MEDICAL PRACTICE

General Practice Observed

“Curing” minor illness in general practice

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A primary health care team's methods to meet economically the needs of a large number of patients in Stockton-on-Tees—a high morbidity area in North-east England—have been described.¹ Our practice has now achieved further reductions in the work load by persuading patients to care for their own minor self-limiting illnesses. Several surveys have shown that “trivia”—multiple consultations about minor illness—are the commonest cause of dissatisfaction among general practitioners. Cartwright² found that one-third of the doctors interviewed complained about unnecessary consultations; one-quarter of the doctors thought that half or more of their consultations were unnecessary; and even on detailed study one-fifth of the consultations were “trivial, inappropriate, or unnecessary.”

Why does minor illness irritate general practitioners? Firstly, it limits the time available for detection and studied treatment of more major conditions. Secondly, it prevents the doctor expanding his care of patients into new areas or alternatively looking after more patients and increasing his own productivity. Thirdly, the sheer pressure of the volume of minor illness can cause him to respond inappropriately—especially by overprescribing antibiotics, with resultant iatrogenic disease. Fourthly, he feels that his skills and knowledge are being under-used, and that less highly trained workers could look after such illness. Fifthly, he is aware that his former teaching about “leaving it too late,” if indeed it ever had much value, has resulted in him being overwhelmed by too many people “coming too early.” Finally, he becomes dismayed by what appears to him to be a loss of resilience and self-reliance in society.

Before 1977 we had responded to minor illness in several ways: (1) by prescribing minor remedies—cough bottles, diarrhoea mixtures, liniments etc—and occasionally by the

overuse of inappropriately powerful medication, especially antibiotics; (2) by permitting patients to request repeat prescriptions for repeat episodes of the same condition “without bothering the doctor.” Hence requests for bottles for chesty coughs, sore throats, diarrhoea, etc were met by writing a prescription; and (3) since over 60% of patients are exempt from prescription charges, the receptionists had given up the struggle of trying to persuade cost-conscious patients in times of financial stringency that they should buy patent medications from the chemist.

Method

The house committee, consisting of the senior members of each of the small teams within the primary health care team (reception, nursing, social work etc), met formally to discuss the problem of minor illness in the practice. Minor illness meant, usually, self-limiting upper respiratory tract infections and gastrointestinal disturbances, although minor aches and pains and minor trauma could also be included. All the team members agreed in principle that patients should treat such illnesses themselves. It became apparent that, apart from simple analgesics, the team members did not take minor medicaments and neither did their families. The major reason for this appeared to be a greater awareness of the self-limiting and harmless characteristics of such illness and a more precise knowledge of their natural history.

Furthermore, general knowledge of the lack of effect, both theoretically and in clinical trials, of many proprietary preparations made them unacceptable.³⁻⁶ The new approach was, therefore, to make patients as aware of these factors as the team members themselves. The major importance of the meetings was that all team members were made aware of the problem and agreed the methods for solving it and their own particular contribution.

ACTION TAKEN*Receptionists*

The receptionists ceased accepting requests for repeat prescriptions for new episodes of previously treated minor illness. Patients were

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instructed to purchase such medications from the chemist. War broke out at the receptionists' window. As a result a notice was put up in the waiting room, to which the Department of Health and Social Security did not object. It read as follows: "Patients are expected to buy their own patent medicines—for example, cough mixtures, diarrhoea preparations, headache tablets etc—from the chemist. This is the policy of the Department of Health and Social Security." Many patients complied, but a few insisted on consultations, seeing these as a means of getting a free prescription. For a short time we had to provide rather more appointments.

Doctor

The doctor assumed his classical role of teacher (*docere*—to teach). After a brief history patients who appeared to be suffering from minor self-limiting illness were carefully examined. Increasingly the examination was preceded by such comments as "from what you tell me I don't think I'll find anything" so that with a similar history subsequently patients would feel that consultations would be unnecessary.

