Analysis of general practice consultation rates among Asian patients

Sir,

A recent survey of general practitioners has shown that more than 50% felt that Asian patients consulted more frequently and had longer consultations than non-Asian patients.[1] They also commented that Asian patients were more likely to present with trivial ailments. It is difficult to measure objectively the degree of frustration felt by general practitioners when confronted with a non-English-speaking Asian patient. What would be simpler and ultimately more informative would be to compare consultation rates of Asians with those of non-Asian patients. A previous study comparing consultation rates of Asian and non-Asian patients showed that the consultation rate of the Asians was more than twice that of the English patients.[2] However, in that study, the total number of patients involved and the statistical data were unavailable.

We have carried out a retrospective analysis of the consultation rates of Asian and non-Asian patients at a general practice in Hemel Hempstead. A total of 217 Asian patients were obtained from the Asian patient register and to avoid errors, these patients were double-checked on the computer which kept an age–sex–address register. The subjects were divided into five age groups, comparable with those used in previous studies of consultation rates.[3] A non-Asian control was selected for each Asian patient at random from the age–sex–address register, matching for age, sex and address as closely as possible. The total number of consultations for the year 1990 was determined by counting all dated entries in the notes for that year except entries made by the practice nurse and entries for repeat prescriptions. The paired *t*-test (Student's test) was used to compare the paired observations.

The number of consultations made by the Asian and non-Asian patients in 1990 is shown in Table 1. There was no significant difference in the number of consultations made by Asian and non-Asian patients for any age group.

It is possible that the perception that Asian patients consult more frequently than non-Asians is linked to language and cultural barriers. Indeed, language problems may prevent the symptoms of Asian patients from being adequately explained thus giving rise to the false impression of presenting with trivial ailments.

Another contributing factor may be that Asians frequently present out of hours, hence appearing to represent a disproportionately large share of the workload. There is clearly a need for a greater understanding of the importance of cultural differences in illness behaviour and of the fact that many of the health problems of ethnic minorities relate to the encounter with a foreign culture. Such understanding will only come through more research.

Table 1. Number of consultations made by the Asian and non-Asian patients in 1990.

Age (years)	No. of consultations: Asian patients	Non-Asian patients
0–4 ($n=28$)	100	119
5–14 ($n=61$)	156	159
15–44 ($n=93$)	247	248
45–64 ($n=26$)	144	96
65–74 ($n=9$)	22	31

n = total number of Asian and non-Asian patients in each age group.

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Side effects of influenza vaccination

Sir,

Our practice has in recent years undertaken an influenza vaccination programme. Anecdotal reports from patients of adverse reactions in third parties prompted us to assess the incidence and severity of side effects in our practice. The data sheet for the vaccine lists local effects such as erythema, tenderness or pain at the site of injection, and systemic effects such as mild fever in the first 48 hours. It states, however, that as a result of the purification method used such side effects are rare.

Margolis and colleagues have reported that concern about side effects was a major deterrent in the United States of America, yet there was a paucity of data about the occurrence of side effects in the population targeted.[1]

We sent a questionnaire to the 146 patients in our practice who had received influenza vaccine in the autumn of 1990 — 120 replies were received. To the question, 'Were you ill following your flu vaccination?', 72 patients responded no. However, 48 patients reported side effects: nine within 24 hours, 11 between one and three days and 10 more than three days later (18 patients did not specify when the side effect occurred). The symptoms reported confirm those mentioned in the data sheet: generally achy (21 patients), pain and swelling around injection site (21), headache (15), high temperature (nine), vomiting (two). The following were reported by one patient each: hearing difficulty, breathing difficulty, common cold, lassitude, rhinitis, lethargy, swelling, shivering, 'flu effect'. Two patients reported a problem with itching.

The patients were also asked if they subsequently contracted influenza despite vaccination. One hundred and three patients reported that they did not, 10 that they did, and five did not know. Two patients did not answer this question.

From this assessment we are reasonably happy that the majority of patients experienced no symptoms after the influenza vaccination. We now feel more confident in reassuring patients that they are unlikely to develop influenza after the vaccination and therefore in encouraging uptake.

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Delay in admitting patients with chest pain

Sir,

In the United Kingdom, most patients with chest pain telephone their general practitioner,[1] who then organizes admission to hospital if appropriate. In South Glamorgan, these arrangements are made via a central bed bureau in the ambulance control centre. As well as giving details of the symptoms and likely diagnosis, the general practitioner usually asks for an ambulance to transport the patient to hospital, and stipulates a time within which the patient should arrive at hospital. If an immediate response is requested, the case is assigned a '999' priority, otherwise the case is labelled as 'doctor's urgent call'.

In order to assess how many patients with possible myocardial infarction, unstable angina or cardiac chest pain were transported to hospital by ambulance, and the time limits given by doctors for admission and any recent changes in these limits, all bed bureau forms for November 1990 and for the same month in the preceding three years were examined (Table 1).

