

Sociocultural differences in patients' expectations at consultations for upper respiratory tract infection

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SUMMARY. Among 214 patients consulting their general practitioner with upper respiratory tract infection, differences in expectation were apparent between Whites, Afro-Caribbeans and Asians. Significantly more Asians (84%) wanted prescriptions for antibiotics and/or other medication than did Afro-Caribbeans (72%) or Whites (47%) ($P < 0.001$). There were no significant differences in terms of what was received but Asians tended to be dissatisfied with the outcome of the consultation. Self-medication before consultation was attempted by 82% of patients; 48% took two or more preparations. Afro-Caribbeans had taken significantly more preparations per person than other groups ($P < 0.05$). Sociocultural factors may influence patients' expectations at consultations for upper respiratory tract infection.

Introduction

APPROXIMATELY 25% of all consultations in general practice are for minor self-limiting respiratory illness.¹ Such consultations present an important opportunity for modifying patients' illness behaviour. Much has been written on the problems of doctor-patient communication,² an understanding of which is a precondition to any attempts at behaviour modification. Underlying these problems is a tendency for doctors to typify patients on the basis of such factors as level of education, class and race, and allow these generalizations to determine the nature of information exchanged.³ Little is known of how sociocultural factors affect the consultation. A small pilot study was therefore designed to investigate differences between three ethnic groups in patients' expectations at consultations for upper respiratory tract infection.

Method

The study was carried out in Wembley, Middlesex, in a practice which forms part of a three-practice health centre on the edge of a new housing estate. Approximately 40% of the 6500 registered patients are non-Whites. Questionnaires were left in the waiting room under a notice requesting that those who had come with a cough, sore throat, runny nose, or 'other' cold symptoms should complete the first section of the questionnaire before consultation with the general practitioner and the second section after the consultation. Parents completed the questionnaires of those aged under 16 years. Patients were asked about medication they had taken before attending and what their reason for attending was. The outcome of the consultation was also noted and compared with patients' expectations.

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The five general practitioners involved had similar prescription policies. Three broad ethnic groups were defined according to parental country of birth — Whites, Afro-Caribbeans and Asians — although the limitations of these divisions are acknowledged. The ethnic groups were not homogeneous: 'Whites' included English and Irish, 'Afro-Caribbeans' were predominantly West Indian but included four West Africans, while 'Asians' embraced those from India, Pakistan, Bangladesh and East Africa.

Differences between groups were tested by the chi-square test.

Results

Of the 235 questionnaires collected, 21 were incompletely filled in. The characteristics of non-responders were not known. The age and sex distribution of the three ethnic groups in the sample of 214 broadly reflected practice workload: similar numbers of males and females were obtained except in the Afro-Caribbean group where women were over-represented. The average duration of symptoms before a patient attended the surgery was six days and this was not related to ethnic group, age or sex nor to expectations or treatment.

Self-medication

The majority of patients overall (82%) had taken self-administered medication prior to consultation and there were no significant differences between the proportions in different ethnic groups (Table 1). Overall 96 patients (45%) had administered two or more preparations and one had administered eight. Nineteen patients had taken more than one antipyretic; aspirin or paracetamol was often administered for runny nose or cough alone: 24 had taken two or more cough medicines (maximum four). Honey and lemon was the commonest home remedy. More Afro-Caribbeans (61%) than Whites (39%) or Asians (39%) had taken two or more self-prescribed medicines ($P < 0.05$). Afro-Caribbeans consumed an average of 2.45 different products per person as compared with 1.60 for Whites and 1.74 for Asians.

Reasons for consultation

Patients' reasons for attending the doctor are also shown on Table 1. Significantly more Asians (84%) and Afro-Caribbeans (72%) wanted a prescription for antibiotics, cough mixture or other medication than Whites (47%) ($P < 0.001$).

