The trouble with patients*

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It has been fashionable to discuss with an element of gloomy relish the problems of the National Health Service, the pattern of its future, and the problems exposed, but not solved, by the searching reorganisation which has not yet had time to settle. I thought, however, that this would be an appropriate occasion to look at some of the characteristics of those who are the only reason for the very existence of the National Health Service, and to discuss some of the problems and troubles that doctors have, either as a result of their own professional training or as a result of society's attitudes in general, with the patients, the customers, the consumers, those who actively or passively are on the receiving end of the whole system of delivery of health care.

The first point is the great number of patients. At a consultation rate of four a year and a list of nearly 2,500, a general practitioner has to survive some 10,000 doctor-patient contacts each year. The very fact that there are so many produces a whole train of problems, since high quality in health care must in the hard world be available only to the small minority of the population in real need. This fact, which, being ignored, has had such interesting consequences, could bring chaos to the world of medicine.

Expenditure on hospitals

The population during the last 20 years has increased by 11 per cent. The National Health Service has expanded in a manner clearly demonstrating a major emphasis on hospitals. The number of hospital doctors has increased by 103 per cent, hospital nurses by 109 per cent, hospital administrators by 100 per cent and the National Health Service headquarters administrators by 449 per cent. During this time general practitioners have increased by only 16 per cent. These figures, and several references to the literature in this section, are taken from Cooper's excellent monograph (Cooper, 1975).

This is a big expansion and projection of these trends to the early beginning of the twenty-first century means that half the population would be employed inside the hospitals. Clearly this has not been produced without a major diversion of public expenditure, and during the last 20 years, although total public expenditure in general has increased by 82 per cent, the particular portion allocated to the National Health Service has increased by 130 per cent (Cooper, 1975). The allocation to the hospital services has increased from 55 to 66 per cent, but to the general medical services has declined from 12 to 8 per cent.

Use of beds

At the same time as we have been emphasising the hospital-based nature of the National Health Service, we have been creating a far more rapid through-put of patients, so that the number of hospital beds has gone down from 453,000 to 450,000. With more rapid discharge to the ill-prepared community, the number of inpatients has doubled to about six million, while new outpatients have increased by 73 per cent. In general practice, consultations have steadied, as we have seen, at roughly four per patient per year and the practitioners' home visiting has declined by about 60 per cent (Royal College of General Practitioners, 1973).

Based on the Yorkshire Oration, 1975

All this has created pressure on the hospital consultants who, predictably enough, have varied in their reactions. The median duration of stay on firms who treat at least 20 peptic ulcers in the year has varied from six to 26 days and for myocardial infarcts from ten to 36 days. If consultants tended to work typically at the upper limits of this alone would have vast repercussions throughout the National Health Service. But their routine range of frequency and duration of inpatient admissions, this is unlikely since from 25 to 40 per cent of acute admissions do not need admission, at least on medical grounds (Butler and Pearson, 1970; Crombie and Cross, 1959). And if they do need admission their duration of stay is likely to be influenced as much by custom as by clinical need (Maxwell, 1974).

None of this bears out accusations about the gross neglect of the National Health Service sometimes ascribed as due either to ignorance or to ill-will. The National Health Service now employs five per cent of the nation's total work force and uses up five-and-a-half per cent of the gross national product. This may well not be enough, but it cannot in fairness be called neglect.

Sickness patterns

With this tremendous organisation available to our people as of right and without the improper financial barrier between the patient and his need, is our society any healthier or any happier? Clearly the answers will vary as much as the beholder, but it is worth looking at what seem to be the normal sickness patterns of our highly developed industrial society.

Unhappily it seems clear that to be unwell is normal. Some wit has said that the only healthy patient is one who has not been thoroughly examined by the doctor. In one survey (Logan and Brooke, 1957) 75 per cent of patients reported some ill health during the preceding month. In another (Wadsworth *et al.*, 1971) 95 per cent thought they had been unwell in the preceding fortnight and in a more recent survey (Dunnell and Cartwright, 1972) 95 per cent had symptoms and nine per cent more than six symptoms in the preceding fortnight.

