

INDIVIDUAL STUDIES

Social class consultation patterns in rural general practice

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THAT there are differences in behaviour towards the doctor between the various social classes is apparent to anyone who has worked in general practice. Social studies (Cartwright 1967, Young and Willmott 1957) have confirmed this. This paper reports the result of a survey in a rural practice which attempts to define these behaviour patterns.

Method

Between 31 October 1966 and 3 February 1967, 1,000 consecutive new cases presenting to one of two partners in a practice of 5,250 patients were studied. All consultations except those for antenatal, immunization or contraceptive advice were included. In each case the sex and social class (Registrar General's Classification) of the patient, the site of consultation (surgery attendance or home visit), the presenting symptom and the necessity for the consultation were recorded. Unnecessary attendances or visits were defined as those in which the patient might reasonably have dealt with his symptoms himself and a visit was also considered unnecessary if a surgery attendance would have been more appropriate. The data were analysed using an IBM 11.30 computer.

For comparison the basic practice structure was analysed by taking a 38 per cent random sample of the list held by the executive council which was broken down into sex and social class groups.

Because patients are free to consult the partner of their choice the senior partner's (SP) attendances and visits for January 1967 were similarly broken down. Comparison between the SP sample and the 1,000 cases allows correction for patient-doctor selection

TABLE I
DISTRIBUTION BY SEX AND SOCIAL CLASS IN 38 PER CENT SAMPLE OF PRACTICE, SENIOR PARTNER'S SAMPLE AND SURVEY OF 1000 CASES. EXPRESSED PER THOUSAND

<i>Male</i>	<i>I</i>	<i>II</i>	<i>III</i>	<i>IV</i>	<i>V</i>	<i>Total</i>
38 per cent	15	76	154	134	101	480
SP	13	115	86	122	55	391
1000.. ..	28	121	118	93	97	457
<i>Female</i>						
38 per cent	40	96	168	137	79	520
SP	27	115	244	158	65	609
1000.. ..	46	136	137	118	106	543
<i>Both sexes</i>						
38 per cent	55	172	322	271	180	1000
SP	40	230	330	280	120	1000
1000.. ..	74	257	255	211	203	1000

Table I shows the figures for the 38 per cent and SP samples and the 1,000 cases; all figures are expressed per thousand. Study of these figures demonstrates a divergence

between the expected (38 per cent) and observed (1,000) figures.

All consultations

1. Sex

In the 1,000 cases there was a preponderance of consultations by women; the SP figures show a similar preponderance of female consultations so that over consultation by women is still present after correction for doctor selection.

2. Social class

Table I shows consultation in the 1,000 cases to be high for social classes I, II and V. Comparison with the SP figures show a degree of doctor selection within the classes. Although social class I over consult one doctor they under consult the other, the net result being a consultation rate much as expected. Social class II shows marked over consultation with both partners. The social class III and IV under consultation rates in the 1,000 cases are partially compensated by a higher SP consultation rate leaving a small net under consultation. Doctor selection in social class V favours the 1,000 cases; so few attend the senior partner that the overall result is under consultation.

Thus: Social class I consults as expected
 Social class II over consults considerably
 Social classes III, IV and V under consult.

3. Social class by sex

1. *Male*. After correction for doctor selection there is over consultation in social classes I and II and under consultation in the remaining classes.

2. *Female*. The figures for female consultation show greater doctor selection but after correction they show over consultation in social classes II and III (the former markedly) the remaining classes behaving much as expected.

Attendances and visits

The ratio of attendance to visit (A/V) for all the 1,000 cases was 3:1.

1. Social class variation

Table II shows the percentage of visits and attendances by sex and social class. Social class V, largely dependent on public transport, predictably has the highest A/V ratio (1.7:1). Surprisingly, social class II, perhaps the most well supplied with private transport, comes second (A/V 2.6:1). Social class IV (A/V 3.5:1), III (A/V 4.2:1) follow with social class I requiring least visits (A/V 5.2:1).

