and job satisfaction[92], disturbed and stressful family relationships[58], education[20] and social class.[14]

On the basis of these and other studies and half a working life in general practice, it is irresistibly tempting to try to construct a model designed to reflect the experiences and decisions which lead an individual to seek general practitioner care.

With the exception of certain administrative requests, patient-initiated consultations with the general practitioner arise from the individual's perception of some form of dis-ease. The basic thesis of this paper is that this leads to some degree of anxiety in the individual. Whether or not the individual feels the need to consult a doctor in order to resolve this anxiety or indeed sees the doctor as the appropriate person to consult is influenced by a variety of factors.

The individual

Basically anxious personalities measured in a variety of ways are more liable both to experience symptoms of illness and to seek

medical care in response to these symptoms. There is some evidence that this is also related to pain threshold[103], and objective measures of pain threshold may provide a useful predictor of the propensity to consult. In addition, the individual is subjected to a variety of cultural and educational influences. There is evidence that both affect the probability that the individual will consult, but the mechanism through which they act is complex.[1, 67, 68] The occupation of the individual may determine when the consultation will take place. Physically demanding occupations, for instance, necessitate early consultations in the case of physically disabling disease.

The symptom

There is no doubt that the particular symptom perceived influences whether or not the individual will consult the doctor. Tables 14 and 15 compare the symptoms recorded by a random sample of women aged from 20 to 44 years and the symptoms they presented to the doctor. It seems likely that the symptom perceived influences the desire to seek care in two ways. The symptom may itself provoke serious anxiety. This seems likely to occur particularly with symptoms such as abdominal and chest pain or abnormal bleeding. The anxiety provoked depends on the individual's interpretation of the symptom, which in turn depends on cultural and educational factors. In addition, the symptom perceived influences the action taken in relation to the individual's expectations that the doctor can relieve the symptom. This probably applies to such things as coughs, sore throat and rashes. Once again, it is ultimately related to educational and cultural factors. Finally, the symptom perceived may influence the action taken in respect of the individual's knowledge of alternative forms of management. Such symptoms as headache and loss of energy or tiredness are examples of this, where the commercial advertising offers a variety of methods of treatment.

TABLE 14 Symptoms from the diaries of 198 patients

Symptom days (first recorded symptoms)	*Number*
Headache	349
Changes in energy, tiredness	198
Backache	142
Cold	126
Disturbance of emotional response	98
Disturbance of gastric function	95
Sore throat	90
Abdominal pain	87
Cough	74
Pain in mouth (toothache)	55
Bleeding and abnormal discharge from nose	50
Disturbance of menstruation	48
Others	566
Total symptom days	1978

TABLE 15 Symptoms presented at 432 consultations in one year initiated by 198 patients keeping health diaries

Symptoms presented	*Number*
Sore throat	33
Cough	29
Abdominal pain	28
Skin rash	22
Disturbance of menstruation	21
Backache	21
Headache	20
Disturbance of bladder function	19
Bleeding or abnormal discharge from genital tract	15
Disturbance of bowel function	14
Chest pain	14
Disturbance of emotional response	11
Others	185
Total	432

Accessibility of doctor

The accessibility of the doctor would be expected, theoretically, to influence the demand for care. In the National Health Service there is no financial disincentive to consult. There are other barriers. The distance patients live from the surgery might be expected to deter consultation. There is no evidence that this is so.[60, 82] Appointment systems have been held responsible for deterring patients from consulting, and it has been suggested that they might militate against the elderly or mentally ill. Such evidence as is available[82] suggests that the reverse is true and that they may reduce the number of consultations for minor acute infective conditions while leading to a redistribution of care in favour of the mentally ill and the aged.

Community resources

There is some evidence that higher demands for medical care are made in newly established communities where there may be fewer resources in the family and the immediate community. Demands for care in new towns appear to be higher than in established communities[3], but whether this is due to lack of resources or to the higher incidence of, for instance, psychiatric illness, is not clear. The effects of a cohesive family on demands for medical care are complex, but American studies[36] indicate that a cohesive family network may be related positively to sick role behaviour in a mother. There is no evidence concerning the role and efficiency of social services on the demands for general practitioner care. There is, however, considerable evidence that a close association between general practitioner and district nurse can reduce the demands for care made on the doctor.[77, 83]

The doctor

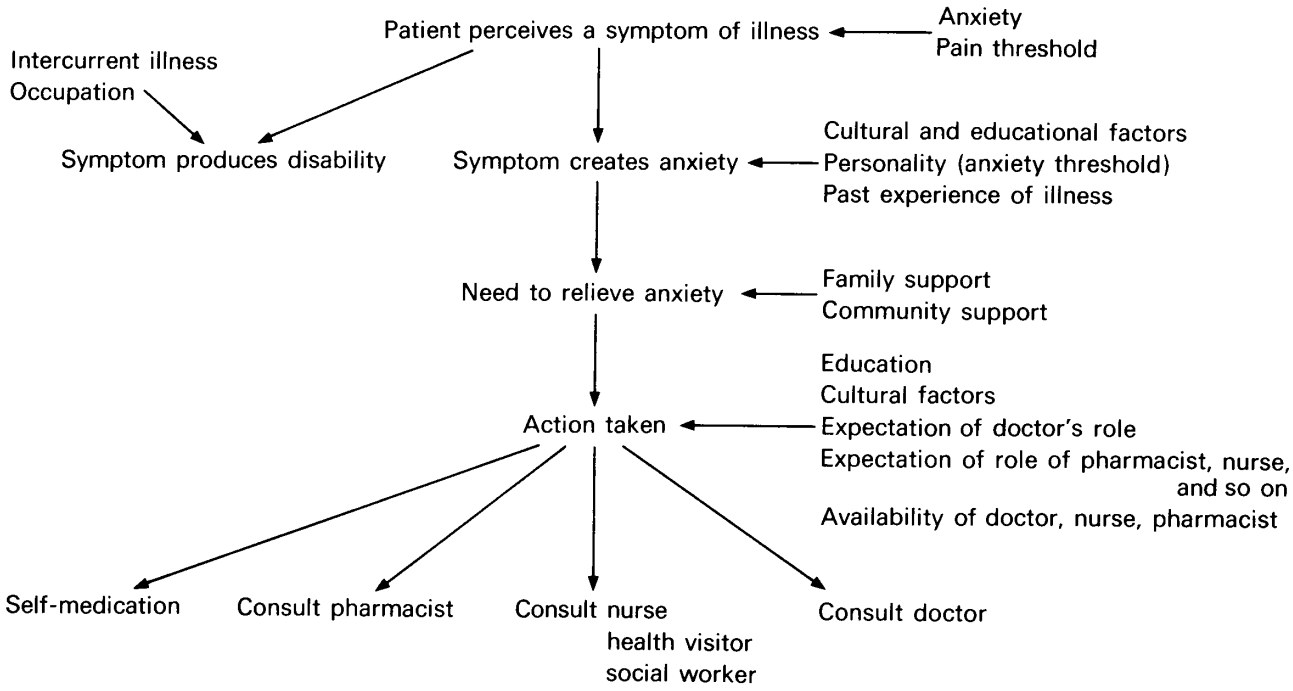
It seems probable that the doctor may be the most important factor in determining when patients experiencing symptoms of illness will consult. It has been shown that a positive policy by a group of doctors not to prescribe for minor respiratory infections resulted in a fall in demand for these disorders.* But studies of doctors in relation to patient expectations are singularly lacking. It is the common experience of doctors working in partnership that the patients of different partners have different expectations of their doctor, and it seems highly probable that the old dictum that doctors get the patients they deserve holds good. Whether the reverse is true, and patients get the doctors they deserve, is much more questionable.

On the basis of the evidence collected about demands for primary care it is possible to develop a model to represent the transition from symptom perception to demand for care from the general practitioner (Figure 4).

On the basis of this model, the crucial factors in determining when a patient experiencing a symptom of illness consults the doctor depend on the anxiety engendered by the particular symptom perceived and the possible ways of resolving this anxiety. If this model is correct, any modification of human behaviour in response to symptoms of new illness must depend on education directed to resolving the anxiety. This would seem to lie primarily in the field of health education. Modifications in the pattern of demand on the general practitioner may be achieved by clarifying the role of those who deliver alternative forms of primary care, such as the pharmacist, the nurse and the social worker. Finally—and probably crucially—the doctor himself, by the way he responds to demands for care in the face of minor illness, will determine future patterns of care. If he prescribes,

*I J Black, 1975, personal communication.

