PRACTICE OBSERVED

Practice Research

"And have you done anything so far?" An examination of lay treatment of children's symptoms

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Abstract

Interview data and health diary material were collected for an investigation of mothers' perceptions of their children's illnesses and of how they routinely coped with minor ailments in their children. The descriptions offered by the mothers of how they treated their children's symptoms and their actual use of various remedies as reported in the health diaries helped clarify the issues and processes concerned in their use of proprietary medicines and home remedies and their attitudes towards prescriptions. There was extensive use of proprietary medicines, yet mothers also used some home remedies or took no action at all. They were found to treat their children's symptoms themselves, contacting their general practitioner only if symptoms did not clear up or became more serious.

Generally mothers should be treated as competent in caring for a child whose health and behaviour are causing concern, and in these cases the skills of the general practitioner should be viewed as complementing those of the mother. Mothers do not invariably expect a prescription from the doctor.

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Introduction

General practitioners may often think that mothers consulting with young children normally expect a prescription[1] and that they are unable or unwilling to treat minor symptoms in a child themselves. Benign self limiting illnesses are the single most common group of ailments seen in general practice, and in conventional terms a doctor may have little more to offer than a lay person. Hence it would not be surprising if many doctors had a low opinion of patients' abilities to look after themselves or their families. Indeed, Cartwright found that many doctors regarded consultation for minor illness as "trivial, inappropriate and unnecessary" and that they would treat these patients as rapidly as possible to make time for "more deserving" patients.[2]

Despite research from the 1950s onwards[3-7] and the concept of the "symptom iceberg" developed by Hannay in the 1970s,[8-10] many doctors seem not to appreciate that the bulk of illness in the community is negotiated without professional intervention. Little research, however, has been conducted into the way mothers deal with their children's symptoms and how they use and feel about the services provided. Research into social aspects of medicine have tended to focus on particular illnesses or on particular medical settings, of which the doctor-patient consultation has been well explored.[11,12] Despite the work of Stimson and Webb,[13] much less is known about patients' behaviour before consultation or about the assumptions underlying such behaviour. This paper explores the following aspects of children's lay care: the use of home nursing and home remedies; the use of over the counter medicines; the process of parental decision making about professional referral; and, finally, parents' opinions about doctors' behaviour, in particular their use of prescribed medicines.

This study differs in important respects from previous, similar work. Helman undertook a medical anthropological study of upper respiratory tract infection but did not examine decision making in any great detail.[14] Most studies have looked at adults' perceptions of their own illnesses and self care rather than those of their

children.[15-17] In contrast with the populations studied by Blaxter and Paterson[18] and Stimson and Webb,[13] our study population was neither deprived nor having contact with the doctor at the time of sampling. Furthermore, our study was not focused on the appreciation by parents of the early stages of potentially life-threatening disease.[19] Finally, in contrast with most other research employing health diaries,[20 21] our study complemented the diaries with simultaneous intensive qualitative interviews, so allowing process to be examined alongside content.

Population and methods

The study was carried out in a new town in Scotland and the sample drawn from one health centre, which mainly served its immediate locality. Fifty four women with at least one child under 5 were randomly selected and interviewed. All but one were married, and the median age was 28 years. There were a total of 113 children in these families, 74 of whom were under 5. The women were contacted at home and all but two agreed to participate. Most lived in development corporation housing, and about half the mothers were in some kind of part time paid employment. Most of the families were working class, and in five cases the husband was out of work. A further six women were interviewed as part of a pilot study.

The study used qualitative sociological techniques and included in depth interviews[22] with the women in their own homes. These lasted between 40 and 120 minutes and were tape recorded, transcribed verbatim, and analysed by qualitative, inductive techniques. The women were also asked to complete health diaries, and 42 did so with varying commitment up to a maximum of four weeks. The mean number of days completed was 22 and the total number of days completed 927. These health diaries were relatively unstructured, asking the mothers to write down if they had noticed anything in their children that day, whether they had taken any action, and how the day had been generally.

Results

From the data it was evident that the mothers monitored their children closely and were constantly aware of subtle changes, often of a behavioural nature. Analysis of the health diary data showed that on 456 (49%) of the 927 days recorded the mothers noticed something in their children and either took some kind of action or took no action at all.