TABLE II
 PERCENTAGE ATTENDANCES AND VISITS BY SEX AND SOCIAL CLASS

		I	II	III	IV	V
Female	A	82.6	72.8	80.3	80.5	60.4
	V	17.4	27.2	19.7	19.5	39.6
Male	A	85.7	71.9	81.4	74.2	66.0
	V	14.3	28.1	18.6	25.8	34.0
Total	A	83.8	72.4	80.8	77.7	63.0
	V	16.2	27.6	19.2	22.3	37.0

2. Sex differences

Both sexes have an overall A/V ratio of 3:1. Males appear to expect a higher visiting rate in social class IV but in social class I their visiting rate is very small (A/V 6:1).

Unnecessary consultations

In all 10.2 per cent of consultations were considered unnecessary.

1. *Sex*

Female unnecessary consultations were higher (10.9 per cent) than those for men (9.4 per cent) thus women, with a higher overall consultation rate, give rise to more unnecessary work than men.

2. *Social class*

Figure I shows the distribution of unnecessary consultations between the social classes divided by sex. In general social class V gives rise to most unnecessary work closely followed by social class I. The remaining classes are about the same and give rise to relatively little unnecessary work. Social class II, with a high visiting rate and a very high consultation rate has a low unnecessary consultation rate. This implies intelligent use of the doctor.

3. *Social class and sex*

When the social classes are divided by sex (figure 1) the tendency for women to give rise to needless work is clearly seen; only in social class III and V are they exceeded by men. Social class I women give rise to more unnecessary work than any other group.

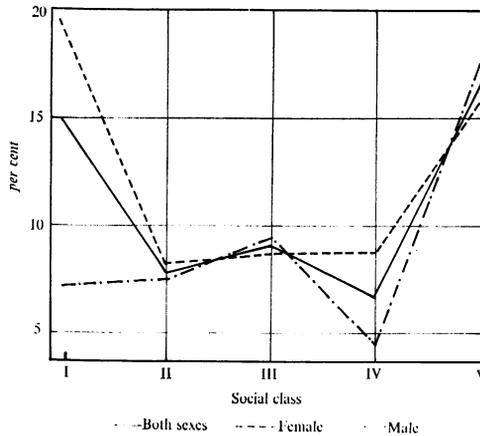


Figure 1
Unnecessary consultations by sex and social class

Table III summarizes the behaviour of the sex-social class groups.

Symptomatology

Many factors, such as time and transport, influence the patient's decision to seek his doctor's advice but the prime reason must be his presenting symptom. To understand the differences in behaviour patterns they must be related to symptomatology.

Symptoms may be related to sex-social class groups either because of differing disease incidence within the groups or because of differing psychosocial attitudes towards the various symptoms.

The presenting symptoms in the 1,000 patients were divided into 40 groups (table IV) of which the 20 commonest symptoms comprised 95 per cent.

TABLE III
SUMMARY OF SOCIAL CLASS BEHAVIOUR

		Consulting rate	Visiting rate	Unnecessary consultation rate
I	Male	High	Low	Very low
	Female	Mean	Low	Very high
II	Male	Very high	High	Low
	Female	Very high	High	Low
III	Male	Low	Low	Low
	Female	High	Low	Low
IV	Male	Low	Mean	Very low
	Female	Mean	Low	Low
V	Male	Low	Very high	High
	Female	Mean	Very high	High

In table V the top 20 symptoms for each sex are shown. Cough, the overall commonest presenting symptom, is much higher for men than for women reflecting their