FIGURE 4 FROM SYMPTOM PERCEPTION TO DEMAND FOR CARE



he reinforces the patient's belief that the demand for care is appropriate. If he rejects the patient he increases the already existing anxiety and insecurity, and this in itself may well lead to alternative patterns of demand. If he consciously educates, explaining his limitations as well as his attributes, he may induce realistic demands. If the doctor acts like God, his patients will expect him to have supernatural powers. Having studied the many factors which influence demand for medical care, it seems probable that the doctor's role in creating expectations which are realistic or otherwise is the most important factor in determining the pattern of demand for minor illness on primary care services.

9

Minor illness in the surgery

A response to a trivial, ill-defined or inappropriate service?

ANN CARTWRIGHT

In this paper I discuss three possible reasons, each related to the service rather than the patients, for people consulting their general practitioner about minor illness. The first relates to ways in which the service is, or may be seen as, trivial and therefore appropriate for minor illness. The second is concerned with the lack of definition of either the scope or range of the general practitioner service, which can again lead to it being seen as appropriate for minor illness. The third is the inaccessibility of other sources of professional help, which may incline people to present their needs in terms of illness so that they fall within the province of the doctor.

A trivial service?

Six aspects of the general practitioner service suggest that it may be, or may appear to be, trivial. These are

the length of consultations

the place of consultation

the nature of the help given

the equipment used and available

the knowledge on which action is taken

the rationing of complaints.

The length of consultations

What shocks me about the data on the length of general practitioner consultations is not the average but the distribution. In a series of 2113 observed consultations the median was 4.2 minutes, the mean 5.0 minutes and only about 1 in 100 took 15 minutes or more.[11] For consultations at which the diagnosis was psychoneurosis, the average time was 5.3 minutes. If appointments are made at five-minute intervals, which seems to be common practice, people will perceive the general practitioner as expecting to be consulted about illnesses and problems which can be dealt with in five minutes. Furthermore, patients are aware if the waiting room is full and feel under pressure to be quick. In many ways the problem is circular. Short consultations can lead to minor illnesses being brought; minor illnesses in the consulting room lead to short consultations. Short consultations can mean that some major problems are not raised. In another study, two-fifths of the women who had recently had a baby felt their general practitioner did not have time to talk about things such as family planning.[12]

The place

Advances in medical technology lead to more and more tests and treatments being carried out in hospital. The number of outpatient attendances per 1000 population in England and Wales rose from 640 in 1959 to 688 in 1969 and 713 in 1971. It was 718 in England in 1974.[41]

Fewer births and fewer deaths are occurring at home. The proportion of births in Great Britain taking place at home fell from 33

per cent in 1961 to 24 per cent in 1966 and 6 per cent in 1973.[109] The proportion of deaths in England and Wales that took place at home has fallen less dramatically: it was 38 per cent in 1963[45] and 32 per cent in 1973.[50, 51]

So the general practitioner is less and less involved with birth and death. Cut off from these major events, he is likely to be seen as an appropriate person to consult for more mundane and even trivial events. If, in addition, he does less home visiting, he may be cutting himself off from the only relatively acute episodes for which children and younger adults do not go to hospital and from elderly patients with the most disabling chronic conditions. And if he uses a deputising service for night calls, he will miss a substantial proportion of the emergencies in his practice.

Nature of help

The most common action taken by general practitioners at consultations is to write a prescription. They do this at about two-thirds to three-quarters of consultations.[14] Certainly some patients see prescribing as an easy way out for the doctor or a way of trivialising a consultation.

> 'Before you've finished saying "I've got a sore throat" you've got a prescription and you're out.'

> 'They're all alike—doctors. As soon as you walk in they've got their pen on the pad. This one doesn't tell you what you've got; he just gives you a prescription: "Take this three times a day", before you've even said what's wrong. They're all like that; ready to give you something for it before getting at the cause of it.'

An examination, on the other hand, was generally seen as taking trouble—but they are said to be carried out at less than half (44 per cent) of consultations.[14]

'I appreciate his attention. He's given me a thorough examination at the surgery—a real thorough overhauling.'

Failure to examine was one of the things of which patients were critical.

'Once or twice I've thought he could give you an examination instead of just relying on what you say. You might say "I've got a pain here." He says "I think I can find something to help that." He might be barking up the wrong tree.'

'Well, with me going with the same complaint all the time. They look at your card to see what you had last time and they think "I'll give the same again" like.'

If at a random quarter of consultations doctors asked patients to undress for examination, then 94 per cent of those with ten or more consultations in a year would be examined. In practice it was two-thirds.[14] It seems, therefore, that some regular chronic or high attenders are never asked to undress for an examination.

Nearly two-thirds of women who had first obtained a prescription for oral contraception from their general practitioner said they were not given any examination at the time.[13] A few women later switched and got their pills from a family planning clinic because they found the clinic took more time or gave them a better examination.[12]

'I never even had a check-up from him [general practitioner] and I wanted to be safe. He just gave me a prescription and never asked me anything.'

'My general practitioner never examined me internally. I do think the family planning clinic gives you more time for discussion and they are more interested.'

I am not arguing that before the pill is prescribed all women should have vaginal examinations, or that all patients should be examined every fourth time they go to the doctor. I am simply describing some of the ways in which the help they are given may make the general practitioner service appear trivial to patients.

Another way is in comparison with the hospital service. One-third of the patients we interviewed in 1964 said they would prefer a general practitioner who sent patients to hospital rather than one who did a number of tests and investigations himself. (Half preferred the latter, the others were uncertain.[14])

Some reasons given for preferring the hospital were

'Your own doctor will send you there anyway nine times out of ten.'

'They do get into things more thoroughly [at hospital]. If anything is radically wrong, it's investigated straight away. You don't have to hang about trying different things.'

But the main reason for preferring to be sent to the hospital was 'because they'd be better equipped to do the tests'.

'In hospital they have everything. They give you a thorough exam. I do believe most people would prefer a hospital investigation unless their doctor was exceptionally well equipped. Dr . . . certainly wouldn't have the equipment in his tiny surgery.'

The equipment used and available

Buchan and Richardson[11] found that an 'instrumental examination' was performed at 31 per cent for the consultations they observed. The most commonly used equipment was stethoscope (at 18 per cent), torch/spatula (at 15 per cent), sphygmomanometer (at 10 per cent), auroscope (at 9 per cent), weighing scales (at 4 per cent) and thermometer (at 3 per cent). The average time taken to use a thermometer was 0.7 minutes and the authors comment that this suggested that reassurance was more important than accurate registration of body temperature. Irvine and Jefferys[64], in a study of 449 general practitioners, comment that 'At first sight it would appear that many practices lacked equipment necessary for adequate patient care' (68 per cent of GPs had vaginal speculae, 35 per cent a haemoglobinometer). They add that direct access to hospital diagnostic services was considerably better than it had been in 1963 (89 per cent of GPs said they had used a vaginal speculum in the previous 12 months, 65 per cent a haemoglobinometer). However, Scott and Gilmore[100], in a study of outpatients in Edinburgh, conclude that 'In a substantial number of referrals to outpatient departments, often for minor disorders in which the diagnosis is not in doubt, the patient is being referred on a purely service-providing or therapeutic basis', and Lamont[72] in an analysis of over 3000 attenders during one month at an accident and emergency department, concluded that more than half the patients did not need hospital care.

In 1964 15 per cent of patients did not feel their doctor had a well equipped surgery.[14]

> 'He doesn't need a surgery. He gives prescriptions. There's not a lot of palaver about it.'

The knowledge on which action is taken

If the hospital doctor has more technological facilities and greater expertise than the general practitioner, the GP has a greater knowledge of his patients as people. He knows them over a longer period; he is more likely to have visited their homes and to know other family members. The knowledge on which he makes decisions is therefore more intimate. But how detailed is it?

