Consulting behaviour in a group of young families

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SUMMARY. From data collected as part of a sociological study of the health care of children in a socially disadvantaged group, a description is given of all the illness perceived by the mothers, and the use of health services, in 139 children during six months. In some circumstances and for some conditions, the mothers of these families might be seen as 'underusing' services, neglecting potentially important symptoms. In other cases, they appeared to be 'overusers' for trivial conditions, especially of the services of their general practitioner. The reasons for their apparently inefficient behaviour are discussed, and suggestions are made about the possible implications for primary care among vulnerable families.

Introduction

IT is often reported that those illness episodes which reach the notice of the doctor are only the tip of the iceberg. Where children are being considered, and in families which are in disadvantaged environments, this knowledge may cause concern, because the underuse of services may have serious consequences (see, for example, Miller *et al.*, 1960; Hyman, 1970; Ford, 1976). On the other hand, it is sometimes alleged that certain groups of families, especially the less well educated, overuse services by consulting for trivialities. This source of frustration was, for instance, the aspect of their practice most likely to be mentioned by the 356 doctors studied by Cartwright and Anderson (1981). Certainly it can be suggested that a better understanding of why patients consult might help general practitioners, especially in relation to poorer families, who may appear to be inefficient users of services.

Aims

The data presented here were collected as part of a sociological study of the health care of children in a socially disadvantaged group of the population (Blaxter and Paterson, 1982). The focus was principally on the concepts of 'health' and 'illness' held by a group of young mothers in their 20s or early 30s, the relationship of their ideas and behaviour to those of their own mothers (women of about 50), and the effect of social circumstances, over two generations, on health-related behaviour. In the course of this study, a record was obtained of all the episodes of illness and all the use made of health services for the children during six months. Most of the consultations involved the general practitioner.

Method

The sample consisted of 58 young families living in Aberdeen, all with a breadwinner in an unskilled or semi-skilled occupation. In these families there were 139 children, of all ages up to 11. There were 39 male and 38 female pre-school children, and 30 male and 32 female primary-school children.

The information about the illness episodes and health-service use of these children was obtained by regular interviews with the young mothers, conducted in their homes. At these monthly visits, the mothers were asked to report any signs and symptoms experienced by the children during the previous four weeks, and to talk about the actions taken, the advice sought and the services used. From these accounts an attempt was made to establish the level of symptomatology which the mother defined as 'illness', and the rules of service use which she applied.

There are no independent data by which the completeness and accuracy of the mothers' accounts of their current service contacts can be judged. Nevertheless, we believe them to be reasonably complete: the relationship which was built up with the families appeared to achieve very full co-operation, and the mothers were unlikely to have invented consultations, since they knew they would be asked for an account of what was said and done. Other sources—the use of records, health

visitor reports and other types of interview—were used to study the children's health history, and the attitudes to health and health services of both generations of women. These data may be relevant in the discussion which follows, but the principal focus is on a factual account of the use of services for the children during the survey period.

Results

Episodes of illness

During the six months of the survey, the young mothers reported an average of 7.14 episodes of illness for each boy and 5.74 for each girl. Episodes were defined not only as acute illness or accidents, but also as the continuance or renewal of chronic conditions if they were mentioned as being troublesome during the month in question. Obviously, the epidemiological significance of these is questionable, since the definition of what was to count remained with the mother. There is no way of comparing the objective seriousness of a symptom which one mother might notice and report, without seeking, professional diagnosis with a similar symptom which another mother might not think worth mentioning. An examination of family patterns showed, however, that there was a marked likelihood of high or low reporting for all the children of a family, and the range between families was great; in some, few illnesses would be reported for any child, and in others there would be many for each of the children. There was a regular trend towards a lower number of reported episodes per child as family size increased, from 7.8 illnesses during the six months for one-child families to 5.7 for each child in four-child families.

An analysis was also made of reporting patterns according to the time of year, and the expected pattern appeared: more acute episodes were reported in winter, and chronic conditions were also more troublesome. Accidents, on the other hand, appeared to be unrelated to season, and about one child in 10 was reported as having a damaging accident (though the damage might be trivial) in any one month.