What the medical profession seems extremely bad at realising or attempting even to consider is, however, that the way a patient feels about his health depends very much more on his attitudes to his work, his family, his home, and his society, than to any mere physical or psychiatric diagnosis. Doctors have ignored the vital sociological component in all illness, from the transient to the most severe, painful, and handicapping.

An example is work-loss related to the job satisfaction of the patient. Leaving aside such minutiae as diagnosis or prognosis, it is clear that men who had a very or fairly high job satisfaction lost on average only 7·8 working days per person per year, whereas those who had a conspicuous component of job dissatisfaction lost 13·1 days per person per year (Office of Population Censuses and Surveys, 1973).

It is also clear that the sort of people matter more than the sort of illness. If we look at the loss of work from the same survey by socioeconomic groups, and again totally ignore minor facts like the diagnosis, we see that the typical professional man lost only 3·9 days per year, employers lost 7·2 days per year, skilled manual workers lost 9·3 days per year, and the unskilled manual workers lost no less than 18·4 days per head per year.

A recent survey of the national figures has shown the somewhat alarming tendency for younger workers to be taking more frequent and shorter spells off work (Department of Health and Social Security, 1976), which must be usually associated with minor illness.

In 1954 the country lost just over 280 million days off work, whereas by 1970 we lost 342 million days certified as due to sickness. During this period more episodes of illness were presenting to the general practitioner but fewer consultations per illness were being

needed (Crombie, 1974). Clearly, then, the vast efforts of the National Health Service seem, at any rate in this aspect, to have done little more than to sanctify the trivial ailment.

A study of certification

It is important, however, to accept the fact that even in our small country the patterns of work and life and culture are surprisingly diverse and varied. A 40 per cent increase in certification during recent decades in the North and West contrasts startlingly with the unchanged figures from East Anglia (Department of Health and Social Security, 1976). It was thought of interest, therefore, to look at the pattern of sickness certification among two mining or industrial practices with full lists centred on villages in Yorkshire. I am most grateful to my colleagues in busy practices for their help in examining their sickness certificates.

Classification

The general practitioners, at my request, graded their sick certificates during a period of two weeks as:

(1) Medically essential, for example when the patient was running a high fever or obviously ill,

(2) Medically desirable, when for example a bronchitic had a virus infection,

(3) Socially reasonable, when a miner was recovering from backstrain and would have gone back to work if he had been a bank clerk,

(4) Those sickness certificates that were just acceptable more on social than medical grounds, but where the general practitioner felt a little uneasy in giving certificates that were more expected than clinically justified,

(5) Finally when the sickness certificates were frankly unjustifiable and an abuse—even if a socially acceptable abuse—of the National Insurance Regulations.

It was quickly seen that almost all the sickness certificates issued by these general practitioners could be divided into a half that was medically essential and half that was medically desirable. Only four per cent were thought to be reasonable on social more than on medical grounds, only one per cent gave the doctor cause for concern, and again only one per cent were thought by the doctor to be really unjustifiable. When one took a look at these sick notes by age, it was easy to confirm that the younger workers were catching up with the older workers in the spells they were having off work. Between the 20s and the 50s there was little difference in the number of sickness certificates issued for each decade, the figures varying only between 20 and 25 per cent. The scale of certification is indicated by one doctor having to issue 29 during a Monday morning surgery. The total analysed from two weeks in two practices was 655 sickness certificates.

Diagnostic categories

Bearing in mind that we are dealing with industrial practices, I thought it interesting to look at the main diagnostic categories, as certified. Twenty-eight per cent were made up of respiratory infections, including clearly a number of transient and self-limiting virus infections. A miscellany of general medical and surgical problems made up 16 per cent and 16 per cent were also certified as due to backstrain. Thirteen per cent were classed as due to trauma. Eleven per cent were due to gastro-intestinal complaints. Other orthopaedic conditions made up an additional ten per cent. Psychiatric and dermatological problems made up only three per cent and two per cent respectively.

