HEALTH CENTRES

Reflections on Primary Health Care in IBN Sina Centre, Bahrain 1979

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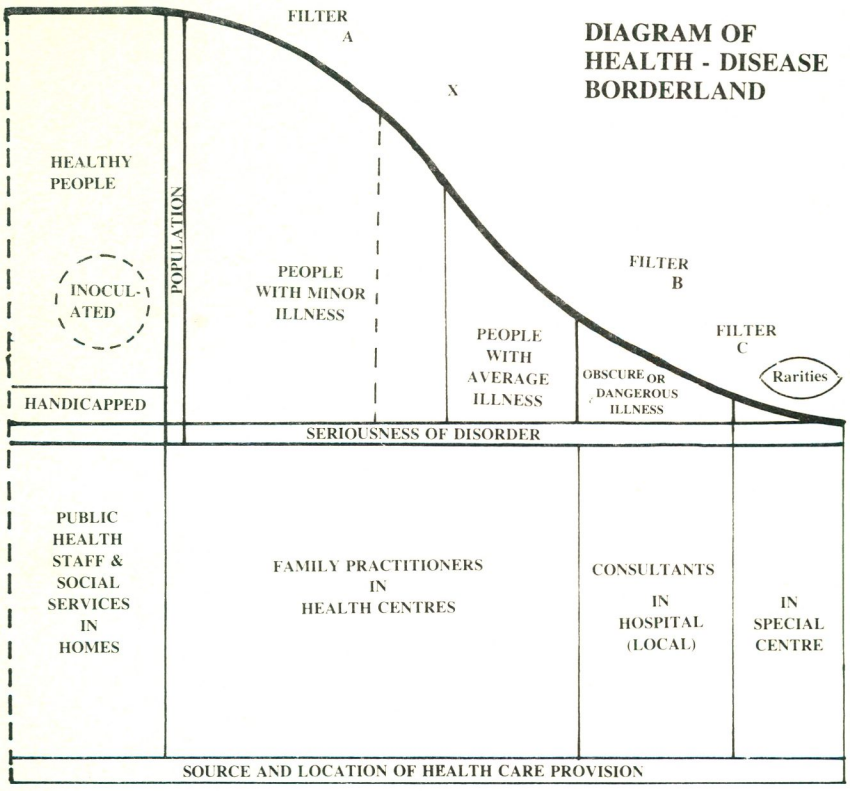
WHEN a doctor moves from the practice of his profession in hospital to practice in a primary health care centre, his first impression is that a very large proportion of his patients suffer from, to him, trivial complaints, matters not requiring a trained doctor's skill for management or cure. And in fact the vast majority of such complaints are self-limited and no harm would come to the patient in the long run if a doctor was not available. This is of course a truism : by contrast with the hospital doctor who is concerned with diagnosing and treating people undoubtedly ill in body or mind or both, the primary care physician works at the interface between health and disease. It is extremely difficult to define health and not easy to define disease (B.M.J. September 29, 1979 - p. 757) So no wonder there is ample room for argument, disagreement, theorising, advice, and criticism concerning the work of doctors who have chosen to practice in the borderland where these two indefinables meet. This situation can be put in semi-graphic form by plotting the numbers of sufferers against the seriousness of their disease. See Diagram.



The process of presentation of patient to doctors can also be regarded as one of filtration, or sieving. Any sick person may present himself or herself or her child to the primary care physician who then decides if the condition is serious enough to warrant referral to the hospital, secondary care, or consultant (Filter B). Out of these referred patients some may need care whichever their local hospital cannot provide : after another filtration process (Filter C) they proceed to a "Super specialist" centre. And a filtration process was already in action (Filter A) : before the patient reached the primary care physician he made the decision that he needed advice or medicine : or a mother decided that the child's crying was due to illness and not merely over tiredness. There are innumerable minor

disorders for which patients do not ask medical attention — fortunately. On the other hand this basic filtration process may go wrong and ignorance of the significance of a symptom may lead to dangerous delay in the diagnosis of a serious condition e.g. transient diplopia.

IBN SINA STUDY 1979

For the months of January and June 1979 a record was kept of the seriousness of the presenting complaints (new episodes) and a subjective judgement made as to whether the patient would have come to any harm if a doctor had not been available. (Table 1).

TABLE NO. 1. ALL NEW CASES

	Total		*Trivial*
January	776	545	70%
June	784	623	79%

Most of these complaints were disorders of the upper respiratory tract. (See Table 2).

TABLE NO. 2

	Total all complaints	*Upper respiratory*	*Injuries*	*Musculo-Skeletal*
January	776	475 (61%)	44 (6%)	46 (6%)
June	784	311 (40%)	98 (12.5%)	62 (8%)

Although the proportion of upper respiratory infections decreased in the summer it still remained by far the largest component of the new case intake (Table 3) "Triviality" was evenly distributed between the three most commonly presenting complaints.

TABLE No.3 (January & June Continued)

	Total	*Trivial*	
Upper Respiratory	786	695	(88%)
Injury	142	122	(86%)
Musculoskeletal	108	80	(74%)

In October a subjective judgement was made for each patient (new or old episode) of the kind of health care needed to ensure return to normal health. (Table 4).