Contact with health services

What actions were taken for these illness episodes? Many, of course, were left untreated. For others, lay remedies were used, or advice was sought from families, friends and pharmacists. The following analysis includes only those presented to the health services, including the general practitioner, outpatient or inpatient departments of the children's hospital, and other specialist clinics such as speech therapy or educational psychology. Visits to child health clinics and patient-initiated consultations with health visitors are also included in cases where the mother was seeking advice about specific symptoms. Routine clinic visits are not included, nor regular visits from health visitors.

Overall, there was an average of 3.51 consultations for each child during the six months. The rates of consultation with different sections of the health service are shown in the Table, expressed as rates per year for easier comparison with other data.

Rates of consultation within the health services, child per year.

	All children	Age		Sex	
		<5	5+	M	F
General practitioner	4.3	4.8	3.6	3.7	4.8
Clinic doctor or health visitor	0.3	0.4	0.2	0.5	0.2
Hospital A and E department	0.4	0.3	0.6	0.4	0.5
Hospital OP or specialist clinic	1.0	0.8	1.4	1.5	0.5
Hospital admission	0.2	0.2	0.2	0.3	0.2
Dentist	0.8	0.2	1.5	1.0	0.5
Number of children	139	77	62	69	70

This particular group were not notably demanding of their general practitioners if their consultation rates are compared, for instance, with national rates reported elsewhere (for example in the General Household Survey). Their rates of attendance at the Accident and Emergency Department (almost once for every two children) and at outpatient or specialist clinics (over once per child) were undoubtedly high. These rates reflected a high incidence of accidents, a preference on the mother's part for going to the A and E department if it seemed at all legitimate, and a high prevalence of chronic and handicapping conditions, especially among boys. The rates of admission to hospital, with one per year per five children, were also high. There were few among the children who had never been admitted to hospital at any time.

Types of illness

Figure 1 shows the numbers of reported episodes, by condition and whether or not this illness was consulted about (once or more) with any health-service professional. It is obvious that some conditions were much less likely to be consulted about than others. In some cases the likely explanation is that many of the symptoms were trivial. 'Coughs and colds' is the extreme example, but many of the 'rashes', or teething problems in infants, were also quite properly seen as amenable to lay treatment. On the other hand, many of the ear conditions (more commonly in boys), eye conditions (more commonly in younger children) or gastric symptoms were perhaps inappropriately seen by the mother as trivial or for some other reason as not requiring treatment. Throat infections were taken very much more seriously than coughs and colds. For other conditions, such as bronchitis, convulsions or infectious diseases, although consultation was usually seen as necessary, there were a few cases for which the mother did not consult. The cases of enuresis and speech and behaviour problems occurred predominantly among

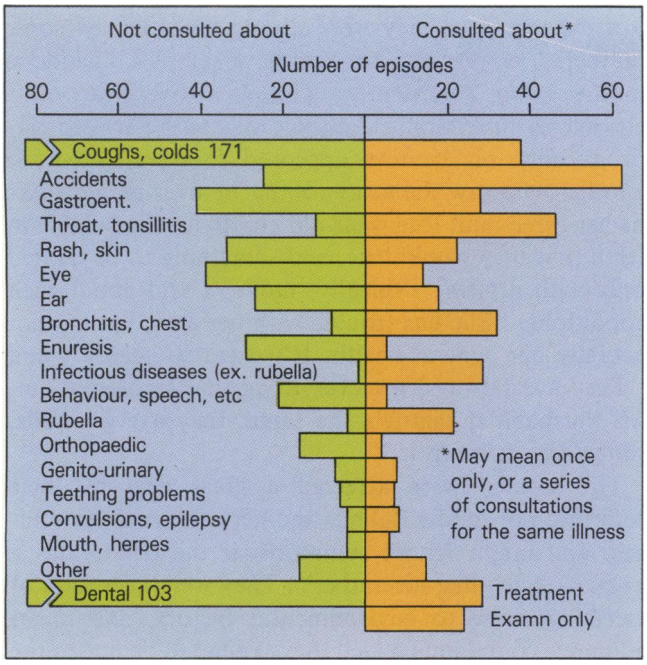

Figure 1. *Number of episodes consulted and not consulted about, 139 children during six months (total number of episodes 869).*