It is seen, therefore, that trauma, backstrain, and other orthopaedic conditions make up no less than 39 per cent of the total sickness certificates issued by these practices, whereas frankly psychiatric causes made up only three per cent. Clearly here we are living in the very physical world of heavy industry and the ability to cope with such heavy work is a deciding factor.

Emotional ill-health

It is apparent that the various psychiatric surveys which have been such a valuable guide to many workers researching in different fields have not been centred on busy Yorkshire mining practices.

Of 1,000 patients in what perhaps may be a rather more typical sample, 1·9 will be admitted to mental hospital, 4·4 will be referred to psychiatric outpatients, 81 will have treatment from the family doctor, and a further 330 will have neurotic symptoms (Taylor and Chave, 1964). In the survey of Shepherd and his colleagues (1966) of the prevalence of psychiatric disorder, psychosis was diagnosed in 5·9 per 1,000 and psychoneurosis in 88 per 1,000. Only ten per cent of these patients were referred for a further opinion. In a London practice 815 out of 1,000 patients had some kind of psychiatric symptomatology (Michael, 1960). Eastwood (1970) found that eight per cent of men and 24 per cent of women had psychiatric disorders and that the general practitioner missed the diagnosis in one fifth of the men and one quarter of the women. Salkind (1969) found that out of 80 consecutive consultations no fewer than 48 per cent of the patients were in a depressed state. No wonder that half of the National Health Service beds are still needed for psychiatric cases.

Faced with this scale of misery 47·2 million psychotropic drug prescriptions at a cost of £21·5 million were prescribed in 1970. Over the five-year period ending in 1970 prescriptions for minor tranquillisers went up by 220 per cent and antidepressives by 320 per cent (Parish, 1971).

Over half these patients apparently receive their psychotropic drugs for less than a month—a brevity of treatment that alone makes the presence of any major disturbance unlikely.

Repeat prescriptions

Yet despite what must be usually just an attempt at symptomatic control—possibly of great value—we live now in the era of the repeat prescription. Patients take drugs today as a routine—women twice as often as men. Indeed one in four patients get no meaningful contact with their doctor except for the repeat prescription (Balint *et al.*, 1970). Three-quarters of adult prescriptions are for repeat prescriptions, nine per cent have been prescribed for over a year, and one in 20 is for a drug repeated over 40 times (Dunnell, 1971). With an average consultation lasting five minutes, still 93 per cent of patients felt their doctor was a good listener (Cartwright, 1967)—surely a fascinating triumph of technique. But are we becoming, under this pressure from patients, more prescribers than doctors?

Seriously-ill psychiatric patients

How do the more seriously ill psychiatric patients fare in all this turmoil? A small-scale survey of some 100 psychiatric readmissions in a northern provincial city demonstrated little cause for complacency or pride.

This survey (Hargreaves, 1974) was of comparatively young patients, half being under 40 and none over 80 years of age. The hospital's readmission rate was well over 50 per cent, and this was understandable since 63 patients in the sample had been admitted two to five times, 21 patients six to ten times, four patients 11 to 15 times, three patients 16 to 20 times, and two had been admitted on more than 20 separate occasions.

Twenty-one patients had been in the hospital for a total time of three to six months, 15 for seven to 11 months, and 21 for over a year. Thirty-five patients had spent a quarter of their life as an inpatient and 15 over half their days. The diagnoses were mainly schizophrenia (40), depression (44), alcoholism (nine), hypomania (eight), and retarded or demented (seven). The family doctor classed over half their families as caring, but half these patients were thought by the researcher to need long-term shelter

and support: yet three-quarters were apparently not even being seen regularly by their general practitioners. According to the general practitioner 27 of these patients saw the doctor regularly, 30 occasionally, five very rarely, four not at all. There were no details about the remainder.