NO ACTION FOR SYMPTOMS

On 160 (35%) of the 456 diary days on which symptoms were noticed no action was recorded. The mean number of diary days with symptoms was 11 (range 1-22). The most common symptoms for which no action was taken were respiratory symptoms (especially a cold or runny nose) and changes in behaviour (especially irritability and tiredness), followed by sickness and diarrhoea and rashes and spots. No action was often the first response to minor symptoms.

ACTION FOR SYMPTOMS

Some kind of action was taken on 296 (65%) diary days on which symptoms were noticed. Diaries contained a mean of seven days (range 1-20) on which some form of action was taken for the child by the mother.

Home nursing and remedies

Traditional home remedies did not feature strongly in the mothers' diaries. As Blaxter and Paterson pointed out, traditional remedies are favoured only by older generations.[18] Nevertheless, home care in terms of nursing care was a common response (table I). Dealing with cuts and grazes, providing drinks, encouraging a child to rest and eat, and making a child with symptoms comfortable were all mentioned. From what the mothers said at interview, plainly some of their home nursing activities had been taught to them by their general practitioner. In particular, the mothers had learnt to sponge a child down if fever was present, to treat croup with steam, and to ensure that a child with fever or who was not eating was given plenty of fluids.

Over the counter remedies

By far the most common response to symptoms was to provide an over the counter remedy for the child (table II). Analgesics and bottles of cough medicine were clearly the most common, certain brand names figuring more prominently. At the time Disprin and Junior Disprin were the most commonly mentioned analgesics and Actifed the most common cough medicine. (This study was conducted before the advent of the limited list and withdrawal of aspirin for use in young children.) The mothers were concerned to relieve the discomfort of their child and would do so at their own expense without consulting their doctor.[23] Mothers appeared to make every effort to treat their child themselves, and this impression was supported by the number of times that over the counter remedies were mentioned. Occasionally, more than one remedy was mentioned on a particular day (especially Disprin and a bottle of cough medicine) or an over the counter remedy given alongside continued home care (for example, "Honey and lemon mixture and plenty to drink").

TABLE I—*Use of home remedies*

Type of remedy	Frequency	Type of remedy	Frequency
Bathed eyes/wounds	18	Set up pillows	5
Bed/rest/off school	14	Keep child cool/sponge down	4
Cool drinks	10	Hot drinks	4
Keep child warm/wrapped up	9	Steam	4
Changes in diet	8	Hot bath	3
Attention and comfort	7	Others	7
Plasters	7		
Total			100

TABLE II—*Use of proprietary medicines*

Type of medicine	Frequency	Type of medicine	Frequency
Analgesics	56	Nose drops	5
Cough medicines	52	Cough lozenges	4
Creams and ointments	24	Antiseptic liquid	3
Vapour rubs	23	Gripe water	2
Teething products	12		
Total			181

Professional consultations

In the diaries the mothers noted that they contacted a health care professional 33 times, which represented only 7·2% of days with something noticed and 11·1% of days with action taken. Of these 33 points of contact, 20 were consultations at the surgery, two home visits by the general practitioner, two telephone calls to a general practitioner, four telephone calls to the health centre in which the mother did not specify whom she spoke to, and five visits to the health centre to see other staff. Plainly the overwhelming response to a child's symptoms was some form of non-professional care. Contacting a health professional was seldom a first response to recognising a symptom unless this was the result of an accident. On the whole, contacting a general practitioner took place after the mother had given the child a range of home treatment but the symptoms either had not begun to clear or had worsened. Coughs were the most common reason for contacting a doctor if they were not showing signs of improvement.

Discussion

The process of doing something for a sick child at home reflected the mothers' notions of illness, their attitudes towards doctors, and their competence as people able and willing to deal with children's symptoms. For example, many of the mothers thought that it was possible to "catch an illness" early:

"I think if you catch it soon enough it helps. If you let it go on too long you really need an antibiotic."

Similarly, if the illness did not clear up they would think about consulting:

"Well they had lots of things like throat infections, colds, constant colds, and

I would sort of rub them with Vick and give the aspirin. If it lasted a couple of days I would take them to the doctor."

The mothers said that they learnt from experience and from what helped each child. These strategies, however, also related to how they saw the role of the general practitioner and their experience of doctors. Contrary to popular belief, these mothers did not expect prescriptions from their doctors, though there were occasions when a mother thought that either her or her child's needs had not been met. Various attitudes were present and mothers had to deal with conflicting views:

"They [the doctors] contradict each other. I think you should just try different wee things for yourself."

