General Practice Observed

The practice brochure: a patient's guide to team care

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Summary and conclusions

A practice brochure describing the primary health care team was given to 262 new and established patients in a group practice. Most liked it, and thought it helpful, and improved their knowledge of team care. When asked how they would respond to certain hypothetical health problems and clinical situations, there was a significantly greater use of non-doctor members of the team than by a matched sample who had not read the brochure. Inappropriate use of members of the team was not engendered.

Introduction

When people "sign on" with a building society, an insurance company, or even a bank, such institutions make considerable efforts to apprise their new members of their aims, their quality, and the extent of the services offered. Information in the form of leaflets and brochures are common-place. This has become more necessary as the scope and facilities of such institutions have increased to meet the complexities of modern living. By contrast, a new patient registering with a general practitioner is lucky to receive even a card with the telephone numbers and surgery times, and indeed many patients get nothing more than a curt nod from a busy receptionist. Considering the great changes that have taken place in general practice in recent years—the swing from single-handed practice to increasingly large groups, the extension of premises and facilities, the expanding "team," the move to health centres—this lack of information is remarkable. In an attempt to correct this deficiency in this practice—one that has developed from a simple five-doctor group plus a few receptionists only 15 years ago to a complex and efficient primary health care team today—it was decided to give all new patients a practice brochure.

This 22-page booklet describes in non-technical language the medical centre and the functions of its staff. Each member of the team—receptionist, nurse, health visitor, social worker, etc—has a page briefly describing her role and how patients may contact her. For instance: "Please feel free to seek nurse advice at any time—there is one on duty at the surgery almost throughout the entire working day and you can also make appointments to see a nurse. . . . The receptionists are there to help you, and anything you tell them will be treated in absolute confidence. There are different telephone numbers for general inquiries, requests for visits, etc, and for appointments. . . . If your children are sick and causing you some concern but you don't think it necessary to bother the doctor, the health visitor will be the person to contact." Although there is a short paragraph on "your own personal" doctor, the major emphasis is on the non-doctor members of the team and their part in patients' health care. In the main it aims to educate patients about the use of primary health care services, but it also contains some reminders of preventive health measures, such as "if you keep active . . . watch your weight . . . don't smoke . . . drink in moderation . . . and don't worry too much . . . then you probably won't need us at all, and that would be just great—for you and for us!"(A copy may be obtained from the Health Education Council, 78 New Oxford Street, London WC1A 1AH.)

The aim of the research study was to see how patients view the purpose and value of the brochure and whether they have any ideas for improving it; whether receipt of the brochure resulted in greater awareness of the staff and facilities of the primary health care team; and whether it modified the way in which patients might use the range of services.

Method

For the purposes of the evaluation it was decided to study women patients aged between 18 and 55 years because they are fairly frequent users of the whole range of services. They were of two types: (1) women newly registering at the Norton Medical Centre, and (2) a matched sample (by age and social class) of women who had been registered with the practice for at least three years. The social class of the patients in the practice approximates to the national average. The study eventually included 515 patients—262 newly registered and 253 established. Half of each group were given a copy of the brochure.

Two to three weeks later all the patients were followed up in their own homes by one of three interviewers employed by the research and intelligence unit of Cleveland County Council. Each patient had been told that this was to take place.

By using "new" and "old" patients some attempt could be made to determine not only the effect of the brochure but also how experience of the practice affected the way in which the services of the primary care team were used. The patients were asked a series of questions: firstly, how did they like the brochure and in what way did they think it helpful; secondly, how did it improve their knowledge of team members; and, thirdly, they were asked to imagine certain health problems and say what they would probably do if faced with them and who would they try to see at the medical centre. Inevitably, the last is only a crude predictor of actual behaviour, and it cannot be assumed that there is a direct correlation between the hypothetical and the actual. Because of the strictures of time in a very busy practice, however, it was impossible to follow up the patients over a long period to measure actual changes in behaviour or in their use of services. For the most part the analyses examined changes that take place in the frequency of dependence on the doctors, ancillary staff, and "self-help," since the brochure aims to modify these with especial emphasis on non-doctor care.

One or two of the questions asked were in fact "catch questions" to see whether reading the brochure had produced any change of attitude that might be deleterious to the patients' health.

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Results

Of the 258 patients given the brochure, 30 had not looked at it: 18 were newly registered and 12 had been with the practice for more than three years. These patients were excluded from the study.