TABLE IV
PRESENTING SYMPTOMS IN THE 1,000 PATIENTS

<i>Symptom</i>	<i>Incidence per cent</i>
Cough (wheeze, 'chesty', cold, catarrh, haemoptysis, 'sinus')	15.5
Skin (rash, spots, boils, chilblains, allergy, rough skin)	14.7
Throat (sore throat, hoarse, lost voice, sore tongue)	9.0
Skeletal pain (rheumatism, arthritis, bone, muscle or joint pain)	8.6
Ears (earache, deafness, discharge, 'muffled')	6.4
Abdominal pain	5.7
Injury	4.3
Eyes (pain, discharge, poor vision, foreign body, squint)	4.3
Diarrhoea and or vomiting	4.2
'Poorly' ('washed out', 'feels awful', 'flu', 'off colour', sweating)	3.1
Stiff or swollen neck	2.8
Headache	2.3
Facial pain (dental pain or swelling, mouth pain)	2.1
Chest pain	2.0
Depression (anxiety, cancerophobia, premenstrual tension, nervous breakdown, sleep-walking)	2.0
Gynaecological (vaginal discharge, heavy or irregular periods, pruritis vulvae, dysmenorrhoea)	1.5
Rectal pain or bleeding	1.4
Lumps (bumps or swellings)	1.4
Urinary symptoms (dysuria, frequency, haematuria, enuresis)	1.3
Fever	1.0
Shortness of breath (can't breathe etc.)	1.0
Parasites	0.8
Male genital (pain, discharge, impotence)	0.7
Giddiness	0.7
Breast pain	0.3
Obesity	0.3
Skeletal deformity	0.3
Hernia	0.3
Epistaxis	0.3
Paralysis	0.3
Varicose veins	0.2
Palpitations	0.2
Insomnia	0.2
No complaint	0.2
Constipation	0.1
Infertility	0.1
Many vague complaints	0.1
Hiccoughs	0.1
Flushes	0.1
Loss of weight	0.1

known increased morbidity to respiratory disease. Injury also is high for men, as are depression and headache for women.

Table VI shows the top 20 symptoms for each social class. Comparison with table IV shows marked variation from the mean for certain symptoms within social class. Social class I complains more frequently than expected of eye, rectal, gynaecological and male genital symptoms. Untoward pelvic interest in this group is probably related to greater knowledge of the significance of rectal or unusual vaginal bleeding.

Social class II symptoms are much as expected except for diarrhoea and vomiting. At the time of the survey virus gastro-enteritis was ubiquitous and presumably affected all social classes yet it was social class II who complained of it most frequently suggesting

TABLE V
THE TOP 20 SYMPTOMS FOR EACH SEX

Female		Male	
Symptom	Incidence per cent	Symptom	Incidence per cent
Skin	14.3	Cough	18.7
Cough	13.0	Skin	15.2
Throat	10.0	Skeletal pain	7.4
Skeletal pain	9.6	Throat	7.4
Ears	5.6	Ears	7.4
Abdominal pain	5.0	Abdominal pain	6.7
D & V	4.1	Injury	5.0
Eyes	4.0	Eyes	4.7
Injury	3.7	D & V	4.3
Poorly	3.3	Poorly	3.0
Headache	3.3	Neck	3.0
Depression	3.0	Chest pain	2.0
Neck	2.8	Face pain	1.5
Gynaecological	2.8	Male genital	1.5
Face pain	2.6	Short of breath	1.3
Chest pain	2.0	Headache	1.1
Rectal pain	1.7	Rectal pain	1.1
Lumps	1.7	Urinary	1.1
Urinary	1.5	Lumps	1.1
Fever	1.2	Giddiness	0.8
		Fever	0.8
		Depression	0.8