General practitioners are often unaware of the needs and disabilities of their elderly patients.[116] A retrospective study of people's lives in the year before they died found that although 96 per cent of the people who died had consulted their GPs during that year, no help had been sought for a sizeable proportion of symptoms: the proportion was over half for loss of bladder control, two-fifths for depression and over a quarter for loss of bowel control.[16]

In a more recent study of elderly patients attending their GP's surgery, patients were asked if they ever had trouble with a number of problems. (For a description of study methods, see Cartwright, Lucas and O'Brien.[17]) Forty-two per cent reported difficulty hearing, 37 per cent difficulty seeing or reading, 46 per cent breathlessness, 32 per cent trouble with feet, 44 per cent stiffness or other difficulties in walking, 39 per cent dizziness, 21 per cent getting too fat, 6 per cent loss of bladder control and 3 per cent getting too thin. Patients were then asked if they thought their doctor knew about their problems. The doctor was thought to be aware of nearly three-fifths of these problems, not to know about one-third and for one-tenth the patient was uncertain whether the doctor knew or not. The doctors had been asked about this independently. When the patient thought the doctor knew about the problem he was right in just over half (55 per cent) of the instances. In the other 45 per cent the doctor was apparently unaware of the problem. The patient was more likely

to be right when he thought the doctor did not know—in 80 per cent of the cases.

A possible explanation for the doctor being unaware of some of these problems is that patients were reporting problems which the doctors thought were of little or no significance. This was obviously not always the reason, as doctors quite often perceived problems which the patients did not report. This is shown in Table 16, which is based on data on 50 patients and 9 symptoms.

TABLE 16 Patients' and doctors' perceptions of problems

Reported by doctor	*Reported by patients*		*Total*
	Yes	*No*	
Yes	52	32	84
No	83	283	366
Total	135	315	450

Source: *Some methodological problems encountered in a study of general practice consultations.*[17]

So, while doctors were apparently aware of only two-fifths of their elderly patients' perceived problems, the elderly patients did not report two-fifths of the problems that the doctors perceived. The proportion of patients reporting difficulties in seeing, trouble with feet and dizziness was more than twice the proportion of doctors who perceived these problems. And no doctors were apparently aware of the incontinence reported by a small proportion of patients. Obviously, people's level of tolerance, expectation and perception vary and this will account for some of the discrepancies. But the data suggest that when elderly patients consult their doctor he often does not look for problems which might be amenable to treatment or relief.

Rationing complaints

The most striking observation of Williamson and colleagues[116] about elderly patients was the frequency of multiple disabilities. 'Men had a mean of 3.26 disabilities of which 1.87 were unknown to the family doctor; women a mean of 3.42 disabilities with 2.03 unknown.' But some doctors like to deal with a single problem at a time. They appear to resent it if patients try to raise another issue, and refer disparagingly to a 'while I'm here doctor' syndrome. They develop techniques for cutting patients off. Two examples from a study of elderly surgery attenders illustrate this.[15]

Doctor	Apart from these palpitations, you're really very healthy, aren't you?
Patient	Yes, yes. Well, I mean, I have varicose veins, you know.
Doctor	Oh yes.
Patient	And I've got a small ulcer, but it's dry now.
Doctor	Mm.
Patient	On my right leg I have a small ulcer.
Doctor	Yes, that's very good.
Patient	But it's drying up gradually. One day I think it's gone completely but it hasn't. It comes back. But ...
Doctor	Now here's the letter to see about your eyes.

Doctor	Righto, well that's it. Very good.
Patient	One or two other aches and pains but I suppose that's old age, I suppose? A bit of rheumatism in my shoulder.
Doctor	OK.
Patient	As I say, the thing is that, well this here, although I've had these aches and pains, I've felt so good in myself, you know . . .
Doctor	That's right.
Patient	I've had—well . . .

Doctor That's right, if you develop further trouble, come back. Otherwise, you don't need to, just keep going.

Other doctors encouraged people to bring up additional problems or symptoms. The first example comes from the early part of a consultation.

Doctor You've been spitting blood?
Patient Yes.
Doctor It comes when you cough?
Patient Yes, but not always.
Doctor Any other trouble?
Patient Well when I've taken that medicine I've been prescribed, that all comes up with it.
Doctor Have you noticed any other trouble at all?
Patient In what way?
Doctor Any other complaints?
Patient No.
Doctor Any pains anywhere?
Patient No.
Doctor Any trouble with your joints or your hands?
Patient Only my feet.

Then from the end of a 9½ minutes' consultation.

Doctor Now was there anything else you might like to talk about?
Patient No, I don't think so, thank you.
Doctor Jolly good, fine. How's your wife by the way? Is she all right?
Patient I think that the fact that I've not been well has done her the world of good.
Doctor Oh good. Busy looking after you.

If patients are only encouraged to discuss a single problem, they may choose the one they feel is most acceptable to the doctor,

or the one he is able to help with most easily and directly. More complex problems and anxieties may only be revealed in a sympathetic and relaxed atmosphere.

Lack of definition of scope or range of general practice

In the conclusion to the study of patients and their GPs carried out in 1964, I wrote: 'The most obvious flaw . . . is the uncertainty about the doctor's role. . . . This lack of job definition . . . adversely affects the relationship between doctors and patients.'[14]

Since then we have had working party reports on primary medical care[10] and on the future general practitioner.[97] As a result of these reports there is probably more agreement among academics about the appropriate range and scope of a general practitioner's work and about the way in which he should be trained; but I am somewhat sceptical that there is greater agreement either among GPs themselves or among patients, or between the two about what is appropriate for referral to the general practitioner.

I have extracted some data from another study (see Table 17).[25] If we accept these predictions and views at face value, it seems that adults often may not consult doctors about depression, persistent headaches, acute sore throats and boils when doctors would feel this appropriate. On the other hand, they may consult about sleeplessness and colds more often than doctors feel reasonable. The other main point which emerges from the data is the lack of unanimity among doctors. Given the enormous 'iceberg' of illness which is not taken to the doctor[61, 106, 114], there is bound to be a large grey area of doubt. And it is largely this grey area which this book is about.

One effect of the uncertainty is that patients often cannot foresee whether doctors will feel it is appropriate to be consulted about certain things. If they miscalculate, they may feel rebuffed and

TABLE 17 Comparison of doctors' and adults' views on self-treatment of various symptoms

	Proportion of doctors who thought symptom suitable for people to treat themselves without consulting a doctor %	*Proportion of adults who thought they would do something themselves (including nothing) without consulting a doctor* %
A constant feeling of depression for about three weeks	9	26
Difficulty in sleeping for about a week	58	45
A heavy cold with temperature and running nose	86	70
A headache more than once a week for about a month	17	40
A very sore throat for about three days and no other symptoms	27	55
A boil that doesn't clear up in a week	12	22
Numbers of doctors or adults = 100%	307	1412

Source: *Medicine takers, prescribers and hoarders.*[25]

may then be less likely to consult in other circumstances which the doctor might feel more sympathetic towards. Two studies[14, 25] have shown that when doctors considered a relatively high proportion of their consultations were for trivial reasons or for ailments which could be self-treated, patients consulted them less frequently. This indicates that patients are somehow discouraged from going to see them again.

I suggest that lack of definition leads not only to minor illness in the consulting room but also to a failure to consult about some major illness at an appropriate stage.

An inappropriate service?

My thesis here is that because the general practitioner service is often the most accessible one, it may be inappropriate for many of the problems that are brought to it.

If people feel they need professional advice or support because of work, housing, leisure or personal relationship problems, who can they turn to? Other professionals may be seen as more appropriate but the general practitioner will often be the most accessible. Some patients may ask him about their non-medical problem direct. Others may feel a need to present with some medical problem—and given the 'iceberg' of symptoms about which doctors are not consulted, it will not be difficult for most people to find at least some opening gambit that they feel will be acceptable to a doctor. Goldberg and Neill report that, of episodes referred by the doctors to the social worker in the practice, 17 per cent presented to the doctor as 'overt social problems only' and 29 per cent as having vague psychosomatic symptoms.[37]

In 1964, the proportion of patients who thought they might consult their doctor if they were worried about a 'personal problem that wasn't strictly medical' was 28 per cent; by 1969 this

proportion was 41 per cent. In the later study[25] almost half the working class patients (46 per cent) thought they might do this, compared with a third of the middle class. These data suggest that this is not a small problem and that it is increasing; the class variation (also found in another study[15]) supports the thesis that other sources might be more appropriate but working class people are less likely than middle class ones to have alternative professional sources of help available.

In conclusion

I have been arguing that the nature of the service influences the subject of consultations, and Table 18 presents some data which suggest that doctors' perceptions about trivialities are related to the way they do their job. To some extent it would seem that what they are seeing is the trivial—or untrivial—way they do their job. Doctors who think a large proportion of their consultations is for trivial, unnecessary or inappropriate reasons attend few courses and carry out few procedures themselves. They are also relatively unlikely to have direct access to hospital beds.[14]

In presenting and selecting this material in the way I have, I have obviously given a distorted view of general practice; I have deliberately assumed the role of devil's advocate. I should like to end with some more positive points.

