Illness-specific cards—a feasibility study

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SUMMARY. To reinforce and extend advice given at consultations, take-home cards for 12 conditions were devised. They were assessed by 32 general practitioners and 306 patients. The response on the whole was favourable and we suggest that this form of patient education could be helpful in primary care.

Introduction

WHILE many doctors are endeavouring to develop more progressive attitudes to health education, until recently little has been published and most work has been descriptive rather than evaluative. Various approaches have been explored, including display machines (Clarke *et al.*, 1977), letters (MacTaggart *et al.*, 1968), leaflets (Russell *et al.*, 1979), brochures (Marsh, 1980), lectures (McCulloch, 1959), seminars (Cull and Bird, 1974) and counselling (MacDonald *et al.*, 1977).

There is evidence that patients learn and remember more information if it is currently relevant to them (Midgeley and Macrae, 1971; Burt *et al.*, 1974; Shaw and McNiven, 1974; Pike, 1975; Rankin *et al.*, 1976) rather than when it is general and anticipatory (Pike, 1959; Whitfield, 1974; Gaskell and Watson, 1978). The only notable exception to this pattern is Morrell and colleagues' (1980) evaluation of a health education booklet. Ley and Spelman (1967) have shown that patients remember little of what they are told in a consultation, but that comprehension, recall and compliance can all be improved with take-home written advice (Ley *et al.*, 1976). Ellis and colleagues (1979) have also shown that responses to written information are significantly better than those to verbal instructions when given to patients on discharge from hospital.

The present paper describes the findings of a working party of the Scottish Council of the Royal College of General Practitioners and the Scottish Health Education Unit (SHEU) (since 1980 the Scottish Health Education Group). This working party considered that it might be worth exploring methods of helping patients to help themselves to understand more about their illnesses by producing notes which the doctor could give to the patient to amplify his or her advice.

Aim

The practical aim was to test whether such illness-specific cards are acceptable to doctors and their patients, and are used by them. The broader aim was to encourage patients to help themselves and to understand their illnesses better.

Method

The cards

Twelve conditions were chosen for this feasibility study. These were conditions upon which general practitioners spend a great deal of time either because they occur frequently or require repeated consultations. Health education literature already available was reviewed, and this material, often considerable, was synthesized so as to be contained on a single card of helpful advice. Where specifically relevant to the condition, the card also contained more information about publications and social support.

Cards were prepared for four acute conditions (coughs and colds, sore throat, 'flu and diarrhoea and vomiting (Figure 1)); three subchronic conditions (enuresis, constipation (Figure 2) and insomnia); and five chronic conditions (chronic disability (Figure 3), bronchitis, heart disease, diabetes and stoma). The acute and subacute cards contained mainly practical advice on how to deal with the condition, but also gave some background information. The chronic cards included useful addresses, details of helpful books and pamphlets and a few practical points for better management.

Because the doctors involved in designing the trial could not agree on the detailed clinical advice, this was kept to a minimum and a boxed area was included on

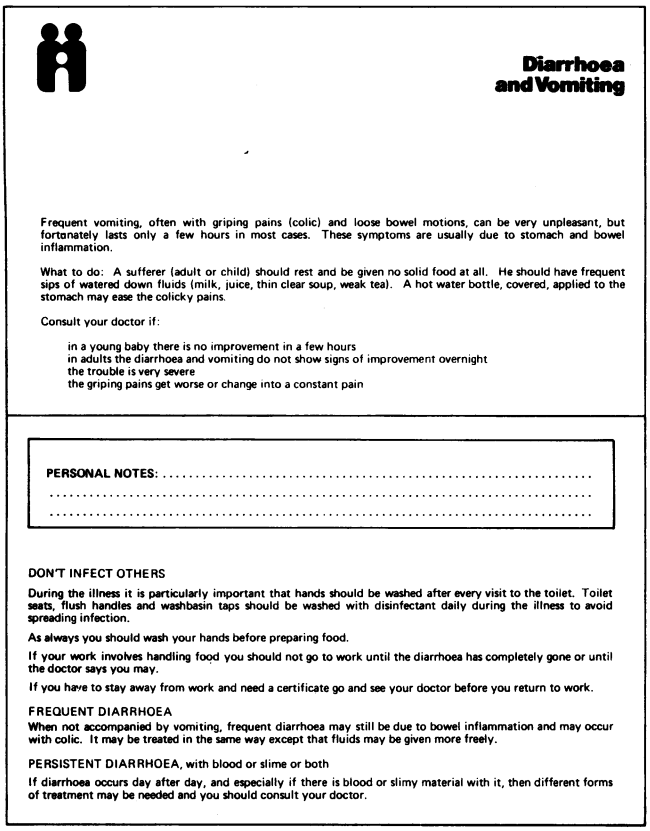


Figure 1. *An acute condition card (diarrhoea and vomiting). Front and reverse of card.*

each card for the general practitioner to write in any personal notes for that particular patient.