Thus the practitioner is, by the very facts of life, besieged by minor illnesses, comparatively out of touch with the grave illnesses, and not yet equipped to deal with the chronically ill. Over half the doctor's 10,000 patient-contacts per year will be with minor illnesses, less than a fifth with serious, and about a fifth with chronic illness. In addition, in the typical practice there will be a good deal of social pathology, with 100 patients receiving supplementary benefits, 100 over 75 years of age, 50 living alone, 60 one-parent families, four illegitimate births, five to ten problem families, 25 alcoholics, and 50 homosexuals. In addition 25 will be deaf, five will be blind, and six severely disabled (Royal College of General Practitioners, 1973).

The more rapid turnover of urban populations, the appointments system the group-practice duty rota, the fall in visiting, and the deputising services have made the doctor a more remote, but not a more respected figure.

Unknown to the doctor in his practice will be perhaps 250 hypertensives, 200 patients with anaemia, 150 bronchitics, ten diabetics, 15 alcoholics, and three cases of carcinoma of the cervix (Royal College of General Practitioners, 1973).

Yet loneliness may cause more suffering than all these. In a country practice survey of their old people and in an area so stable that only 28 per cent of the pensioners were living more than 20 miles from their birth-place, 29 per cent were receiving no or few visitors (Evans *et al.*, 1970). Indeed the general picture of the old in this practice was of lonely, stoical characters who normally had an abnormal E.C.G., who had an equal chance of being classed by the doctor as healthy or ill, who saw the doctor less than five times a year, whose teeth were deplorable, and who badly needed a chiropodist.

But the geriatric explosion is soon to burst upon us and will radically change the scene for the worse. A 30 per cent increase in our over-75s is due in a mere decade. At the present level of bed-use, to maintain our existing level of service in the Trent Regional Health Authority we shall need an extra 1,500 beds. If the Glasgow increase in the geriatric population applies to the whole of Scotland, in a decade they will need 1,800 more beds, 60 extra doctors and 700 nurses (Isaacs *et al.*, 1972).

But the present bed-use will not be enough since it is the most aged groups that are increasing. The consultation rate with their general practitioner is much higher, and the dependency rate at home goes from 16 per cent at 70 to double that at 85 years of age (Isaacs *et al.*, 1972).

And even now we have our problems. Over ten per cent of females over 80 are demented and something like four out of five of the demented are cared for in the community (Kay *et al.*, 1964). In Glasgow, among those over 65 dying at home who were either incontinent, immobile, or confused, or more than one of these, Isaacs found that only one in five had a home help or a district nurse.

And if, horrified, we go to the young, we still have our problems. Alcoholism is growing, gonorrhoea and non-specific urethritis are increasing, and intentional drug overdose is now an acute national epidemic. And these extremes of youth and age between them make accidents a major industry, while the middle-aged can be newly defined as those who are burdened with geriatric problems before they have been liberated from their children's delinquencies.

There is good reason for our use of psychotropic drugs. We may even on occasion need them ourselves, when we pause to stop and ponder our own major failures in preventive medicine—obesity, smoking, heart disease, and dental caries.

Of course medicine has had its triumphs: but we must not overstate our case, for we have demonstrated an infinite capacity for growth but a limited capacity for benefit. And these lessons over the years our patients have taught to us. On a two-year follow-up after discharge from hospital 56·6 per cent of patients will be dead or unimproved (Ferguson and McPhail, 1954).

Yet these patients, so numerous, accident-prone, infectious, idle, ageing, greedy, distressed and lunatic, and brave, dependent on a variety of prescribed rubbish from cough mixture to sleeping pills, still have trust in us, and still can inspire us with something of their humour and their courage. It is a sort of divine blackmail that, despite all the difficulties, makes one believe in the future of our calling.' We will indeed have to think clearly, to change with the times, and yet retain our professional integrity.

But the trouble with doctors, as Kipling would put it, is another story.

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