Convincing reassurance was then given about the minor importance of the illness, including a detailed account of its expected course. The rarity of the "48-hour 'flu'" was emphasised, and patients were taught that some minor illnesses may drag on for two or even three weeks. Indications for re-consultation were spelt out. The value of medications in treating such illnesses was discussed, and most were dismissed as possibly offering some slight symptomatic relief but as often unpleasant side effects. The place of common-sense home remedies, particularly increasing fluid intake, dietary modifications, and using simple analgesics was emphasised, and the value of steam in respiratory infection was mentioned. Patients were left free to purchase patent remedies from the chemist if they wished, but their doubtful value prevented the doctor from prescribing them any longer. It was necessary not to recommend patent medicines, or patients could insist on the doctor prescribing them under his terms of service. Many patients had delayed for a few days before consulting the doctor. Hence one of the common collusions between patient and doctor was that the patient was actually improving; physical examination often confirmed this.

In a teaching practice the role of doctor/teacher was shown to the trainees. The trainees in turn became teachers of patients and although handicapped by being less familiar to the patient and by their inexperience, trainees were not handicapped by previous prescribing rituals; hence their non-prescribing was accepted. Indeed awareness that young doctors "fresh out of medical schools" did not prescribe fortified the action of their trainers. It was important that the trainees in particular learnt this consultative technique since they see a higher proportion of acute illness than established doctors.

Health visitor

The health visitor was able to advise about managing minor illness, especially in childhood, without being handicapped by the feeling that recourse to pills, medicines, and consultations with the doctors was necessary. The health visitor's role in this area increased dramatically.

Nurses

For several years it has been practice policy to encourage patients to consult nurses if in doubt about the significance of their symptoms and this is spelt out on the card that describes the appointment and telephone systems operating in the practice. Any follow-up of minor illness has been passed to nurses to an increasing extent and once such follow-up has been carried out it is not uncommon for patients to consult them in the first instance about recurrences. For example, in acute cystitis, a common fairly minor illness among women, routine urine cultures after acute episodes are mostly carried out by the nurse; increasingly patients take their new episodes of cystitis to her. Similarly the nurses working in the well-woman, family planning, and antenatal clinics are often dealing with vaginal infections, anaemia, and obesity, and many patients now consult nurses about these unpleasant but not serious conditions.⁷ Although this was not a new aspect of practice policy, the encouragement of self-treatment of minor illness has also fortified nurse care of minor illness.

Results

It was fortuitous that the National Health Service Prescription Pricing Authority priced all the prescriptions of general practitioners in Cleveland County in the roughly comparable months of January 1976 and February 1977. The latter month was six weeks after the new policy on minor illness had been started.

The number of items prescribed by the partnership fell by 19% between the two months (table I). This contrasted with a fall of only 3% for general practitioners in the area as a whole. The cost of prescribing between the two months rose only 4% in the practice but 23% in the area (table II). Something in the order of £10 000 000 could have been saved in one month by general practitioners if the implementation of this policy had been universal (table III).

TABLE I—Decrease in items prescribed within partnership compared with Cleveland County as a whole

	No of items prescribed Jan 1976	No of items prescribed Feb 1977	Decrease in No of items (%)
Partner A	1794	1560	13
B	1416	1197	15
C	2074	1804	13
D	1419	1238	13
E*	2301	1523	34
Partnership	8987	7322	19
Cleveland County	293 792	285 941	3

*Partner E changed between January 1976 and February 1977; some of the differences in the results may be attributable to that.

TABLE II—Change in cost of prescribing within partnership compared with Cleveland County as a whole

	Total cost of prescriptions Jan 76 (£)	Total cost of prescriptions Feb 77 (£)	Change in cost (£)	Change in cost (%)
Partner A	2722	2947	+ 225	+ 8
B	2148	2175	+ 27	+ 1
C	3200	3748	+ 548	+ 17
D	2186	2361	+ 175	+ 8
E*	3601	3147	- 454	- 13
Partnership	13 857	14 378	+ 521	+ 4
Cleveland County	426 103	524 637	+ 98 534	+ 23

*Partner E changed between January 1976 and February 1977; some of the differences in the results may be attributable to that.