Outcome of consultation

Overall, 27% of patients received antibiotics, 24% a prescription for other drugs and 49% advice alone (Table 1). No significant differences between the ethnic groups emerged. There was a tendency for Asians to be disappointed in the outcome: 47% of the 38 Asians who received only advice or other medication would have preferred antibiotics compared with 23% of 74 Whites and 25% of 44 Afro-Caribbeans.

Table 1. Comparison between different ethnic groups in self-medication before attending the doctor, reasons for consulting and outcome of consultation.

	Percentage of patients			
	Whites (n = 109)	Afro- Caribbeans (n = 54)	Asians (n = 51)	All (n = 214)
Self-medication				
Patient took:				
At least one preparation	85	81	76	82
Two or more preparations	39	61*	39	45
Reason for consultation				
Patient expected:				
Examination and reassurance	68	39	47	56
Particular information about illness	39	44	47	43
Sick note	6	15	22	12
Medication of some kind				
Antibiotics	47	72***	84***	62
Cough mixture or other medication	33	44	49	40
Outcome of consultation				
Patient given:				
Advice only	50	44	49	49
Antibiotics	32	19	25	27
Other medication	17	37	25	24

n = total number of respondents. ***P < 0.001. *P < 0.05.

Discussion

According to Dunnell and Cartwright, nearly four-fifths of general practitioners do something to encourage appropriate self-treatment.⁴ The extent and nature of self-medication revealed here confirms previous studies. Much advice to self-prescribe may be superfluous as most patients will already have done so. In this study 82% of respondents had used a self-prescribed medication (average 2.3 different products) prior to consultation. The larger number of products consumed by Afro-Caribbeans may be due to the greater number of women in this group. Dunnell and Cartwright found that women consumed more non-prescribed medication than men and attributed this to readier availability of products while shopping.⁴

Over half of the patients consulted the doctor for an examination and reassurance. The proportion of Whites in this study who expected to get prescriptions at consultation are comparable to other studies reporting 43% to 52%^{5,6} but a significantly greater proportion of ethnic minority patients wanted antibiotics or other prescribed medicine. Reasons for these cultural differences may be the influence upon expectation of traditional medical systems, greater faith in the doctor or differing understandings of the nature of infection and its treatment.

Nearly half the patients received advice alone and the rates of antibiotic prescribing are lower than those in several other studies.⁷⁻⁹ The similarity between ethnic groups in the proportions given antibiotics suggests that antibiotic prescribing policies were consistently applied. While dissatisfaction was more commonly expressed by Asian patients, presumably reflecting

frustrated expectations, this may have been exacerbated by language or communication problems.

There is little evidence that ethnic minority groups make heavier demands on their general practitioners than the indigenous population.¹⁰ This study does suggest however differences in expectation between different cultural groups with regard to the treatment of upper respiratory tract infection. Gender, education, traditional beliefs, greater faith in the doctor, differing understandings of the nature of infection and its treatment are some of the inter-related factors that may generate these differences. They merit further investigation.

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How many days of bed rest for acute low back pain?

Bed rest is usually recommended for acute low back pain. Although the optimal duration of bed rest is uncertain, a given prescription may directly affect the number of days lost from work or other activities. In a randomized trial, the consequences of recommending two days of bed rest (group I) were compared with those of recommending seven days (group II).

The subjects were 203 walk-in patients with mechanical low back pain; 78% had acute pain (<30 days), and none had marked neurological deficits. Follow-up data were obtained at three weeks (93%) and three months (88%). Although compliance with the recommendation of bed rest was variable, patients randomly assigned to group I missed 45% fewer days of work than those assigned to group II (3.1 vs. 5.6 days, $P = 0.01$), and no differences were observed in other functional, physiologic, or perceived outcomes.

For many patients without neuromotor deficits, clinicians may be able to recommend two days of bed rest rather than longer periods, without any perceptible difference in clinical outcome. If widely applied, this policy might substantially reduce absenteeism from work and the resulting indirect costs of low back pain for both patients and employers.

Source: Deyo RA, Diehl AK, Rosenthal M. How many days of bed rest for acute low back pain? *N Engl J Med* 1986; 315: 1064-1070.