SUBJECTIVE IMPRESSIONS

Ninety-eight per cent of both new and established patients who had read the brochure found no difficulty in understanding it, 89% of both groups enjoyed reading it, and less than 5% did not. Nine per cent of new and 10% of established patients had some suggestions for improving the brochure and these were primarily concerned with the need for telephone numbers and times of clinics. (The practice has a separate telephone card that is also given to patients.) Seventy-four per cent of new and 81% of established patients thought the cartoons improved the booklet but 13% of new and 9% of established patients had reservations about them. Sixteen per cent of new and 12% of established patients said they had heard of a "primary health care team" before reading the brochure.

All respondents were asked which, of several statements shown to them, was the description that best fitted their understanding of a primary health care team. Seventy-three per cent of new and 81% of established patients chose the one statement that described it most accurately: "Doctors, nurses, and other members of staff who share the problems and work of the practice."

Seventy-three per cent of new and 55% of established patients said that they found out something they did not already know: 64% of new patients had not realised the variety of services available compared with 24% of established patients, and 26% of established patients said they did not know that marriage guidance counsellors were available at the medical centre.

Table I shows the response to an open-ended question on what patients considered to be "the main message of the brochure" while table II shows the response to several specific choices that were offered to patients including those "messages" that the author of the brochure thought most important. "The staff work as a team" and "Consult other members of the team (rather than the doctor)" were identified by both new and established patients as the most important messages.

DEALING WITH HEALTH PROBLEMS

Patients' responses to three hypothetical problems showed a significant swing (over 10%) to seeing the nurse and an associated trend away from seeing the doctor after reading the practice brochure. These related to a persistent graze on the hand, sunburn with blisters, and a constipated 4-year-old child. In four questions—problems with baby weaning, "flu" for two days, uncomfortable piles for two weeks, and symptoms of cystitis—there was no significant swing in consultations, although overall doctors were used less and nurses slightly more by the group who had read the brochure.

For the five "catch" questions where doctor consultation was considered appropriate (febrile child with ear-ache; patient unconscious from sleeping pills; very heavy vaginal discharge for a month or two; hard lump in breast; vomiting, febrile, glassy-eyed 10-year-old) there was no evidence that the brochure produced any change to inappropriate use of other members of the team.

IDENTIFICATION OF APPROPRIATE CLINICAL SERVICES

After reading the practice brochure there was a significant swing towards consultation with family-planning or other nurses and away from consultation with the doctor by patients who were perfectly well but had had no cervical smear for seven years and those considering changing from the contraceptive pill to an intrauterine contraceptive device.

There was a significant swing towards nurse consultation and a trend away from doctor consultation after reading the brochure by patients needing removal of stitches and by patients on the pill or with an intrauterine device who had had no check-up for a year. There was no difference in behaviour by a newly pregnant patient nor by one with a baby due for its second immunisation against diphtheria/tetanus. A catch question about bleeding in between periods on two or three occasions showed a trend away from the doctor and towards the family-planning nurse.

Overall the swing to nurse consultations after reading the brochure was more pronounced in new patients than established patients. There were no appreciable differences in change of behaviour when the results were examined by the patients' social class.

Discussion

At a time when economy and curtailment of services is all important, the proffering of yet another NHS "goody" for patients has to be examined carefully. As would be expected the patients' response to a gift was positive—they were delighted with the brochure and considered it tangible evidence that the practice cared about them. Many professed that it had captured their interest, was enjoyable, and one suggested "that it was the sort of thing that she thought only happened in America." The patients were enthusiastic about the cartoons and considered that they made the brochure entertaining and underlined the points in the text. One patient thought that it was nice to know that going to the doctor, normally a worrying prospect, could be seen to have its lighter side. As a method of developing good early rapport with new patients the brochure has been a great success and existing rapport with established patients has been fortified.

The apparent lack of knowledge of the concept of the primary health care team by patients before reading the brochure must come as a shock to a profession that has enthusiastically espoused this method of delivering care. It could be, however, that some patients were aware of the system but not of its correct name.