In the study in which we tape-recorded general practitioners' consultations, interviewed patients before and after the consultations and doctors afterwards[17], we were aware of the complex nature of nearly all the transactions. Most of the elderly patients in this study had a long-term, ongoing relationship with their doctor and during the consultation many issues were hinted at or raised direct. As an illustration of the range of topics covered I have listed below all the ones discussed at a single consultation.

TABLE 18 Doctor's perceptions of the proportion of 'trivial' consultations and various aspects of his work

	Proportion of consultations estimated by the doctor to be for reasons he felt trivial, unnecessary or inappropriate				
	Less than 10%	10% < 25%	25% < 50%	50% < 75%	75% *or more*
Proportion who had attended any courses in last five years	67%	58%	58%	54%	34%
Proportion with direct access to NHS hospital beds	48%	45%	38%	29%	21%
Average score on procedure carried out themselves	4.0	3.9	4.1	3.3	2.1
Average number of diagnostic facilities available (out of four)	3.3	3.1	2.9	2.8	2.7
Number of doctors (= 100%)	65	121	126	79	29

Source: *Patients and their doctors.*[14]

Some were referred to on several occasions; others were mentioned in passing.

Topics discussed at one consultation

Length of time since last visit
General state of health: 'felt like a bit of washed-up, screwed-up rag'
Working from 7 in morning to 8, 9, 10 at night
Missing meals
Drinking a lot of tea and coffee
Twinges in chest—what they felt like; when they happened
Indigestion
Teeth
Age
Living alone
When husband died
What husband did
How long been living at present address
Patient's job (managing cats' home); used to look after dogs too
Neighbour's naughty (borstal) boy
Not taking a holiday—difficulties in taking holiday
House—previous anxiety about security; needs modernising
Pumping water—deep well; carrying water
Son—coming to see patient; buying her house; whether married; where living
Other children
Patient tied to work; never 'off hook'
Times of meals; interruptions
People being more troubled and anxious about pets than about wives and children
Things getting under patient's skin
Patient getting fun out of job and enjoying it
Fluid building up under knee
Blood pressure
Depression and mood changes
Possibility of having to give up work
Getting undressed
Putting on weight
Wasting doctor's time when nothing the matter
Waking up short of breath
Getting up at night to pass wate
Age when periods stopped—subsequent bleeding
Wearing tight stockings

Swollen ankles	Diet
Previous broken leg	Heart test
Cyst—possibility of taking it off; not malignant	Blood test
	Anaemia
Patient's view that if cysts removed from dogs, more come up	Urine test
	Hospital appointment—for tests
	Coming back to see doctor

The mix of medical and social problems and the amount of information about the patient's work, family and housing circumstances, revealed mostly by the doctor's questions, will rarely be found in hospital practice. The extent of involvement and support suggested by this sort of professional concern is one of the main achievements and attractions of general practice. Some of the topics might be classified as trivial but, within the context of that consultation, it can be argued that all the discussion was relevant and that it added to the doctor's understanding of the patient's problems and made the patient feel that she was being looked after by someone who cared about her as a person.

I suggest that 'minor illness' can only be eliminated from the consulting room by adding to the iceberg of more serious untreated illness and at the expense of good patient–doctor relationships.

10

Absence from work attributed to sickness

WARD GARDNER

How much absence is due to *bona fide* illness and how much to opting out of the work situation? A few individuals are frequently away from work while a few are never absent. Studies of the state of health of these two unusual groups as revealed by medical examination show that while the frequently sick are often 'healthy' on medical examination, the never sick may have organic disease, physical impairment and resultant disability. What, then, can be said in a positive way about absence attributed to sickness and why do people 'go sick'?

Figure 5 shows the proportion of time lost in the UK insured* population attributed to sickness and attributed to injury and disease arising at work. Table 19 indicates the UK regional variations in the working days lost through sickness; note also the general upward trend despite improvements in the public's health. Table 20 gives a breakdown of the general reasons for absence from work.

Duration and spells

In any given population there are two common indicators used to measure sickness

*National Health Insurance.

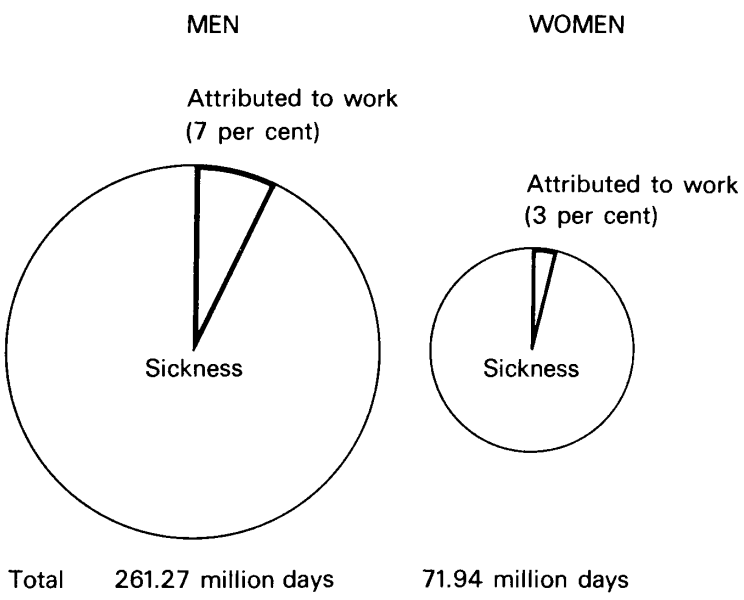
TABLE 19 Working days* lost through sickness: males

Days of certified incapacity per man at risk	*1967–68*	*1968–69*	*1969–70*	*1970–71*	*1971–72*	*1972–73*
United Kingdom	16.6	16.8	17.8	17.7	16.2	16.9
Great Britain	16.4	16.7	17.6	16.2	16.0	16.7
England						
North	24.4	25.5	25.9	23.9	24.3	25.3
Yorkshire and Humberside	19.9	20.3	21.5	20.5	20.5	21.5
East Midlands	14.8	15.3	15.9	15.1	15.0	15.9
East Anglia	12.3	12.4	13.4	11.3	11.7	12.9
South East	10.8	10.8	11.5	10.4	10.1	10.5
South West	15.0	15.6	17.2	15.9	15.3	16.0
West Midlands	14.7	15.3	15.5	14.0	13.8	14.8
North West	21.2	21.5	22.2	20.6	19.8	21.0
Wales	29.7	30.6	33.1	31.2	30.8	32.2
Scotland	20.5	20.9	22.0	19.9	19.5	20.0
Northern Ireland	24.1	24.4	26.0	24.4	25.6	27.1
Total days of certified incapacity (millions)	259.8	264.0	276.6	273.8	248.6	259.7

* Not actual working days, but 312-day year (excluding first three days).

Source: *Social trends, no 6, 1975.*[109]

FIGURE 5 TIME LOST ATTRIBUTED TO SICKNESS AND TO INJURY AND DISEASE ARISING AT WORK



Source: *Health at work.*[35]

the total number of days lost from work, which is the sum of the *durations* of individual absences

the total number of occasions of absence, which is the sum of the total number of individual *spells* of absence.

For example, 30 days could be lost by a person in one spell. Another individual might be absent for 30 days in ten spells of 3 days each. The first probably suffered a *bona fide* illness, the second was probably opting out of work and using sickness as the

TABLE 20 Absence from work, 1972

	Reasons for absence from work					
	Own illness/ accident		*Strike/short-time/ lay-off*		*Personal or other reasons*	
	Male	*Female*	*Male*	*Female*	*Male*	*Female*
Percentage of each age group absent in reference week						
18–24	5.1	7.9	2.3	1.0	2.0	1.3
25–34	4.2	4.4	1.9	0.9	1.5	2.6
35–44	5.4	5.2	1.2	1.3	0.9	2.7
45–54	5.6	4.1	1.7	0.6	0.8	2.6
55–64	7.1	4.5	1.5	1.4	0.5	1.6
65 and over	4.9	4.4	0.4	–	1.1	1.1
Percentage of length of absence of those* away from work in reference week						
Less than 1 week	55.9	69.6	68.8	–	–	85.8
1–2 weeks	12.5	12.6	11.6	–	–	7.1
2–4 weeks	11.7	10.1	10.9	–	–	1.8
4–13 weeks	15.1	4.9	8.7	–	–	4.4
Over 13 weeks	4.8	2.8	–	–	–	0.9
Total	100.0	100.0	100.0	†	†	100.0

* Aged 15 and over.
† Sample size too small.