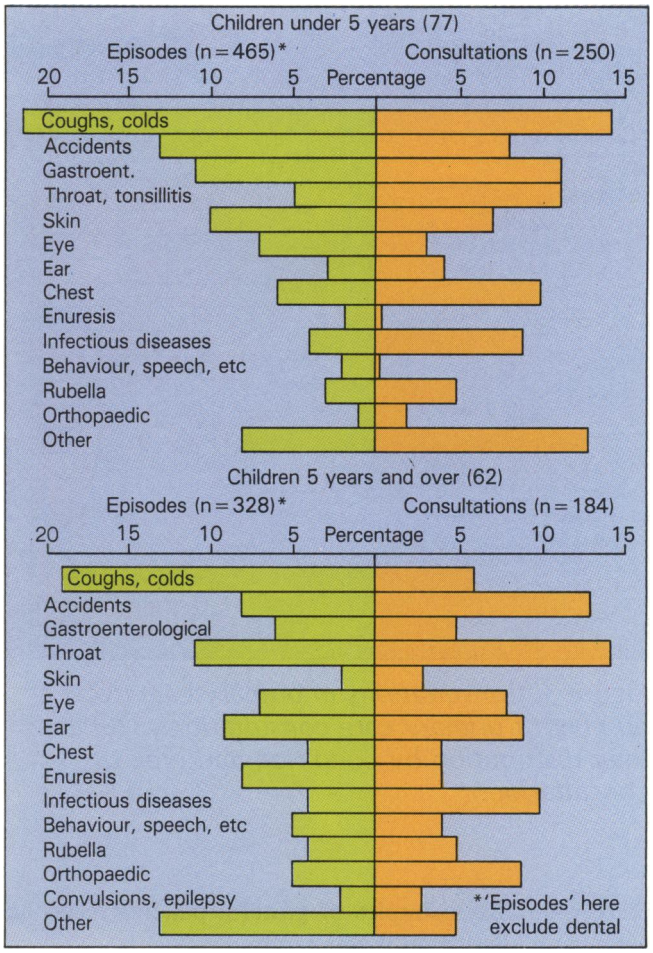

Figure 2. *Proportions of all episodes by age and condition, compared with proportions of all consultations with any sector of the health service.*

boys. Most of these had been clinically identified at some time, and although they caused much concern, few received treatment during the survey period. Dental conditions, which constituted so large a proportion of the older children's 'episodes'—especially in boys—are a special case: since they were recorded only where the child had obvious decay or was experiencing pain, by definition these all required treatment. Very frequently they did not receive it.

Figure 2 demonstrates, for younger and older children, the nature of the load upon the health services created by these 139 children compared with the distribution of illness episodes in each age-group. Since some conditions, if they were consulted about, might involve several consultations with the general practitioner, or a series of attendances at outpatient clinics, these represent a greater load of health-service work than Figure 1 might suggest. Thus accidents and orthopaedic conditions (especially in older children) were responsible for repeated hospital visits; childhood infectious diseases were demanding of the general practitioner's services; some of the respiratory infections in younger children required more than one consultation; and the minority of eye and ear conditions among older children which were taken for professional help often resulted in many clinic visits.

Figure 3 selects only the primary care consultations—those at a clinic or with a health visitor, and those with the general practitioner at the surgery, by telephone or in the patient's home—and shows how they were distributed by condition. A higher proportion of these consultations were home visits than is usually reported—37 per cent of the general practitioner consultations for children 0–4 years, and 38 per cent for children over five.

It is obvious that the major part of the general practitioner's work-load for this group of children was made up of relatively few conditions. Nearly one fifth of the primary-care consultations were for coughs and colds, and if throat conditions, infectious diseases and gastro-intestinal symptoms are added, over half the consultations are accounted for. Respiratory infections and rashes were the symptoms most likely to be taken to the child health clinic, and though these were usually in infants (as, of course, were teething problems), there was some use of clinics, as the Table shows, for older children. The largest number of home visits was for infectious diseases, though as Figure 3 shows, some of these were also taken to the surgery.