Most important, however, is the evidence in the results that reading the brochure improved the accuracy in the way patients would use the various members of the primary health care team. The common view in general practice is that patients tend to bring all their troubles to their doctor. The practice brochure seems to encourage a more appropriate use of services, and patients with a brochure would approach other members of the team more frequently. Hence there should be a considerable saving in doctors' time, not to mention a decrease in doctors' irritation. The second commonest theme of the brochure identified by patients (table I), "Don't bother the doctor unnecessarily," and the message most often selected (table II),

TABLE I—*Results of response to question on what patients consider to be the main message of the brochure*

	% of new patients (n = 119)	% of established patients (n = 109)
Explains service	66	72
Don't bother the doctor unnecessarily	30	30
Who to approach for information or service	29	14
Practice is sympathetic	10	10
Practice advocates self-care	5	6
Other	13	17
Don't know	9	4
Total per cent	162	153

TABLE II—*Patients' choice of "most important message brochure is trying to get across"*

	% of new patients (n = 119)	% of established patients (n = 109)
Treat own minor ailments	37	43
Consult other members of the team (rather than the doctor)	45	42
Give up smoking, drinking, and take more exercise	11	17
The staff work as a team	49	49
Try to give practice a break at weekends	14	18
Description of staff and departments	40	33
Don't know	2	4
Total per cent	198	197

"The staff work as a team," certainly seem to be getting across. Interestingly, established patients found it almost as helpful as newly registered ones.

In only one catch question—the patient with recurrent bleeding between periods—was it thought that patients might consult the family-planning nurse inappropriately rather than the doctor, but in the team setting and with the appropriate training the nurse can rapidly redirect a patient with such symptoms.

Suffice to say that the brochure is in continuous use and is continuing to be enjoyed by patients. It serves as some reminder to them to have various preventive health measures (cervical smear, immunisation, etc) updated from time to time.

It will need modification as time goes by and the team changes and also as we gain ideas from other practices who will, we hope, produce better and more appropriate brochures in the future for their particular settings.

We thank the patients and the members of the Norton Primary Health Care Team who participated directly and indirectly in the study, the Health Education Council for providing financial support for the research, and DHSS for granting one of us (GNM) "prolonged study leave" during which time the practice brochure was designed and written. The research was carried out by Cleveland County Research and Intelligence Unit and was directed by Mr G A Sharp.

WORDS FOREIGN NAMES How should foreign names be pronounced? It is one thing if a person emigrates. He should be allowed to alter, if necessary, what would then become a foreign name to something readable and pronounceable in the country of adoption. Thus the eighteenth-century German composer Händel dropped the umlaut after he came to England and became Handel. People from all countries in Europe who flocked to America altered the spelling and pronunciation of their names, or had them altered by immigration officials, to achieve compatibility with English phonetics and orthography. It is, however, entirely another matter when we pronounce, or attempt to pronounce, the names of foreign colleagues. Medicine is international and foreign names abound in medical publications. Should we pronounce these names as the owners of the names do, (or did)? Or should they be Anglicised? Or something in between? You may ask, "Does it matter so long as it is understood?" I think it does. Nowadays we meet our foreign colleagues both at home and abroad with increasing frequency. In the interests of intelligibility and courtesy, not to mention avoidance of sounding ridiculous, we should certainly attempt to adopt the correct pronunciation. That this is so becomes manifest if the boot is on the other foot. Then, according to the nationality of the speaker, Smith may become Smeece; Wright becomes Vrigt; Bates, Bah-tess; Vaughan, Fowg-hun (to a German not knowing better). While foreigners conscientiously trying to say "Hughes" run the risk of pharyngeal spasm and trismus, the danger may be mitigated by following the continental rules of pronunciation and saying Hug-hess or achieving an approximation with Yooze.

Replacing the boot on the original foot, let us take some French surnames well known in medical history. The first column shows the name, the second how it is usually pronounced in England; the third gives an approximately correct native pronunciation, and the fourth uses the international phonetic alphabet in the interests of accuracy. The stressed syllable is preceded by an apostrophe.

Arthus	'Ahthus	Ar'tewce	ɑʀ'tys
Braille	Brayl	Brye (like why)	bʀɑ:y
Marey	'Mary	Mah'ray	mɑ'ʀɛ:y
Marfan	'Mahfan	Mar'fong	mɑʀ'fɑ
Danlos*	'Danloss	Dong'low	dɑ'lo:

It must be out of respect for the great man that we say Sharko and not Tsharkott. The French do not play quite fair with Arthus, where the terminal s is pronounced; yet with Camus (the 1957 Nobel prizewinner for literature) the s is silent. But, great heavens, who are we to complain? Pardonable difficulties arise with *Lutembacher*—an obviously Germanic name (Loo'temba*ch*er) frenchified to Lewtombahshay (approximately). Obviously, one can give only a few examples; but turning now to Germanic names, we have the following —adopting the same system.

