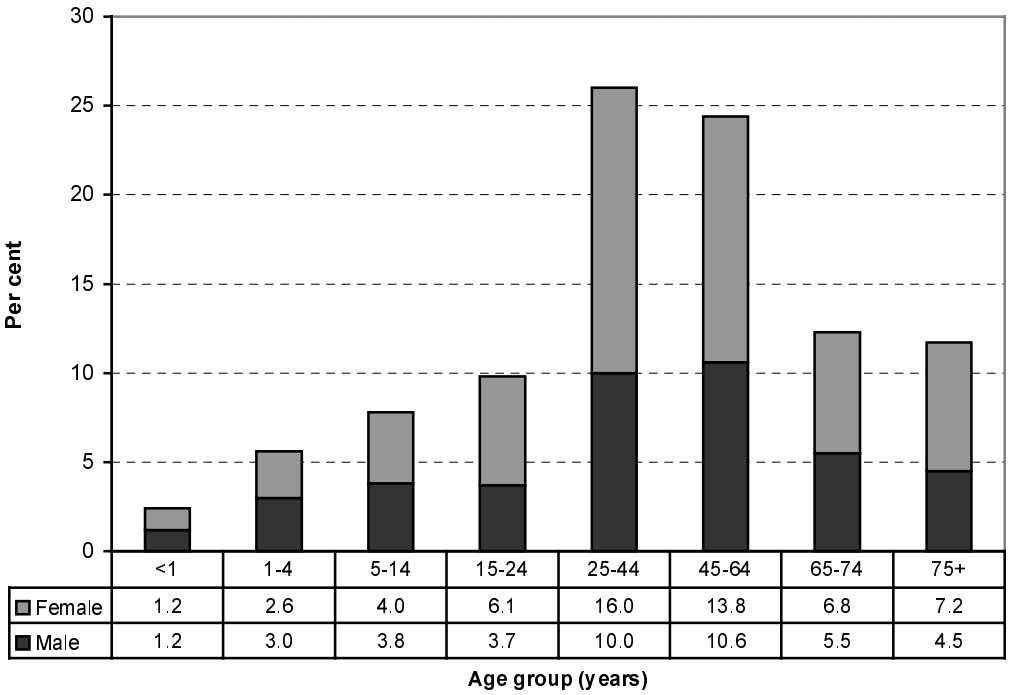
6. The patients

6.1 Patient characteristics

6.1.1 Age–sex distribution of patients

Figure 6.1 shows the age–sex distribution of patient encounters recorded in the survey. Age was not recorded at 1.1% of encounters and sex was missing at 1.5% of encounters (Table 6.1). Approximately one in six patient encounters were with children (15.8%), one in ten were with young adults (9.8%), and approximately one in four with patients in each of the following age groups, 25–44 years (26.0%), 45–64 years (24.4%), and 65 years and older (24.0%).



	<1	1-4	5-14	15-24	25-44	45-64	65-74	75+
Female	1.2	2.6	4.0	6.1	16.0	13.8	6.8	7.2
Male	1.2	3.0	3.8	3.7	10.0	10.6	5.5	4.5

Figure 6.1: Age-sex distribution of patients at encounter

Overall there were more female than male patient encounters (57.7% compared with 42.3%). This was reflected across all age groups except for patients aged 1–4 years where there were slightly more male than female encounters. Gender differences were greatest in the reproductive years (25–44 years age group), and in the elderly (75+ years), where there are more females than males in the general population.

6.1.2 Other patient characteristics

For each encounter the GP indicated whether the patient was new to the practice or had been seen previously. The patient was new to the practice at 9.2% of encounters. Almost half of the encounters were with patients who held a health care card (47.3%) and 3.4% were with persons who held a Department of Veterans' Affairs card. At 14.5% of encounters the patient was from a non-English speaking background, and at only 1.1% was the patient Aboriginal and/or Torres Strait Islander.