Discussion

The accounts which the mothers gave of their interviews with their doctors suggested that there was sometimes conflict about their consultation practices—though

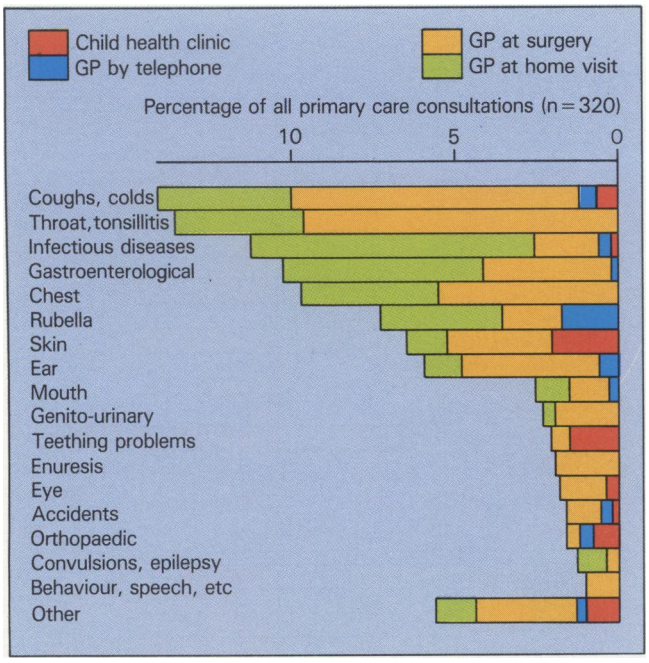

Figure 3. *Consultations in primary care (total number of primary care consultations 320) and their distribution by condition and type of consultation.*

there were also examples of grateful patients receiving very sympathetic and understanding service.

When conflict about the appropriateness of consultation did occur, what were the reasons? Of course, to assemble these data into tables and diagrams gives to some extent a false view, suggesting regularities which do not exist. Some of the reasons for fussing, on the one hand, or neglecting symptoms on the other, were individual and contextual. Whether a child was taken for professional advice might depend only to a lesser degree upon the actual symptoms and more upon day-to-day circumstances in the family. Practical contingencies which made a visit to the doctor more or less easy, family events and relationships, and the mother's own state of physical or emotional health were all influential. Individual relationships with particular doctors and the mothers' previous experiences in contact with health services also influenced perceptions of the proper occasions for consulting.

There are, however, some generalizations which can be made, and these will be summarized briefly. None of these young families was in particularly prosperous circumstances, and some were socially troubled and living in poor environments. Many of the mothers came themselves from families which had been severely socially disadvantaged in the past. Their expectations of what constituted normal health, for themselves and to a lesser extent for their children, were notably low. Coughs, colds, minor infections, sickness and diarrhoea, and (in particular) ear conditions and dental decay were accepted as normal within this context of low expectations; they were simply not seen, by some mothers, as relevant to health. Examples include a mother who persistently ignored a five year old's chronic ear infection, treating it only with her own eardrops until his hearing appeared to be affected, or another who saw the acute toothache over many weeks of her three- and four-year-old children as inevitable in teeth that they would lose, and something to be treated only with aspirin. Typically, mothers said about such conditions: "She has trouble with her ears, but it's not actually her general health. It's extra to health", and "They aye [always] get everything that's going about, his [husband's] family's the same, they aye get boils, things aye turn septic."

The women were affected a great deal by their perception of family failings and hereditary susceptibilities, and might ignore symptoms if the child "has a weak stomach like her father". They were also fond of ascribing cause to environmental factors, and might minimize complaints which they 'knew' to be due to the weather, an unwise diet or "something in the water".

At the extreme, these attitudes in some mothers might add up to a generalized apathy, a fatalistic sense that illness was inevitable and a general reluctance to seek professional help. Also, a run of illnesses within a family might make the mother feel that the doctor will say "Oh no, not *her* again!", and several women, recounting how they felt they had been criticized for delay, tried to explain how difficult it was to know when a child was "really ill".