Evaluation

We attempted to evaluate the cards' usefulness by supplying them to 50 local volunteer doctors from the S.E. Scotland Faculty and by obtaining the responses of both the doctors and their patients.

Each general practitioner received five cards for each condition in an indexed box suitable for keeping on the desk. The doctors were asked to keep a register of patients and conditions; there was no suggestion that patients should be selected. There were freepost questionnaires seeking patients' and doctors' opinions of the cards. The exercise was spread over only four months, after which doctors were asked to return their questionnaires and registers, no matter how many cards they had issued. We intended to follow up those patients who did not return their assessment forms.

Results

Patients' response

Five hundred and fifteen cards and questionnaires were issued and 303 (58·9 per cent) usable questionnaires were returned. A further 65 forms had to be discarded as incomplete, although 62 of these were appreciative. There was no response from 147 (28·5 per cent) patients. Patient views are summarized in Tables 1–3.

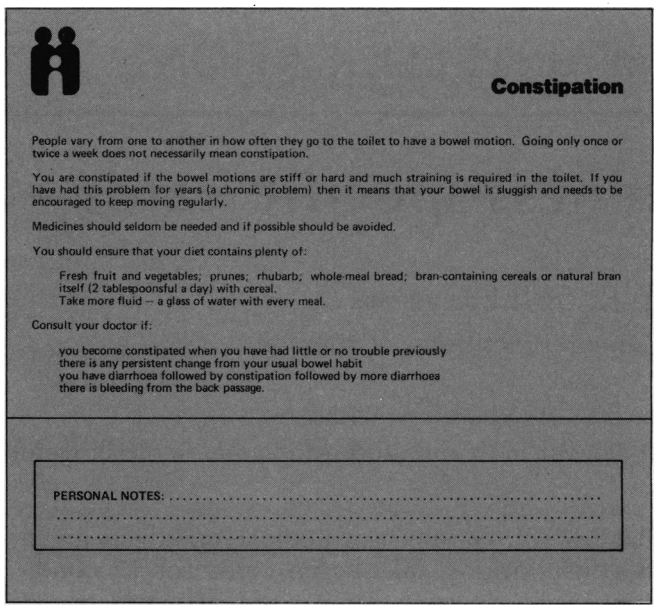


Figure 2. *A subchronic condition card (constipation). Front and reverse of card.*

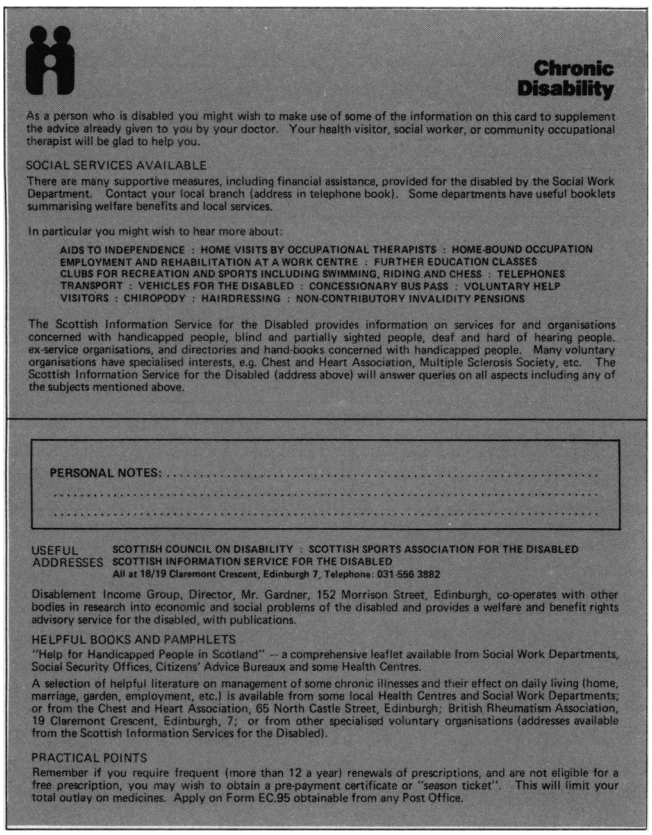
More than half (67) of the respondents found the acute cards helpful in managing their condition and 66 had gained new knowledge. The diarrhoea and vomiting advice card was the most popular of this set.