TABLE III—Savings to the NHS in one month's prescribing costs

Cost of prescriptions in practice Jan 1976	£13 857
Cost of prescriptions in Feb 1977 if area percentage increase had operated	£17 044
Actual cost of prescriptions in practice in Feb 1977	£14 378
Saving to NHS by practice in one month	£2 666
Total saving to NHS in one month if 20 000 GPs had implemented this policy	£10 664 000

Of the items dispensed by the chemist nearest to the surgery, 80% are for the practice. During the first three months of the new policy on minor illness items prescribed fell 15% as compared with the previous year, contrasting with a fall of only 4% for chemists in the area as a whole. Initially extra consultations were necessary to educate some patients about the new system but the ultimate outcome of not prescribing for minor illness has now meant a great fall in the total number of consultations.

Discussion

The consultation process has changed, for when no prescription is to be given a careful and comprehensive examination is necessary. This now takes place more often. In addition, doctors, in addition to educating them about managing minor illness, are finding time to link this with general health education—

especially the cessation of smoking, losing weight, and the encouragement of exercise. A common finding too has been that when no prescription is offered the patient seems more ready to declare the real problem that bothers him—for instance, a psychiatric or marital problem. Over-reaction to, and prescribing for, the minor illness itself can prevent the major problems being discovered. As with any teaching it became necessary for the doctor to know his subject. Hence there has been some extra study of the virology of common respiratory infections and a closer look at studies of minor illness in general.

Some patients have been delighted with this new style of consultation, sharing with doctors an anxiety about the number of pills, medicines, and antibiotics currently being consumed. Patients are well aware of iatrogenic disease and are pleased to see attempts made to prevent it. Some patients' attitudes to the consultation have changed in that children particularly are brought "just for you to check him over doctor," without any expectation of a prescription if nothing is found after the examination.

A regrettable shortcoming of our methods was that the local pharmacists were not told in advance that it was to take place and therefore were unable to anticipate economies in supplies and staff. As a result of this, however, moves are taking place to include the chemists more actively in the primary health care team.

Although the new policy was meant to rationalise and reduce prescribing for minor illness only, the savings effected no doubt partly reflect a greater awareness of prescribing as a whole in any consultation about any problem. The end result has been a

considerable saving in the cost of the drug bill for the National Health Service, coupled with more time becoming available for more serious illnesses and more patients.

A leader in the *BMJ*⁸ suggested that "attitudes cannot be changed overnight and it would be unrealistic to expect habits and beliefs established over 30 years to be eradicated easily." Although perhaps not achieving its end results overnight, we have certainly achieved far more than any of the team members expected in a comparatively short time. We think that to some degree there has been the hoped for "return to the old virtues of self-reliance and independence."⁸

Without the co-ordinated effort and support of the whole primary health care team in Norton Medical Centre this paper could not have been written.

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Contemporary Themes

The other handicap: brightness

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Summary

Because of changing attitudes to the measurement of mental abilities, only the slow child is assessed and receives special educational help. By contrast, the bright child may remain undetected because unassessed. For these children there are few special provisions, and they may present as behaviourally disturbed or educationally retarded. We describe four such children, and we feel that more facilities should be devoted to helping bright children, both at home and in school.

Introduction

The concept of the intelligence quotient (IQ) has lost some of its importance over the last 10 years for various methodological,

political, social, and ethical reasons. The testing movement and the proliferation of written tests used by schools, industry, and vocational guidance have more often assessed social status, educational opportunity, and literacy rather than the individual's ability to think, reason, and plan effectively in a verbal and motor setting, as was originally intended. Children who are socially and linguistically impoverished or immature often do badly in such tests, and the results, as in the 11-plus examination, can prejudice a child's educational opportunities and future. To balance out such inequalities, measurements of differential mental abilities have been largely abandoned within the state educational sector. Instead, the emphasis has rightly been on helping the child to develop and fulfil himself, whatever his level of skills.

Despite the disquiet felt by the critics of the IQ test, there must still be means by which to measure an individual's performance with the use of a reputable, individually administered test. Few educationalists and paediatricians would dispute the need to recognise and provide special educational facilities for children whose IQ is less than about 70. These children constitute about 2.5% of the school population, and there are excellent schools available for them in Great Britain.

A similar number of children occupy the upper end of the Gaussian curve of the distribution of intelligence, having an IQ greater than 130. Nevertheless, there is little agreement

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