TABLE VI
THE TOP 20 SYMPTOMS BY SOCIAL CLASS

I percentage		II percentage		III percentage		IV percentage		V percentage		
Skin	16.0	Cough	13.9	Cough	16.2	Skin	18.1	Cough	15.0	
Cough	13.3	Skin	13.1	Skin	14.6	Cough	17.6	Skin	12.5	
Throat	9.3	Throat	11.2	Ears	9.2	Skeletal pain	11.0	Skeletal pain	11.0	
Ears	8.0	D & V	7.7	Skeletal pain	7.3	Throat	6.7	Throat	11.0	
Eye	8.0	Skeletal pain	6.5	Throat	6.9	Abdominal pain	6.2	Abdominal pain	8.5	
Skeletal pain	6.6	Abdominal pain	5.8	Neck	3.8	Eye	5.7	Injury	7.5	
Injury	5.3	Ears	5.4	Eye	3.8	Ears	5.2	Ears	4.5	
Rectal	5.3	Poorly	4.2	Abdominal pain	3.5	Injury	4.3	Neck	3.5	
Gynaecological	5.3	Eye	3.8	Injury	3.1	D & V	3.3	Face	3.5	
Abdominal pain	4.0	Neck	3.1	D & V	3.1	Poorly	3.3	Depression	2.5	
Poorly	2.6	Injury	2.6	Poorly	2.6	Headache	3.3	D & V	2.5	
Depression	2.6	Headache	2.3	Chest pain	2.6	Face pain	2.4	Eye	2.5	
Male genital	2.6	Depression	1.9	Depression	2.3	Chest pain	1.8	Poorly	2.0	
Headache	1.3	Fever	1.9	Rectal	2.3	Neck	1.4	Headache	2.0	
Chest pain	1.3	Chest pain	1.5	Headache	1.9	Giddiness	1.4	Chest pain	2.0	
D & V	1.3	Face pain	1.5	Gynaecological	1.9	Lumps	1.4	Short of breath	1.0	
Face pain	1.3	Frequency	1.5	Frequency	1.9	Depression	1.0	Gynaecological	1.0	
Giddiness	1.3	Gynaecological	1.2	Lumps	1.5	Rectal	1.0	Frequency	1.0	
Lumps	1.3	Lumps	1.2	Short of breath	1.5	Short of breath	1.0	Male genital	1.0	
Parasites	1.3	Rectal	1.2	Face pain	1.5	Frequency	1.0	Parasites	1.0	
		Short of breath	} 0.8	Parasites	1.5			Giddiness	1.0	
		Male genital							Fever	1.0
		Parasites							Lumps	1.0
		Weight							Hernia	1.0
		None								
		Epistaxis								

that this social class views these symptoms with greater concern than other groups do.

Social class III symptomatology follows the expected overall rates with slight increase in the incidence of ear symptoms.

In social class IV the symptoms are particularly interesting. Skin and cough have a higher incidence than in any other group. Skeletal pain, low for the first three classes comes into third place for social classes IV and V, probably because of its relationship to manual labour. Perhaps the most significant fact however is the very low incidence (less than 0.5 per cent) of gynaecological symptoms. This may be related to greater disinclination among this group to discuss gynaecological problems with the doctor but its significance lies in its possible relationship to the known increase in mortality in low social class to cervical carcinoma.

Abdominal pain and injury (the latter predictably) are high in social class V. Gynaecological complaints are again very low and rectal complaints are absent.

Unnecessary work

Of the 746 surgery attendances 38 (5.3 per cent) were considered unnecessary, of these the symptom of cough gave rise to 17 consultations (18.3 per cent of all consultations for cough, 44.7 per cent of all unnecessary consultations).

Of 254 visits 62 (24.4 per cent) were unnecessary; thus the bulk of unnecessary work arises from visits. Table VII shows the symptomatology of unnecessary visits by social