The majority of patients who received the subchronic information cards found them interesting and worth keeping. The insomnia and enuresis cards were not found very helpful as regards management or conveying new knowledge; the constipation card was found more informative.

The response to the chronic cards was noticeably higher. All but three respondents found their text understandable. Ninety (70·8 per cent) stated that they had found their card useful. Although not many of the organizations mentioned had been contacted or joined, 10 chronically disabled people did contact some helpful agency which they did not know about before receiving the card. We felt that this was an encouraging step forward, despite the fact that 21 had taken no action by the end of the study. Only a few patients had sent off for further information, but again we felt that the positive aspect should be emphasized, since six chronically disabled people did write for further information as a result of receiving an illness-specific card. A considerable number (42, or 33 per cent) claimed that the card had helped them to cope better with their condition, and 55 (43 per cent) said that they had learned something new. The diabetic and stoma cards seemed to have been the least helpful, but such patients do receive a lot of support and information through the hospital and other agencies.

Doctors' response

Thirty-two of the 50 doctors who had agreed to take part completed the assessment questionnaires.



Chronic Disability

As a person who is disabled you might wish to make use of some of the information on this card to supplement the advice already given to you by your doctor. Your health visitor, social worker, or community occupational therapist will be glad to help you.

SOCIAL SERVICES AVAILABLE

There are many supportive measures, including financial assistance, provided for the disabled by the Social Work Department. Contact your local branch (address in telephone book). Some departments have useful booklets summarising welfare benefits and local services.

In particular you might wish to hear more about:

AIDS TO INDEPENDENCE : HOME VISITS BY OCCUPATIONAL THERAPISTS : HOME-BOUND OCCUPATION
EMPLOYMENT AND REHABILITATION AT A WORK CENTRE : FURTHER EDUCATION CLASSES
CLUBS FOR RECREATION AND SPORTS INCLUDING SWIMMING, RIDING AND CHESS : TELEPHONES
TRANSPORT : VEHICLES FOR THE DISABLED : CONCESSIONARY BUS PASS : VOLUNTARY HELP
VISITORS : CHIROPODY : HAIRDRESSING : NON-CONTRIBUTORY INVALIDITY PENSIONS

The Scottish Information Service for the Disabled provides information on services for and organisations concerned with handicapped people, blind and partially sighted people, deaf and hard of hearing people, ex-service organisations, and directories and hand-books concerned with handicapped people. Many voluntary organisations have specialised interests, e.g. Chest and Heart Association, Multiple Sclerosis Society, etc. The Scottish Information Service for the Disabled (address above) will answer queries on all aspects including any of the subjects mentioned above.

PERSONAL NOTES: .....

USEFUL ADDRESSES
SCOTTISH COUNCIL ON DISABILITY : SCOTTISH SPORTS ASSOCIATION FOR THE DISABLED
SCOTTISH INFORMATION SERVICE FOR THE DISABLED
All at 18/19 Claremont Crescent, Edinburgh 7, Telephone: 031-556 3882

Disablement Income Group, Director, Mr. Gardner, 152 Morrison Street, Edinburgh, co-operates with other bodies in research into economic and social problems of the disabled and provides a welfare and benefit rights advisory service for the disabled, with publications.

HELPFUL BOOKS AND PAMPHLETS

"Help for Handicapped People in Scotland" -- a comprehensive leaflet available from Social Work Departments, Social Security Offices, Citizens' Advice Bureaux and some Health Centres.

A selection of helpful literature on management of some chronic illnesses and their effect on daily living (home, marriage, garden, employment, etc.) is available from some local Health Centres and Social Work Departments; or from the Chest and Heart Association, 65 North Castle Street, Edinburgh; British Rheumatism Association, 19 Claremont Crescent, Edinburgh, 7; or from other specialised voluntary organisations (addresses available from the Scottish Information Services for the Disabled).