Source: *Social trends, no 6, 1975.*[109]

socially acceptable peg on which to hang the absence. The person who takes only one spell of 1–3 days in a year is, however, likely to have been ill and is likely to be, for example, a manager with 'flu or a shift worker with a bad cold.

A generalisation can be made: infrequent spells of long duration absence are likely to be due to *bona fide* illness; conversely, the shorter the duration of absences and the more frequent the spells of absence, the more likely will these absences be related to social and not to medical factors.

So, 'minor illness' which causes frequent spells of short-term absence is likely to be due primarily to a medical problem and will probably not be *bona fide* illness. It is most likely to be a problem of occupational or social origin in disguise.

For this reason, doctors will almost certainly not be able to do very much of value unless they understand both the occupational and social factors involved, and cooperate, liaise and discuss the problems with the patient *and* with others involved; for example, supervision at work, and any occupational medical or nursing people at the place of work.

About 5 per cent of any work force accounts for about 30 per cent of all spells. These tend to be younger people with repeated short-term absences. A further 5 per cent of the work force accounts for about 30 per cent of the days lost. These tend to be older people with long-term *bona fide* illness, although about half of these people appeared to have sustained a jaundiced view of life arising out of childhood and work problems.

Why do some people go absent and others not?

A look at the 'never sick' may help answer this question. Many of the 'never sick' are to be found among managers whose hobby and

interest is work. In an average blue collar group the 'never absent' will be around 5 per cent. In their way, they are just as unusual as the frequently sick when compared with the majority of the work force. The 'never absent' are usually over the age of 30 and claim to have had a wonderfully happy childhood (despite factual evidence in some of family tragedy or bereavement) but marital discord is not uncommon among them. They have an excellent attendance record, and are content, not hankering after promotion. They will have no history of nervous trouble, backache or bowel disorder. They may also show a marked preference to using a bicycle or walking to work even though they own cars. These people are not necessarily the best of workers, but their attendance record is impeccable. Disabled people often have very good attendance records. The factors which induce people to be absent from work repeatedly have little to do with *bona fide* illness or with so-called sickness. The link with illness is secondary.

Culture and payment in relation to absences

Regional and personal variations in absences show clearly that repeated short-term absences have little to do with sickness but much to do with cultural norms, like or dislike of work, the complexity of the journey to and from work and the rate of sickness benefit payable for absence attributed to sickness—because absence will increase as higher rates are paid in 'blue collar' jobs and then only when previous sick pay was low. The sick pay issue still generates dogmatic (prejudiced) assertions. However, evidence shows that when sick pay has previously been nil or minimal and is then increased considerably, sickness absence rates rise sharply but then fall. On the other hand, and most importantly, many organisations give senior staff full pay when sick. The Post Office and the Civil Service give full pay from the first day of absence. All these groups (and subgroups in various jobs) have rates which compare very favourably with industry in

TABLE 21 Job satisfaction and absence from work due to illness or injury, 1971

Degree of job satisfaction	*Percentage absent in a two week period*	*Average work days lost per man per year*
Very or fairly satisfied	4.7	7.8
Neutral	6.0	8.4
Rather or very dissatisfied	6.9	11.2
Total	5.0	8.1

Source: General household survey.[48]

general. There is no evidence to substantiate allegations that levels of sick pay, social security benefits and so on are important causes of high rates of absence except in a few of the lowest paid.

However, the idea that money is the only real motivation dies hard, and the belief that levels of sick pay and unemployment directly influence rates of absence attributed to sickness is still held by some people despite evidence to the contrary. Absences attributed to sickness are actually higher in areas and times of high unemployment.

Bona fide illness has little, if any, relationship with frequent short-term sickness absences except in such obvious situations as an influenza epidemic. Minor illness causing repeated absence from work is a cultural, social and occupational problem, but is not a medical problem.

Medical certification

Whilst there may be a place for medical certification in record

linkage studies and epidemiological research to detect occupational hazards, canteen squalor, or safety of drivers, pilots and so on, there is absolutely no ground for supposing that they can be used to *control* short-term absence or that they have any value whatever in preventing abuse of sick pay funds. The time has come to admit quite openly that medical certificates are, for all practical purposes, issued on demand. Some doctors and many managers believe that control can be exerted by medical certification, but all available studies indicate the futility of this approach. However, there is a case for placing the onus on the individual to certify himself. Formal weekly self-certification is far better than oral explanation and provides records of absences. Control is possible by reviewing the frequency of spells and by reviewing all cases of absence after, say, the third certificate.

Conclusion

Much of the minor illness for which people are absent from work requires little in the way of medical treatment because the absences are largely socially determined and are not medical in origin. Much, of course, needs to be done—but this is not a paper on the *control* of absence from work. The conclusion that repeated short-term absences have little to do with *bona fide* illness and much to do with other factors needs to be widely understood and acted on, for it is only in this way that the problem can be usefully tackled.

References

1 ASHFORD, J.R. *and* PEARSON, N.G. *Who uses the health services and why? Journal of the Royal Statistical Society, Series A (General),* vol. 133, 1970. pp. 295–357.

2 BAGLEY, C. *Mental illness in immigrant minorities in London. Journal of Biosocial Science,* vol. 3, no. 4. October, 1971. pp. 449–459.

3 BAIN, D.J.G. *and* PHILIP, A.E. *Going to the doctor—attendances by members of 100 families in their first year in a new town. Journal of the Royal College of General Practitioners,* vol. 25, 1975. pp. 821–827.

4 BALINT, M. *The doctor, his patient and the illness.* Second edition. London, Pitman Medical, 1964. pp. xii 395.

5 BANKS, M. *and others. Factors influencing demand for primary medical care in women aged 20–44 years: a preliminary report,* by M. Banks, S. Beresford, D. Morrell, J. Waller *and* C. Watkins. *International Journal of Epidemiology,* vol. 4, no. 3. September, 1975. pp. 189–195.

6 BHARDWAJ, S.M. *Attitude toward different systems of medicine: a survey of four villages in the Punjab—India. Social Science and Medicine,* vol. 9, no. 11/12. November/December, 1975. pp. 603–612.

7 BOTT, Elizabeth. *Family and social network.* Second edition. London, Tavistock Publications, 1971. pp. 363.

8 BOWERS, D.M. *Public relations. World Medicine,* vol. 9, no. 11. 27 February, 1974. p. 105.

9 BRITISH MEDICAL ASSOCIATION. BOARD OF SCIENCE AND EDUCATION. *Report of the panel on primary health care teams.* Chairman: Sir John Peel. London, B.M.A., 1974. pp.35.

10 BRITISH MEDICAL ASSOCIATION. PLANNING UNIT. *Report of the working party on primary medical care.* London, B.M.A., 1970. pp. 80. *Planning Unit Report, no. 4.*

11 BUCHAN, I.C. *and* RICHARDSON, I.M. *Time study of consultations in general practice.* Edinburgh, Scottish Home and Health Department, 1973. pp. vi 42. *Scottish Health Service Studies, no. 27.*

12 CARTWRIGHT, A. *How many children?* London, Routledge and Kegan Paul, 1976, pp. 212.

13 CARTWRIGHT, A. *Parents and family planning services.* London, Routledge and Kegan Paul, 1970. pp. x 293.

14 CARTWRIGHT, A. *Patients and their doctors: a study of general practice.* London, Routledge and Kegan Paul, 1967. pp. 295.

15 CARTWRIGHT, A. *and* O'BRIEN, M. *Social class variations in health care and in the nature of general practitioner consultations. in* STACY, Margaret. *editor. The sociology of the National Health Service.* Keele, University of Keele, 1976. pp. 77–98. *Sociological review monograph 22.*

16 CARTWRIGHT, A. *and others. Life before death,* by A. Cartwright, L. Hockey *and* John L. Anderson. London, Routledge and Kegan Paul, 1973. pp. x 300.

17 CARTWRIGHT, A. *and others. Some methodological problems encountered in a study of general practice consultations,* by A. Cartwright, S. Lucas *and* M. O'Brien. *Journal of the Royal College of General Practitioners,* vol. 26, no. 173. December, 1976. pp. 894–906.

18 CHESTERFIELD HOSPITAL MANAGEMENT COMMITTEE. *An experiment in out-patient information, report no. 1,* by K. Trout. Sheffield, Sheffield Regional Hospital Board, 1973. pp. ii 72.