For these reasons, and for some conditions, they might have been seen as underconsulters. The other side of the coin is the conflict caused by their sometimes overfrequent demands for what their doctors appeared to consider as trivialities. Despite apparently deciding that continuous respiratory infections were normal, some mothers, whose family histories were full of tuberculosis and bronchitis, had an obsessive fear of anything "going to the chest". Infectious diseases, rashes and high fevers also caused conflict, with doctors showing some irritation at being called as an emergency to children with rubella. Again, family history was relevant: the older generation of women had passed on to their daughters the memory of whole families struck down by scarlet fever and diphtheria only 30 or 40 years ago. The child's or the family's medical history could also affect the reaction to other symptoms if they were suggestive of conditions which had handicapped members of older generations.

Another reason for repeated consultations was the young mother's feeling, in many cases, that they were not given sufficient information, or that communication between hospital specialists, general practitioner, clinic doctors, health visitors, school health services and social services seemed to them to be poor. They may, of course, have been quite mistaken. Those mothers who were most anxious about their children, especially for chronic conditions, tended to use services in a 'super-

market' manner, seeking diagnosis and advice wherever they could find it: to many of them, the system seemed fragmented and the lines of responsibility unclear. They lacked the confidence or social skills to make their perplexities clear or to demand the information which they felt they lacked. They also believed that they, with their particular knowledge of their child, were not being listened to: it is likely, of course, that they had not known the correct person to approach. For these mothers, repeated consultations were merely their patchwork way of trying to make sense of the situation.

Conclusion

In short, the reasons for 'inefficient' use of general practitioner services were sometimes individual and related to the practicalities of life, and sometimes more patterned and predictable, related to social circumstances and history. This is, of course, only one small group in a particular subculture, and it cannot necessarily be generalized to other groups. Since it is typical of those groups whose health-care behaviour is sometimes criticized, however, the consulting patterns displayed may be relevant to a better understanding of vulnerable groups. The ways in which conflict might be avoided, and more 'efficient' use of services fostered, would seem to depend, at least in part, on the general practitioners' own view of their function. Mechanic (1970) found that there was a broad division between those who saw themselves primarily as clinicians, oriented towards a technical response to demand, and those who saw their function as more social, providing total family doctor care. As Horobin and McIntosh (1979) have noted, the more narrowly the general practitioner defines the boundaries of appropriate care, the more presentations will be seen as inappropriate and the more referral there may be to other sections of the health or social services. If the Mechanic's clinician wishes to influence demand, then patient education must be given priority. Marsh (1977) has shown that practice workloads can be reduced, with apparent satisfaction to both doctors and patients, by examination, explanation and health education, instead of prescription. If the family doctor model is favoured, it would perhaps be advantageous—for these particularly troubled families—if the general practitioner were more clearly seen as the central co-ordinator of services and provider of information and advice. Those mothers in our sample who did have such a relationship with their doctor, and who felt that they had been given clear education about the condition of their particular child, were probably the less demanding and were certainly the less critical.

It must be noted that neither course—patient education about the self-management of minor symptoms, or the willing assumption of total sociomedical care—promises any great saving of doctors' time. Families with young children, in disadvantaged circumstances, are perhaps always likely to need a great deal of it.

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Epileptic seizures in the elderly

Eighty-one elderly patients with epileptic seizures are described, of whom 60 were investigated by computed tomography. The cause was cerebrovascular disease in 44 per cent, tumour in 12 per cent, extracerebral in 11 per cent and unknown in 16 per cent. Partial seizures were commoner in patients with tumour than with other causes.

Source: Roberts, M. A., Godfrey, J. W. & Caird, F. I. (1982). Epileptic seizures in the elderly: 1. Aetiology and type of seizure. *Age and Ageing,* **11**, 24–28.

Rotas more acceptable than deputizing services

"The use of rota systems—either of doctors in a practice or of those from neighbouring practices—for night and weekend cover seems to be generally acceptable, though satisfaction is strongly related to the time taken to answer the call. The use of deputizing services leads to much greater dissatisfaction, irrespective of waiting time."

Source: Sawyer, L. & Arber, S. (1982). Changes in home visiting and night and weekend cover: the patient's view. *British Medical Journal,* **284**, 1531-1534.