PRACTICAL POINTS

Remember if you require frequent (more than 12 a year) renewals of prescriptions, and are not eligible for a free prescription, you may wish to obtain a pre-payment certificate or "season ticket". This will limit your total outlay on medicines. Apply on Form EC.95 obtainable from any Post Office.

Figure 3. *A chronic condition card (chronic disability). Front and reverse of card.*

Nearly all responders suggested further topics for cards. Twenty-eight thought that the idea of the cards was a good one and approved of the acute more than the chronic. Twenty-five approved of the design of the cards as they were.

Several (six) commented that it was difficult to remember to issue cards at all, and also that to explain the project was very time-consuming, which tended to be a handicap. Four felt the cards were suitable for and acceptable to only a minority of patients. One doctor used the cards to assist receptionists, and another found the acute cards specially useful when he did not feel a prescription was necessary. Some doctors felt that a set form is not flexible or personal enough, but very few (four) had ever made use of the space for written advice. Four doctors felt that the word 'chronic' was not acceptable, as it could cause anxiety; they felt it should be omitted in future. Some commented that most diabetics are already sufficiently well informed and that few would benefit from the card. It was suggested that an order form for further supplies should be included.

Discussion

This feasibility study involved a carefully designed but rather complex method of evaluation which proved to be both time-consuming and discouraging. Discussion with 16 of the 18 non-responding doctors made it clear that this was the main reason for the limited response; however, they still supported the concept of written reinforcement for patients.

It must be emphasized that 28 of the 32 responding doctors thought the idea of the cards was sound. Acute cards were often used in place of a prescription and could be equally therapeutic; as the cards are designed to be kept, a family could collect information on common conditions and learn when in receptive mood.

The doctors who composed the cards and those who took part in the pilot study had differing opinions about what information should be included. This is a common problem, as was clearly illustrated by a report of how a proposed self-help manual by a group of physicians from Guy's Hospital Medical School foundered through lack of agreement (Williamson and Danaher, 1977). Since it is essential that an aid is acceptable to the user, we therefore agreed to reduce the clinical advice to a core of knowledge that was acceptable to all and to create space where personal advice could be added. Surprisingly few doctors (four) noted that they had used this space. Perhaps it was felt that there was risk in writing advice which may not remain relevant.

Unfortunately, we have little information about the patients who received cards. The chance of someone receiving a card depended upon his or her consulting within the four project months, and upon the general practitioner remembering and deciding to offer a card. To save time, entries in the general practitioner registers were cut to one line but, even so, many registers were incomplete. This was especially so for the more trivial acute conditions. Form-filling is a burden in a busy surgery, but as a result the planned follow-up was very limited and much information was lost.

The response from patients was varied but generally complimentary. Although only a minority had acted on the information in the chronic cards, they are now receiving more help, and the figure should not necessarily be computed against the larger number who had not yet acted by the end of the study.

There was a noticeable difference between responses for chronic conditions (78 per cent) and the others (50 per cent subchronic, 50 per cent acute). It could be postulated that patients with less serious acute complaints may not have had treatment as their first consideration, and that short-lasting illness is as soon forgotten as a questionnaire. Subchronic conditions may be more resistant to improvement and less socially acceptable, or these patients may have been disappointed to receive a card of advice rather than a prescription, and for these reasons have co-operated half-heartedly; in contrast, chronic patients have continuing needs and may thus be more compliant. But these must remain conjectures when 65 responses could not be included and follow-up contact was minimal.

It was suggested by some patients that the cards could be distributed by others, for example pharmacists, health visitors, receptionists or even the Post Office, but we maintain that the personal gift is important to the

Table 1. Patients' response, acute cards.

	Coughs and colds 43 returned (83 issued)		Sore throats 32 returned (68 issued)		'Flu 26 returned (51 issued)		Diarrhoea and vomiting 25 returned (48 issued)	
	Yes	No	Yes	No	Yes	No	Yes	No
1. Information found useful	36	7	24	8	22	4	24	1
2. Helpful for management	19	22	14	18	13	13	21	3
3. New knowledge gained	21	20	12	20	14	12	19	5
4. Worth keeping	34	8	22	10	21	4	24	1
5. Wish other similar cards	37	4	26	6	18	3	21	4
6. Approve idea of cards	39	4	27	5	22	4	23	2

Table 2. Patients' response, subchronic cards.