The proportion of patients requiring an immediate ambulance response increased between 1987 and 1990 from 23.8% to 37.2% (chi square test, $P<0.02$). However, the percentage of patients travelling to hospital by private transport (appoximately 10%), and the percentage of patients having hospital admission after one hour or more requested (about 25%) stayed virtually constant between 1987 and 1990. There was a reduction in the percentage of requests for urgent patient transport within 30 minutes, from 39.8% in 1987 to 14.1% in 1990.

Because of the benefits of early thrombolytic therapy[2] it is not surprising that there has been a move towards more rapid transport to hospital. In fact, it seems strange that all patients with cardiac chest pain are not conveyed to hospital with a 999 response.

It may be that a proportion of the patients processed by the bed bureau had contraindications to thrombolytic treatment, known to the attending doctor but not mentioned to, or recorded by, the ambulance control officer. There may have been some cases where the diagnosis of acute myocardial infarction was not seriously considered. However, the early diagnosis of acute myocardial infarction is difficult[3] and few general practitioners carry electrocardiographs to aid such diagnosis.[4]

Attending doctors, aware of the pressures on the ambulance service, may sometimes enter into negotiations with the bed bureau staff concerning time limits, such that doctors are asked to stipulate longer time limits during busy periods. This may account for the increasing number of cases requiring urgent transport within 31–59 minutes, and also the proportion of patients arriving at hospital by own transport. However, if all chest pain cases had warranted an automatic 999 response there would only have been an extra three 999 calls each day.

Only by requesting an immediate response can it be certain that the next available emergency ambulance will be dispatched at once. 999 calls always take priority over doctors' urgent calls. Furthermore, at a time when standards of ambulance responses to 999 calls are being improved (50% response within eight minutes, 95% within 14 minutes, in urban areas), the response standard to doctors' urgent calls is being relaxed, such that these calls may be allowed 15 minutes more than stipulated by the general practitioner and still be judged satisfactory.[5]

Unless an acute myocardial infarction can be confidently ruled out, all patients with cardiac chest pain, unstable angina, or possible myocardial infarction should immediately be transported to hospital by a fully equipped emergency ambulance so that the decision whether or not to administer thrombolytic therapy may be made at the earliest opportunity.

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Table 1. Percentage of patients admitted to hospital in November 1987–90 with a diagnosis of possible myocardial infarction, unstable angina or cardiac chest pain, showing time limits stipulated by general practitioners.

Year	Total number of calls	Time limit on admission (% of patients)				
		Immediate	≤30 min	31–59 min	≥60 min	Own transport
1987	181	*23.8*	*39.8*	*2.8*	*24.3*	*9.4*
1988	179	*27.6*	*39.4*	*1.8*	*22.9*	*8.2*
1989	123	*23.6*	*38.2*	*0.8*	*28.5*	*8.9*
1990	156	*37.2*	*14.1*	*14.1*	*23.1*	*11.5*

Diagnosis and treatment of acute myocardial infarction

Sir,

We would like to draw attention to the difficulties inherent in the prompt diagnosis and treatment with thrombolytic therapy of acute myocardial infarction. Between November 1989 and February 1990, we conducted a survey of all patients assessed in a district general hospital with clinical features suggestive of acute myocardial infarction. Initial assessment consisted of taking a patient history and electrocardiograph reading. Blood was taken for later estimation of enzyme levels characteristically raised in acute myocardial infarction. The criterion for entry into the survey was suspicion by the duty medical officer of acute myocardial infarction, on the basis of the patient's history, with or without chest pain.

The criteria for administration of thrombolytic therapy were: a history of chest pain within 24 hours of the onset of symptoms, or characteristic elevation of at least 1 mm of the ST segment on the electrocardiograph recording and no recognized contraindications to therapy. The criterion for a definitive diagnosis of acute myocardial infarction was increased levels of the three enzymes greater than the upper limits of the reference ranges in our laboratory, indicative of myocardial infarction (creatine kinase >180 U l^{-1}, amino aspartase >40 U l^{-1}, and lactic dehydrogenase >450 U l^{-1}).

A total of 305 patients entered the survey. Acute myocardial infarction was confirmed in 147 patients and the diagnosis was excluded in 157 patients; conclusive assessment was not possible in one patient. Fifty patients with a diagnosis of acute myocardial infarction received thrombolytic therapy but a total of 106 patients with confirmed acute myocardial infarction had no contraindications to this therapy. Of the 41 patients with contraindications, two had gastrointestinal bleeding, 11 had a duodenal ulcer, 23 had hypertension, and 38 presented more than 24 hours after onset of symptoms. Six of 157 patients in whom acute myocardial infarction was excluded received thrombolytic therapy.

These results indicate that approximately 53% of eligible patients received suboptimal treatment. If, for example, 100 000 eligible patients are seen each year in hospitals in the United Kingdom, and if the use of thrombolytic therapy is associated with at least a 10% reduction in mortality in the first 35 days after acute myocardial infarction,[1,2] overall mortality could be substantially reduced if a rapid, accurate and specific means of identifying