19 CLYNE, M.B. *Indian patients. Practitioner,* vol. 193, no. 1154. August, 1964. pp. 195–199.

20 COLLINS, Jane. *Some factors associated with the use of medical services for a trivial condition. in* DAVIES, A. Michael. *editor. Uses of epidemiology in planning health services. Proceedings of the sixth international scientific meeting of the International Epidemiology Association, August 29–September 3, 1971.* Primosten, Yugoslavia. Belgrade, Savremena Administracija Publishing House, 1973. pp. 596–600.

21 CROMBIE, D.L. *Changes in patterns of recorded morbidity. in* TAYLOR, David. *editor. Benefits and risks in medical care: a symposium held by the Office of Health Economics.* London, Office of Health Economics, 1974. pp. 17–41.

22 DALLAS, D.M. *Sex education in school and society.* Windsor (Berks.), National Foundation for Educational Research in England and Wales Publishing Company, 1972. pp. 104.

23 DAY, Robin. *Troubled reflections of a television journalist. Encounter,* vol. 34, no. 5. May, 1970. pp. 78–88.

24 *Disease education by the BBC. British Medical Journal,* vol. 1. 1 March, 1958. pp. 510–511.

25 DUNNELL, K. *and* CARTWRIGHT, A. *Medicine takers, prescribers and hoarders.* London, Routledge and Kegan Paul, 1972. pp. 208. *Institute for Social Studies in Medical Care Reports.*

26 EHRENREICH, B. *Gender and objectivity in medicine. International Journal of Health Services,* vol. 4, no. 4. Fall, 1974. pp. 617–623.

27 ELLIOTT-BINNS, C.P. *An analysis of lay medicine. Journal of the Royal College of General Practitioners,* vol. 23, 1973. pp. 255–264.

28 FLETCHER, C.M. *Communication in medicine.* London, Nuffield Provincial Hospitals Trust, 1973. pp. ix 121. *Rock Carling Fellowship 1972.*

29 FLETCHER, Charles M. *Health education. Proceedings of the Royal Society of Medicine,* vol. 62. April, 1969. pp. 398–399.

30 FRIED, M. *Social differences in mental health. in* KOSA, J. *and* ZOLA, I.K. *editors. Poverty and health: a sociological analysis.* (revised edition.) Cambridge, Massachusetts, Harvard University Press, 1975. pp. 135–192. (A Commonwealth Fund Book.)

31 FRY, John. *Common diseases—their nature, incidence and care.* Lancaster, Medical and Technical Publishing Company Limited, 1974. pp. 232.

32 FRY, J. *Natural history of hypertension: a case for selective non-treatment. Lancet,* vol. 2, no. 7878. 24 August, 1974. pp. 431–433.

33 *The future of broadcasting: a report presented by the Social Morality Council, October 1973.* Chairman: Dame Margaret Miles. London, S.M.C., 1974. pp. 100.

34 GARDNER, A.W. *editor. Proceedings of the symposium on absence from work attributed to sickness.* Second edition. London, Society of Occupational Medicine, 1977. pp. 162.

35 GARDNER, W. *and* TAYLOR, P. *Health at work.* London, Associated Business Programmes, 1975. pp. 170.

36 GEERTSEN, H.R. *and* GRAY, R.M. *Familistic orientation and inclination towards adopting the sick role. Journal of Marriage and the Family,* vol. 32, 1970. pp. 638–646.

37 GOLDBERG, E.M. *and* NEILL, J.E. *Social work in general practice.* London, Allen and Unwin, 1972. pp. 189. *National Institute Social Services Library, no. 24.*

38 GREAT BRITAIN. DEPARTMENT OF HEALTH AND SOCIAL SECURITY. *Digest of statistics analysing certificates of incapacity, June 1969–May 1970.* London, D.H.S.S., 1972. pp. 432.

39 GREAT BRITAIN. DEPARTMENT OF HEALTH AND SOCIAL SECURITY. *General medical services. Report of the joint working party.* London, H.M. Stationery Office, 1974. pp. 60.

40 GREAT BRITAIN. DEPARTMENT OF HEALTH AND SOCIAL SECURITY. *Health and personal social services statistics for England (with summary tables for Great Britain) 1973.* London, H.M. Stationery Office, 1973. pp. 176.

41 GREAT BRITAIN. DEPARTMENT OF HEALTH AND SOCIAL SECURITY. *Health and personal social services statistics for England (with summary tables for Great Britain) 1975.* London, H.M. Stationery Office, 1976. pp. 186.

42 GREAT BRITAIN. DEPARTMENT OF HEALTH AND SOCIAL SECURITY. *Hospital inpatient enquiry of 1972.* London, H.M. Stationery Office, 1974. pp. 320.

43 GREAT BRITAIN. DEPARTMENT OF HEALTH AND SOCIAL SECURITY. *Prevention and health—everybody's business: a reassessment of public and personal health.* London, H.M. Stationery Office, 1976. pp. 96.

44 GREAT BRITAIN. DEPARTMENT OF HEALTH AND SOCIAL SECURITY. *Priorities for health and personal social services in England: a consultative document.* London, H.M. Stationery Office, 1976. pp. iv 83.

45 GREAT BRITAIN. GENERAL REGISTER OFFICE. *The Registrar General's statistical review of England and Wales for the year 1963. Part One: Tables, medical.* London, H.M. Stationery Office, 1965.

46 GREAT BRITAIN. MINISTRY OF HEALTH. THE CENTRAL HEALTH SERVICES COUNCIL AND THE SCOTTISH HEALTH SERVICES COUNCIL. *Report of the joint committee of the Central and Scottish Health Services Councils on health education.* Chairman: Lord Cohen. London, H.M. Stationery Office, 1964. pp. 26, para. 62.

47 GREAT BRITAIN. OFFICE OF POPULATION CENSUSES AND SURVEYS. *Family planning services in England and Wales.* London, H.M. Stationery Office, 1973. pp. 168.

48 GREAT BRITAIN. OFFICE OF POPULATION CENSUSES AND SURVEYS. *General household survey 1971, introductory report.* London, H.M. Stationery Office, 1973. pp. 380 plus appendix pp. 191.

49 GREAT BRITAIN. OFFICE OF POPULATION CENSUSES AND SURVEYS. *Morbidity statistics from general practice. Second national study 1970–71.* London, H.M. Stationery Office, 1974. pp. 211. *Studies on Medical and Population Subjects, no. 26.*

50 GREAT BRITAIN. OFFICE OF POPULATION CENSUSES AND SURVEYS. *The Registrar General's statistical review of England and Wales for the year 1973. Part One A: Tables, medical.* London, H.M. Stationery Office, 1975.

51 GREAT BRITAIN. OFFICE OF POPULATION CENSUSES AND SURVEYS. *The Registrar General's statistical review of England and Wales for the year 1973. Part One B: Tables, medical.* London, H.M. Stationery Office, 1976.

52 GREAT BRITAIN. PARLIAMENT. *Medicines Act 1968. Ch. 67.* London, H.M. Stationery Office. pp. vi 165.

53 GREAT BRITAIN. PARLIAMENT. *The Royal Charter for the continuance of The British Broadcasting Corporation.* London, H.M. Stationery Office, 1964. pp. 17 *Cmnd. 2385.*

54 GREAT BRITAIN. PARLIAMENT. *Television Act 1964, Ch. 21.* London, H.M. Stationery Office. pp. ii 40.

55 GROGONO, A.W. *and* WOODGATE, D.J. *Index for measuring health. Lancet,* vol. 2, no. 7732. 6 November, 1971. pp. 1024–1026.

56 GROOMBRIDGE, B. *Television and the people: a programme for democratic participation.* Harmondsworth, Penguin, 1972. pp. 254.

57 HART, J.T. *The inverse care law. Lancet,* vol. 1, no. 7696. 27 February, 1971. pp. 405–412.

58 HINKLE, L.E. *and* WOLFF, H.G. *Ecologic investigations of the relationship between illness, life experiences and the social environment. Annals of Internal Medicine,* vol. 49, 1958. pp. 1373–1388.

59 HODGKIN, Keith. *Towards earlier diagnosis: a guide to general practice.* Third edition. London, Churchill Livingstone, 1973. pp. xviii 729.

60 HOPKINS, E.J. *and others. The relation of patients' age, sex and distance from surgery to the demand on the family doctor,* by E.J. Hopkins, A. Pye, M. Solomon *and* S. Solomon. *Journal of the Royal College of General Practitioners,* vol. 16, 1968. pp. 368–378.