	Enuresis 15 returned (31 issued)		Constipation 14 returned (30 issued)		Insomnia 22 returned (41 issued)	
	Yes	No	Yes	No	Yes	No
1. Information found useful	10	5	11	3	15	6
2. Helpful for management	6	7	7	4	5	15
3. New knowledge gained	6	8	10	3	8	12
4. Worth keeping	9	6	12	2	11	7
5. Would like other similar cards	7	4	8	3	15	7
6. Approve idea of cards	12	2	12	1	20	2

Table 3. Patients' response, chronic cards.

	Chronic disability 35 returned (38 issued)		Bronchitis 27 returned (38 issued)		Heart disease 24 returned (34 issued)		Diabetes 33 returned (34 issued)		Stoma 7 returned (19 issued)	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
1. Card easily understood	30	—	24	—	24	—	28	3	7	—
2. Information useful	27	3	16	8	22	2	20	11	5	2
3. New knowledge gained	14	8	11	8	19	2	10	16	1	4
4. Worth keeping	25	2	20	3	22	2	21	10	7	—
5. Other agency contacted	10	21	2	17	6	13	6	26	2	5
6. Organization joined	4	25	—	21	—	20	3	29	2	5
7. Sent for literature etc.	6	24	1	21	1	20	3	30	1	6
8. Coping better	10	18	8	14	13	8	9	23	2	3
9. Would like similar cards	11	15	3	20	6	15	8	23	3	3
10. Approve idea of cards	30	3	20	4	23	—	27	4	5	—

patient and for results. Two doctors suggested that a tear-off prescription pad be prepared with the number and title of the different cards on it. The doctor would simply tick the appropriate number and the patient would give this script to the receptionist. The receptionist would therefore be in charge of the cards, would issue the cards to the patients on the recommendation of the doctor and would look after the replenishment of stocks. While this would not permit the doctor to add personal advice, noticeably few had done so in the pilot project.

As to the future, we shall consider these ideas and several others, and the cards will be modified.

Much has been learned but four points stand out.

1. Where values and attitudes are concerned, it is difficult to evaluate with rigorous accuracy.

2. Research procedures must be quick and simple if they are to be followed.

3. Patient education must be very, very 'patient'.

4. While there is no one panacea for the demand for patient education aids, a prepared card to some extent

meets the very practical requirements recommended in the RCGP Report No. 18 that "ideally what is done should be effective, free from risk and easy for both doctors and patients to achieve" (Royal College of General Practitioners, 1981).

We set out to examine if such aids were acceptable to and used by general practitioners and their patients and found encouraging evidence that this is so. The cards were cheap to produce (2p each in 1978) and the containers were not expensive (under £1). We note with interest the 'Patient Counselling Compendium' recently provided for general practitioners through the courtesy of various drug firms, and hope that this interesting development, so similar to our own, is being evaluated.

We contend that doctors and patients could be helped by such aids. It has been emphasized (Stott and Davis, 1979) that an important component in the consultation is the doctor's opportunity "to modify the patient's help-seeking behaviour" and also his "management of continuing problems". Such cards could help the doctor to achieve these objectives and at the same time help patients to help themselves.

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Prescribing for Parkinson's disease

In a survey of all 2,069 inpatients at 14 geriatric centres, 249 were found to have received drugs for the treatment of parkinsonism. Levodopa, usually in combination with a decarboxylase inhibitor, was the most frequently prescribed drug. Compared with the recommendations for its use in Parkinson's disease, over 75 per cent of patients received inadequate and widely spaced doses. Furthermore, dopamine antagonists were concurrently prescribed to one third of patients who received levodopa. There was a high incidence of treatment failure (30 per cent), and a low incidence of drug-induced dyskinesia (3 per cent). The findings suggest that many of the patients did not have Parkinson's disease but rather rigid-akinetic syndromes associated with degenerative brain disease.

Source: White N. J. & Barnes, T. R. E. (1981). Senile parkinsonism, a survey of current treatment. *Age and Ageing,* **10,** 81-86.

Weight-gain in breast-fed babies

Healthy breast-fed Australian infants had weight increments in the second three months of infancy which were well below standard figures for normal weight reported from Britain and more closely resembled data from developing countries. There is a need for more information about reference values against which international information can validly be compared.

Source: Hitchcock, N. E., Gracey, M. & Owles, E. N. (1981). Growth of healthy breast-fed infants in the first six months. *Lancet,* **2,** 64-65.