Virchow	'Verchov	'Feershow	'firço:

In my student days the twisted wires with which surgeons performed craniotomy (the Gigli saw) were referred to as "giggly" saw. Since the great Italian tenor of the same name became known to all, honourable amends have been made with "jeel-yee."

In general, ignorance of German pronunciation does not lead to serious errors, though there are some curious inconsistencies. Thus Bach (J S, the composer) is usually mispronounced Bark, while Mach (Ernst, the philosopher-physicist whose name has been adopted for the speed scale in relation to the velocity of sound) is definitely Mack (one, two etc). In fact, the names should rhyme. This is not the place for a course in the pronunciation of foreign languages, and I wish to do no more than draw attention to a deficiency that can give offence or provoke unseemly mirth. All that a chairman or moderator at an international congress has to do, after all, is to ask the speaker *sotto voce* how to pronounce his name and then do his level best. I cannot conclude, however, without a brief reference to Turkish. Turkish names do not as yet appear often in medical publications or crop up frequently at meetings. Yet there is one that is forever popping up eponymously because new "causes" of his syndrome are constantly being discovered. I refer to Behçet. This is usually mispronounced "baysay," regardless of the fact that in French a cedilla never precedes an e. Be-h-chet is correct with the h sounded separately. The blame for this little difficulty may be laid squarely at the feet of Kemal Atatürk. When he changed the Turkish alphabet from Arabic to Latin characters in 1928, he was most unfortunate in the choice of advisers. The Turkish alphabet is loaded with diacritical marks and the phonetic values bear little relation to those of other languages using Latin characters. So all is forgiven.

As to ensuring that one's name is pronounced correctly after emigrating, even the best laid plans may go awry. When, in 1823, the 36-year-old Purkyně (pronounced 'Poor-kin-yeh) left his native Bohemia, where the Czech language was his mother-tongue, to take the chair in physiology at Breslau, he adopted the spelling Purkinje for his name, to ensure that it was pronounced correctly by the German-speaking population. Breslau had been part of Prussia since 1742. Generations of British and American doctors accordingly pronounced his name Per-'kin-je. That is the spelling and pronunciation applied to his eponymous fibres in the heart and cells in the cerebellum. Professor J P Hill, who taught me embryology at University College London, did, however, emphasise the correct pronunciation but without the slightest effect on his pupils. Doubtless the soul of Jan Purkyně is muttering the Czech equivalent of "You can't win." But that is not all. After the second world war Breslau reverted to Poland; it is spelt Wrocław (compositor please note the ł), and pronounced Vrotswuv. You definitely can't win.

* Of the Ehlers-Danlos syndrome.

SAXIFRAGE Chenodeoxycholic acid administered by mouth is used for dissolving plain cholesterol stones. Bladder and kidney stones may sometimes be dissolved by repeated irrigation with Renacidin solution, which contains a mixture of salts in which citric acid and magnesium acid citrate predominate. Surgical removal of calculi is the general rule because the underlying cause may be eradicated at the same time. Still, no patient likes operations, and in bygone days removal of bladder calculi by the perineal route ("cutting for stone") must have been anticipated with horror. Not surprisingly, medical—in the sense of non-invasive—remedies were sought. Herbs of the genus *Saxifraga* were formerly used for treating stone and gravel, in the belief that they would break the stone into fragments —hence the name, L *saxum*, rock+frag-, root of *frangere*, to break. The notion that the plant had this property probably stemmed in the first place from the tendency that some species exhibit to grow among stones and in clefts between rocks. Indeed, they are cultivated in rock gardens. An alternative suggestion about the basis for the esteem in which saxifrage was held refers to the tubercles on the root of *Saxifraga granulata* (White Meadow S), which were likened to fragments of stone. The erstwhile doctrine of signatures was based on the hypothesis of curing like with like. This latter suggestion was a later belief. As long ago as the first century, Pliny the Elder wrote in his *Natural History*, "It breaks stones and dislodges them from the body wonderfully." B J FREEDMAN.