61 HORDER, J. *and* HORDER, E. *Illness in general practice. Practitioner,* vol. 173, no. 1034. August, 1974. pp. 177–187.

62 ILLICH, I. *Medical nemesis: the expropriation of health.* London, Calder and Boyars, 1975. pp. 183.

63 INDEPENDENT BROADCASTING AUTHORITY. *Annual report and accounts 1972–1973.* London, I.B.A., 1973. pp. 116.

64 IRVINE, D. *and* JEFFERYS, M. *B.M.A. planning unit survey of general practice 1969. British Medical Journal,* vol. 4, no. 5786. 27 November, 1971. pp. 535–543.

65 JACOB, A. *The personality of patients in the 'artificial practice'. Journal of the Royal College of General Practitioners,* vol. 17, 1969. pp. 299–303.

66 JONES, R.V.H. *Self-medication in a small community. Journal of the Royal College of General Practitioners,* vol. 26, no. 167. June, 1976. pp. 410–413.

67 KASL, S.V. *and* COBB, S. *Health behaviour, illness behaviour and sick role behaviour. Part One: Health and illness behaviour. Archives of Environmental Health,* vol. 12. February, 1966. pp. 246–266.

68 KASL, S.V. *and* COBB, S. *Health behaviour, illness behaviour and sick role behaviour. Part Two: Sick role behaviour. Archives of Environmental Health,* vol. 12. April, 1966. pp. 531–541.

69 KESSEL, N. *and* SHEPHERD, M. *The health and attitudes of people who seldom consult a doctor. Medical Care,* vol. 3, no. 1. January–March, 1965. pp. 6–10.

70 KORN, R. *The private citizen, the social expert and the social problem. in* ROSENBURG, M. *editor. Mass society in crisis.* New York, Macmillan, 1964.

71 KOSA, J. *and* ZOLA, I.K. *editors. Poverty and health: a sociological analysis.* (revised edition.) Cambridge, Massachusetts, Harvard University Press, 1975. pp. xii 456. (A Commonwealth Fund Book.)

72 LAMONT, D. *The casualty dilemma. Lancet,* vol. 2. 25 November, 1961. pp. 1190–1193.

73 LICHTNER, S. *and* PFLANZ, M. *Appendectomy in the Federal Republic of Germany: epidemiology and medical care patterns. Medical Care,* vol. 9, no. 4. July–August, 1971. pp. 311–330.

74 McCARTHY, M. *Healers and leukaemia. Health and Social Services Journal,* vol. 84, no. 4405. 21 September, 1974. p. 2158.

75 McKINLAY, J.B. *The help-seeking behavior of the poor. in* KOSA, J. *and* ZOLA, I.K. *editors. Poverty and health: a sociological analysis.* (revised edition.) Cambridge, Massachusetts, Harvard University Press, 1975. pp. 224–273.

76 McWHINNEY, I.R. *The early signs of illness: observations in general practice.* London, Pitman Medical, 1964. pp. ix 189.

77 MARSH, G.N. *and* McNAY, R.A. *Team work load in an English general practice—1. British Medical Journal,* vol. 1, no. 5903. 23 February, 1974. pp. 315–318.

78 MECHANIC, D. *Medical sociology: a selective view.* New York, Free Press, 1968. pp. 480.

79 MECHANIC, D. *Sociocultural and social-psychological factors affecting personal responses to psychological disorder. Journal of Health and Social Behaviour,* vol. 16, 1975. pp. 393–404.

80 MILES, A. *The responsibility of the press. The problems arising from the growing public interest in medicine and therapeutics: a meeting of the Library of the lay section of the Royal Society of Medicine and the Medico pharmaceutical Forum.* London, R.S.M., 4 October, 1972. pp. 20–27.

81 MOORE, M.F. *and others. First contact decisions in general practice: a comparison between a nurse and three general practitioners,* by M.F. Moore, J.H. Barber, E.T. Robinson *and* T.R. Taylor. *Lancet,* vol. 1, no. 7807. 14 April, 1973. pp. 817–819.

82 MORRELL, D.C. *and* KASAP, H. *The effect of an appointment system on demand for medical care. International Journal of Epidemiology,* vol. 1, no. 2. 25 January, 1972. pp. 143–151.

83 MORRELL, D.C. *and* NICHOLSON, S. *Measuring the results of changes in the method of delivering primary medical care. Journal of the Royal College of General Practitioners,* vol. 24, 1974. pp. 111–118.

84 MOSER, C.A. *and* KALTON, G. *Survey methods in social investigation.* Second edition. London, Heinemann Educational, 1971. pp. 549.

85 NEWELL, K.W. *editor. Health by the people.* Geneva, World Health Organization, 1975. pp. xii 206.

86 *News or advertising? Lancet,* vol. 1, no. 7856. 23 March, 1974. p. 493.

87 OFFICE OF HEALTH ECONOMICS. *The health care dilemma: or, 'Am I kranken, doctor?'* London, O.H.E., 1975. pp. 24.

88 OFFICE OF HEALTH ECONOMICS. *Prospects in health.* London, O.H.E., 1971. pp. 24. *Studies on Current Health Problems, no. 37.*

89 PARSONS, T. *Social system.* London, Routledge and Kegan Paul, 1970. pp. 594.

90 PIKE, L.A. *The consumer demand for health education. Journal of the Royal College of General Practitioners,* vol. 21, 1971. pp. 156–160.

91 POLLIACK, M.R. *The relationship between Cornell medical index scores and attendance rates. Journal of the Royal College of General Practitioners,* vol. 21, 1971. pp. 453–459.

92 RAHE, R.H. *and others. Demographic and psychosocial factors in acute illness reporting,* by R. Rahe, E. Gunderson *and* J. Ransom. *Journal of Chronic Diseases,* vol. 23, no. 4. 1970/71. pp. 245–257.

93 REEDY, B.L. *The new health practitioners in America—a comparative study.* London, King Edward's Hospital Fund for London, 1978. pp. 79.

94 REID, R. *The responsibility of the new media. The problems arising from the growing public interest in medicines and therapeutics: a meeting of the Library of the lay section of the Royal Society of Medicine and the Medico pharmaceutical Forum.* London, R.S.M., 4 October, 1972. pp. 27–33.

95 ROBINSON, David. *The process of becoming ill.* London, Routledge and Kegan Paul, 1971. pp. 144.

96 ROGHMAN, K.J. *and* HAGGERTY, R.J. *The diary as a research instrument in the study of health and illness behaviour: experiences with a random sample of young families. Medical Care,* vol. 10, no. 2. March–April, 1972. pp. 143–163.

97 ROYAL COLLEGE OF GENERAL PRACTITIONERS. *The future general practitioner: learning and teaching.* London, British Medical Journal for R.C.G.P., 1972. pp. 265.

98 ROYAL COLLEGE OF GENERAL PRACTITIONERS. *Present state and future needs of general practice.* Third edition. London, Journal of the R.C.G.P., 1973. pp. 63. *Report from General Practice, 16.*

99 ROYAL COLLEGE OF NURSING *and* ROYAL COLLEGE OF GENERAL PRACTITIONERS. *Report of the joint working party on 'Nursing general practice in the re-organised Health Service' 1974.* Chairmen: Dr John G.R. Clarke and Helen Baker. London, Rcn and R.C.G.P., 1974. pp. 43.

100 SCOTT, R. *and* GILMORE, M. *The Edinburgh hospitals. in* McLachlan, Gordon. *editor. Problems and progress in medical care.* London, Oxford University Press for Nuffield Provincial Hospitals Trust, 1966. pp. 3–41. *Essays on Current Research, second series, vol. 2.*

101 SHAW, R.M. *Health authorities' view. Proceedings of the Royal Society of Medicine,* vol. 62. April, 1969. pp. 396–398.

102 SHAWCROSS, Lord. *The nature of the interest and the problems it creates. The problems arising from the growing public interest in medicine and therapeutics: a meeting of the Library of the lay section of the Royal Society of Medicine and the Medico pharmaceutical Forum.* London, R.S.M., 4 October, 1972. pp. 1–8.

103 SMITH, Robert. *The pain threshold. Update,* vol. 9, no. 11. 1 December, 1974. pp. 1463–1468.

104 STEINMAN, R. *and* TRAUNSTEIN, D.M. *Redefining deviance: the self-help challenge to the human services. Journal of Applied Behavioural Science,* vol. 12, no. 3. 1976. pp. 347–361.