TABLE NO. 4

Type of Health Care Needed	*New*	*Old*	*Total*	*%*
None e.g. Frivolous school children	17			1.2
Any family e.g. 2 days sore throat	320	30	350	26.3
Intelligent family e.g. small furuncle	126	18	144	10.8
Advice & medicine from nurse, pharmacist, or other aide e.g. child with mild diarrhoea	274	64	338	25.4
Doctor's attention but it would not make much difference to the course of the disease	119	92	211	15.8
Doctor's attention, making notable difference to the course of a minor disease.	101	30	131	9.8
Doctor's attention making notable difference to the course of a major disease.	31	78	109	8.1
Beyond capability of Primary centre. Referred	32			2.4

DISCUSSION

The figures quoted refer to the practice of a somewhat privileged non-Arab doctor working in a somewhat privileged health centre : most primary care doctors would be seeing more patients more rapidly than the writer, and their "Triviality - load" — would be higher. What is the effect (a) on the doctor and (b) on the patients, of providing so much time, effort and material towards fulfilling demand rather than need ?. Illich "Limits to Medicine" has indicted the medical profession in the west for its creation of a medicine-addicted society and a self-perpetuating health industry.

There is a danger that the provision of a free "disease — service" rather than "health — service" in an evolving community like Bahrain may lead in the same direction unless the front line doctors can be spared some of the "triviality — load" they bear at present, Stott and Davis (J.R. Coll. G.P. 1979) have offered a very practical analysis of the use of the family practitioners consultation time :-

A) Management of Presenting problem.

B) Modification of help seeking behaviour.

C) Management of continuing problems.

D) Opportunistic health promotion.

It stands to reason that the extension of the doctor's influence in B, C and D depends on a reduction in the time spent on A. At present the time spent on the short-term policy — supplying the patient's demand concerning A — is hindering the long term requirement of time to be spent on B, C and D. Besides this a rapid sucession of short consultations for trivial complaints ultimately leads to what can be termed "compassion fatigue", let alone "intellectual atrophy" in the doctor.

Can the situation be changed by the arrival of a new generation of vocationally trained family physicians whose up to date knowledge of scientific medicine is matched by their interest in the psychological and social problems of their patients. Unfortunately a doctor keen to, and capable of practising in B, C and D, discovers that these are for more demanding of time than simple A activity : he may chose to withdraw from the pressures of an A - demanding community and seek (to him) more satisfying work elsewhere : This has already happened within the U.K. National Health Service.

POSSIBLE APPROACHES

Theoretically, if the total hours of a doctor's work is divided by the number of patients seen, each patient could have an uninterrupted 6 minutes consultation which would give time for A, B, C and D activity. In fact the uneveness of influx and the demands of a few patients for much longer consultation soon reduce this theoretical average to time for A only in the vast majority of interviews.

An increase in the total number of doctors would ultimately mean an acceptable average duration of interview : Bahrain already has an exceedingly high doctor : population ratio (about 1 to 1000) in comparison with most parts of the world — surely no more should be attracted here even by financial bait.

There remains consideration of how to shift the burden of trivial illness off the doctor's shoulders elsewhere.

Patient Education is obviously a priority and in television we have an instrument of enormous potential as long as the health education programme is intimately connected to the needs of the community as seen by the doctor in the health centre not the public health expert concerned with major disease. The doctor in the health centre is the one whose person to person effort (Activity D of Stott & Davis) can be made or marred by the concurrent T.V. education.

There remains the thorny question as to the introduction of a paramedical filter as indicated in the diagram at X. In many, if not most parts of the world such a filter is essential simply because sufficient doctors are not available nor could be paid for if they were. In many hospitals the casuality department sister of experience ity department sister of experience ("Sergeant-major type") acts as a filter to turn away trivialities, though this is hardly possible nowadays with a sophisticated and demanding public. But competent nurses can be trained in the elements of diagnosis and in Britian some practices employ nurses to whom is delegated the responsibility for first home visits to sick children — of course with the necessary back up from the doctor when called for. There is no reason why a filtration — nurse suitably trained should not be available for patients who realise that their complaint, or their child's complaint, is not serious and who would see her quickly and go home rather than wait an hour to get the same medication and advice from a doctor.

Again in the U.K. many simple medications are bought by patients directly from the chemist who has sufficient medical background to differentiate between a cough due to transient upper respiratory infection and one of a month's

duration in an obviously ailing sufferer.

Finally it must often seem to the hard pressed doctor in the health centre seeing a large number of patients in rapid succession and asking them almost identical questions for a few expected replies and issuing a limited number of standardised simple prescriptions, that his job could be done by a computer. This is not such a remote or unacceptable suggestion as it sounds. Computer interviewing is already with us for particular purposes (Middle East Health December 1978 — pp 16) and in some situations has advantages over interview by a doctor.

In the Health Centres of Bahrain doctor's time saved by any such means would not be used to shorten his hours of work or increase his time for coffee. These are many other activities which could be expanded if the doctors had the time for them : home visiting with the Public Health Staff, Morbidity surveys inside and outside the centre, preparation of problem orientated summaries of the patient's records, child development assessments, training of non-medical Health Centre staff in First Aid and Health Education, formal Health Education talks and displays for waiting room patient. These are some which come to mind, in addition, of course, to increasing B.C and D activity within consultations.

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(1978) Middle East Health Dec. p. 16

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H.E. Shaikh Hamad Bin Isa Al-Khalifa the Heir Apparent and Defence Minister shaking hands with the Members of the Staff of the Military Hospital.