Generally the mothers were competent and responded to being treated as such. They did not want to be given a prescription for the sake of it and tended to go to the doctor having already tried something themselves. Though initial expectations may have been that the doctor would be able to do something about minor conditions, experience as motherhood progressed taught otherwise and mothers became able to treat many episodes themselves and to understand that often the doctor could do no more than they:

"Well I mean you're doing everything that's possible and that's that. I'd rather he said that than said nothing and gives you a bottle and you don't know what the bottle's for. I would prefer that the doctor would say: 'You're doing everything that you can. I can't help you any more. But at least you are settled in your mind.'"

The miracle of antibiotics, perhaps salient in the 1950s and 1960s, was no longer a pervasive idea and the mothers in this sample realised that many conditions did not need an antibiotic. Mothers thought that for routine coughs and colds there was not much that could be done that they were not doing already. After a few days, if the child was not better, the mother would want the doctor to check that everything was all right; thus an examination and diagnosis or an "all clear" became more important than a prescription. The mothers said that it did not worry them if they went to the doctor and did not get anything, because they received reassurance and learnt from advice provided during the consultation.

This is not to say that there was not the occasional conflict of opinions between the mother and the general practitioner, especially when the mother considered that her child's needs may not have been adequately met. Mothers may have not been able to afford over the counter remedies or may have thought that they could not follow the doctor's advice to wait for an episode to take its course or leave a child crying. It is important to remember that it is the mother who is left to cope with a child with troublesome symptoms, even if these are not anything to worry about medically.

IMPLICATIONS FOR GENERAL PRACTICE

One of the most pertinent points that emerged was the importance of the general practitioner being aware of what the mother has done for her child so far and why she has decided to contact the doctor at this particular point. It is only in this way that the general practitioner can decide whether the mother thinks that something more serious may be going on, or whether she thinks that the doctor may be able to provide more suitable treatment, or whether she simply needs the reassurance that all is well and that she is responding appropriately.

The mother, who has been shown to monitor closely her child's health and wellbeing, needs to be treated as competent in dealing with the often difficult task of caring for a child whose health and behaviour are giving cause for concern. She has not chosen to consult the doctor lightly and is seldom attending with the specific expectation of receiving a prescription. She may think that the illness has gone on long enough and that the child needs antibiotics, but none the less is accepting the doctor's diagnosis and treatment if this is not the outcome of the consultation. Given the self limiting nature of many childhood ailments, general practitioners should feel that they can discuss, in a relaxed way, the treatment options, provide health education, and deal in a sensitive and understanding way with the needs of the mother and child. More attention should be focused on the role of general practitioners as advice givers and reassurers, his or her skills being seen as complementing rather than conflicting with those of the mothers themselves.

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ONE HUNDRED YEARS AGO

In the second Lettsomian lecture, delivered by Dr Langdon Down, before the Medical Society of London, on Monday last, a report of which will be found elsewhere, some interesting remarks fell from him in reference to the effect of the higher education of women in the production of feeble-mindedness in their offspring. Coming from so good an authority, and based as they are on an experience of infantile mental affections extending over so long a period of time, they have a scientific as well as a social interest, which justifies attention being called to them. No objection, he said, was shown to women being taught everything relating to art, music, or their emotional life, but directly attempts were made to cultivate their judgment, to teach them how to reason, to inculcate habits of self-control, the proposal was met by clamours which, in his opinion, were not based on experience, and, so far as the etiology of feeblemindedness was concerned, were likely to be prejudicial. Still more emphatic was Dr Down's assertion that if there was one thing more certain than another about the production of idiocy, it was the danger which arose from the culture of only one side of a woman's nature. The whole gist of the matter lies in the necessity of proportioning the education given to the physical and mental calibre of the recipient. The average female mind is often assumed to be inferior in power and compass to the average male intellect, but the difference is not, according to Dr Langdon Down, such as to render it either desirable or necessary to restrict female education to the narrow limits of the drawing-room and the kitchen. Reliable statistics on the subject are not forthcoming, and it is even difficult to imagine any which could command acceptance. The observance of ordinary care, and the mandates of elementary physiological knowledge, will in all probability afford as great a safeguard in this direction as they do in the region of athletic exercise for girls. Either or both may be overdone, but if this occur, it is only in consequence of inattention to, or ignorance of, this very important subject. (*British Medical Journal* 1887;i:170.)