105 STIMSON, G. *and* WEBB, B. *Going to see the doctor: the consultation process in general practice.* London and Boston, Routledge and Kegan Paul, 1975. pp. viii 155. *Medicine, Illness and Society.*

106 STOCKS, Percy. *Sickness in the population of England and Wales in 1944–47.* London, H.M. Stationery Office, 1949. pp. iv 51. *General Register Office Studies on Medical and Population Subjects, no. 2.*

107 TAYLOR, Peter. *Sickness absence: facts and misconceptions. Journal of the Royal College of Physicians of London,* vol. 8, no. 4. July, 1974. pp. 315–333.

108 TAYLOR, Peter. *Sickness absence resistance. Transactions of the Society of Occupational Medicine,* vol. 18, no. 3. July, 1968. pp. 96–100.

109 THOMPSON, Eric J. *editor. Social trends, no. 6, 1975: a publication of the Government Statistical Service.* London, H.M. Stationery Office, 1975. pp. 272.

110 TODD, J.E. *Children's dental health in England and Wales 1973.* London, H.M. Stationery Office, 1975. pp. vi 387. *Office of Population Censuses and Surveys, Social Survey Division.*

111 TUCKETT, D. *editor. An introduction to medical sociology.* London. Tavistock Publications, 1976. pp. viii 412.

112 TUNBRIDGE, R.E. *The point of view of the medical profession. The problems arising from the growing public interest in medicine and therapeutics: a meeting of the Library of the lay section of the Royal Society of Medicine and the Medico pharmaceutical Forum.* London, R.S.M., 4 October, 1972. pp. 8–13.

113 WADE, N. *Scientists and the press: cancer scare story that wasn't. Science,* vol. 174, no. 4010. 12 November, 1971. pp. 679–680.

114 WADSWORTH, M.E.J. *and others. Health and sickness: the choice of treatment: perception of an illness and use of services in an urban community,* by M.E.J. Wadsworth, W.J.H. Butterfield *and* R. Blaney. London, Tavistock Publications, 1971. pp. xii 114.

115 WILLIAMSON, John D. *and* DANAHER, K. *Self-care in health.* London, Croom Helm, 1978. pp. 216.

116 WILLIAMSON, J. *and others. Old people at home: their unreported needs,* by J. Williamson, I.H. Stokoe, S. Gray, M. Fisher, A. Smith, A. McGhee *and* E. Stephenson. *Lancet,* vol. 1. 23 May, 1964. pp. 1117–1120.

117 WORLD HEALTH ORGANIZATION. *Community health nursing: report of a W.H.O. Expert Committee.* Chairman: Dr Ines Durana. Geneva, W.H.O., 1974. pp. 28. *W.H.O. Technical Report Series, no. 558.*

118 WORLD HEALTH ORGANIZATION. *International classification of diseases: manual of the international statistical classification of diseases, injuries, and causes of death, volume one.* Geneva, W.H.O., 1977. pp. 773.

119 YARROW, A. *The use of the mass media in health education. Community Health,* vol. 4, no. 5. 1973. pp. 244–248.

120 ZOLA, I.K. *Culture and symptoms: an analysis of patients presenting complaints. American Sociological Review,* vol. 31, 1966. pp. 615–630.

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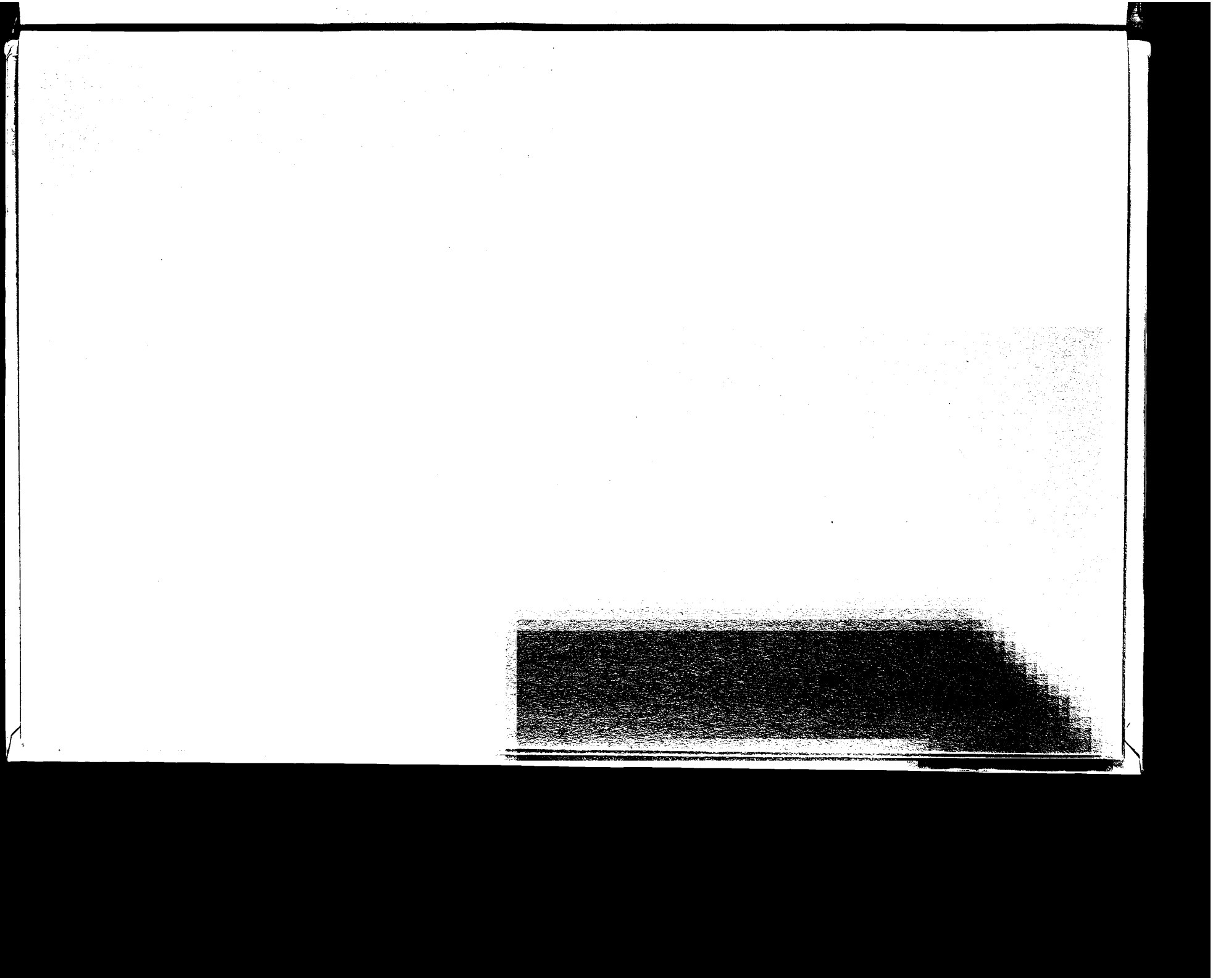

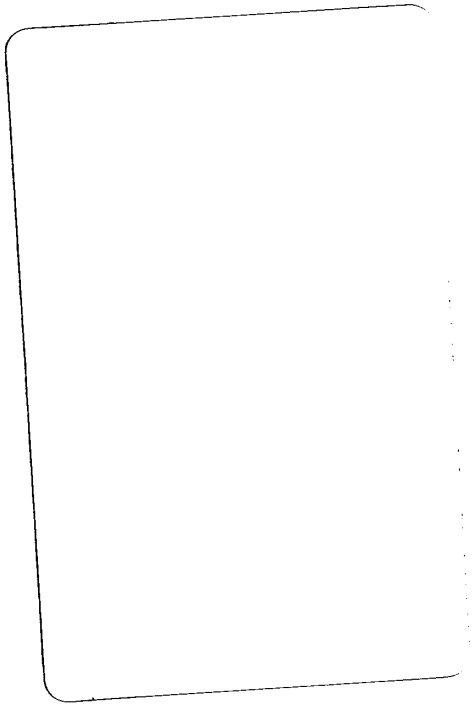

Management of Minor Illness

These papers were originally presented at a seminar on the management of minor illness, one of a series supported by the King's Fund as a contribution towards the study of priorities in medical care and the performance of management in relation to medical services. The distinguished authors, who were members of the seminar, revised the papers for publication in this collection. It is published with a companion volume, *Management of Chronic Illness*, edited by Mark McCarthy and Peter Millard, from the same series of seminars.

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