TABLE VII
UNNECESSARY VISITS BY SOCIAL CLASS AND SYMPTOM

<i>Symptom</i>	<i>I</i>	<i>II</i>	<i>III</i>	<i>IV</i>	<i>V</i>	<i>Total</i>
Cough	4 (4)	7 (13)	7 (12)	4 (15)	9 (16)	31 (60)
Poorly	1 (2)	3 (7)	2 (2)	1 (3)	1 (2)	8 (16)
Injury	1 (1)	0 (0)	0 (1)	1 (2)	2 (2)	4 (6)
Skin	0 (0)	1 (6)	0 (5)	1 (2)	2 (5)	4 (18)
D & V	0 (0)	1 (12)	1 (4)	0 (6)	0 (3)	2 (25)
Eye	1 (1)	0 (1)	0 (0)	0 (1)	1 (1)	2 (4)
Neck	0 (0)	0 (5)	1 (2)	0 (2)	1 (6)	2 (15)
Face	0 (0)	0 (1)	1 (1)	1 (1)	0 (0)	2 (3)
Rectal	0 (0)	0 (0)	1 (1)	0 (0)	0 (0)	1 (1)
Palpitation	0 (0)	0 (0)	1 (1)	0 (0)	0 (1)	1 (2)
Giddiness	0 (0)	0 (0)	1 (1)	0 (1)	0 (0)	1 (2)
Throat	0 (2)	0 (5)	0 (4)	1 (5)	0 (12)	1 (28)
Paralysis	0 (1)	0 (0)	0 (0)	0 (1)	1 (1)	1 (3)
Skeletal pain	0 (0)	0 (4)	0 (2)	0 (2)	1 (7)	1 (15)
Depression	0 (0)	0 (1)	0 (1)	0 (0)	1 (1)	1 (3)
All other symptoms ..	0 (1)	0 (16)	0 (12)	0 (6)	0 (18)	0 (53)
TOTAL	7 (12)	12 (71)	15 (49)	9 (47)	19 (75)	62 (254)
Percentage unnecessary ..	54.4	16.9	30.6	19.1	25.3	24.4

Figures in parenthesis give total number of visits in group for given symptom.

class. This shows the exceptionally high rate of unreasonable requests for visits from social class I. Half of unnecessary requests for visits are caused by cough and other fairly common causes are 'poorly', injury and skin.

Discussion

Considerable variation of sex and social class behaviour is shown; this is related to

symptomatology which in turn may be due to differing disease incidence or to differing psycho-social attitudes to various symptoms within the groups.

Under-consulting groups represent a reservoir of potential disease and are therefore at risk. These groups are men of social classes III, IV and V. Other groups under consult about certain symptoms; social classes II, IV and V about rectal complaints and women of social class IV and V about gynaecological complaints. These at-risk groups should be considered more seriously and accurate diagnosis pursued.

Whilst over consultation and unnecessary work must be discouraged, it should be borne in mind that if patients are to report serious complaints early, a certain amount of unnecessary work will be unavoidable. This survey shows the chief culprits to be social classes I (particularly the women) and V. The chief symptom giving rise to unnecessary work is cough.

Greater education of patients directed at particular groups is needed and greater pressure to bring patients to the surgery, rather than to ask for a visit, is indicated.

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There are personal habits of less gravity than the ones I have mentioned which it is well to guard against, or, if they are formed, to relinquish. A man who may be called at a moment's warning into the fragrant boudoir of suffering loveliness should not unsweeten its atmosphere with reminiscences of extinguished meerschaums. He should remember that the sick are sensitive and fastidious, that they love the sweet odours and the pure tints of flowers, and if his presence is not like the breath of the rose, if his hands are not like the leaf of the lily, his visit may be unwelcome, and if he looks behind him he may see a window thrown open after he has left the sick-chamber. I remember too well the old doctor who sometimes came to help me through those inward griefs to which childhood is liable. "Far off his coming"—shall I say "shone", and finish the Miltonic phrase, or leave the verb to the happy conjectures of my audience? Before him came a soul-subduing whiff of ipecacuanha, and after him lingered a shuddering consciousness of rhubarb. He had lived so much among his medicaments that he had at last become himself a drug, and to have him pass through a sick-chamber was a stronger dose than a conscientious disciple of Hahnemann would think it safe to administer.

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