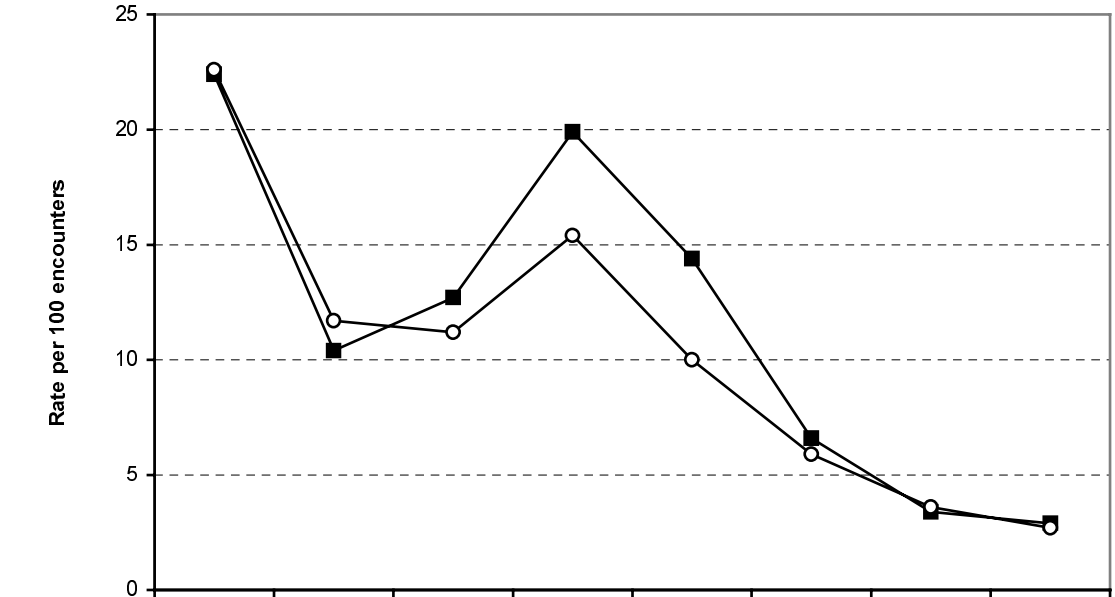
Table 6.1: Characteristics of the patients at encounters

Patient variable	Number	% of encounters (N=96,901)	95% LCI	95% UCI
Sex	. .	. .	. .	. .
Males	40,370	42.3	41.6	43.0
Females	55,057	57.7	57.0	58.4
Missing	1,474	. .	. .	. .
Age group	. .	. .	. .	. .
<1 year	2,337	2.4	2.2	2.7
1–4 years	5,417	5.7	5.3	6.0
5–14 years	7,411	7.7	7.3	8.1
15–24 years	9,433	9.8	9.4	10.2
25–44 years	24,886	26.0	25.3	26.7
45–64 years	23,393	24.4	23.8	25.0
65–74 years	11,756	12.3	11.7	12.8
75+ years	11,245	11.7	11.1	12.4
Missing age	1,023	. .	. .	. .
Other characteristics	. .	. .	. .	. .
New patient to practice	8,824	9.2	8.6	9.8
Health care card	41,748	47.3	45.8	48.8
Veterans' Affairs Gold Card	2,910	3.0	2.7	3.3
Veterans' Affairs White Card	366	0.4	0.2	0.5
Non-English speaking background	14,021	14.5	13.0	16.7
Aboriginal	1,011	1.0	0.3	1.8
Torres Strait Islander	115	0.1	0.0	0.5
Aboriginal & Torres Strait Islander	36	0.04	0.0	0.9

Note: Abbreviations: UCI – Upper confidence interval, LCI – Lower confidence interval

6.1.3 Age–sex specific rates of new patients

The relative rate of new patient presentations for each age–sex patient group demonstrated that about one in four male and female patients aged less than one year were new to the practice. The relative number of new patients decreased with age so that by far the majority of elderly patients had been to the practice on prior occasions. Figure 6.2 demonstrates that only 10–15% of older children were new to the practice but that of young adults, particularly young men (15–24 years), about one in five encounters are with new patients.



	<1	1-4	5-14	15-24	25-44	45-64	65-74	75+
Male	22.4	10.4	12.7	19.9	14.4	6.6	3.4	2.9
Female	22.6	11.7	11.2	15.4	10.0	5.9	3.6	2.7

Figure 6.2: Age-sex specific rates of new patients

6.1.4 Age–sex specific rates of encounters with persons holding a health care card

The age–sex specific rates of health care card holders demonstrated that at one-third of encounters with children (aged less than 15 years) and adults aged less than 45 years the patient held a health care card. This rate then increased to approximately 40% of encounters with patients in the 45–64 years age group and then sharply increased for encounters with the elderly. At three-quarters of all encounters with women of 65 years or more, the patient held a health care card. A somewhat lesser proportion of encounters with adult males in all age groups were with a health care card holder than encounters with adult females (Figure 6.3).

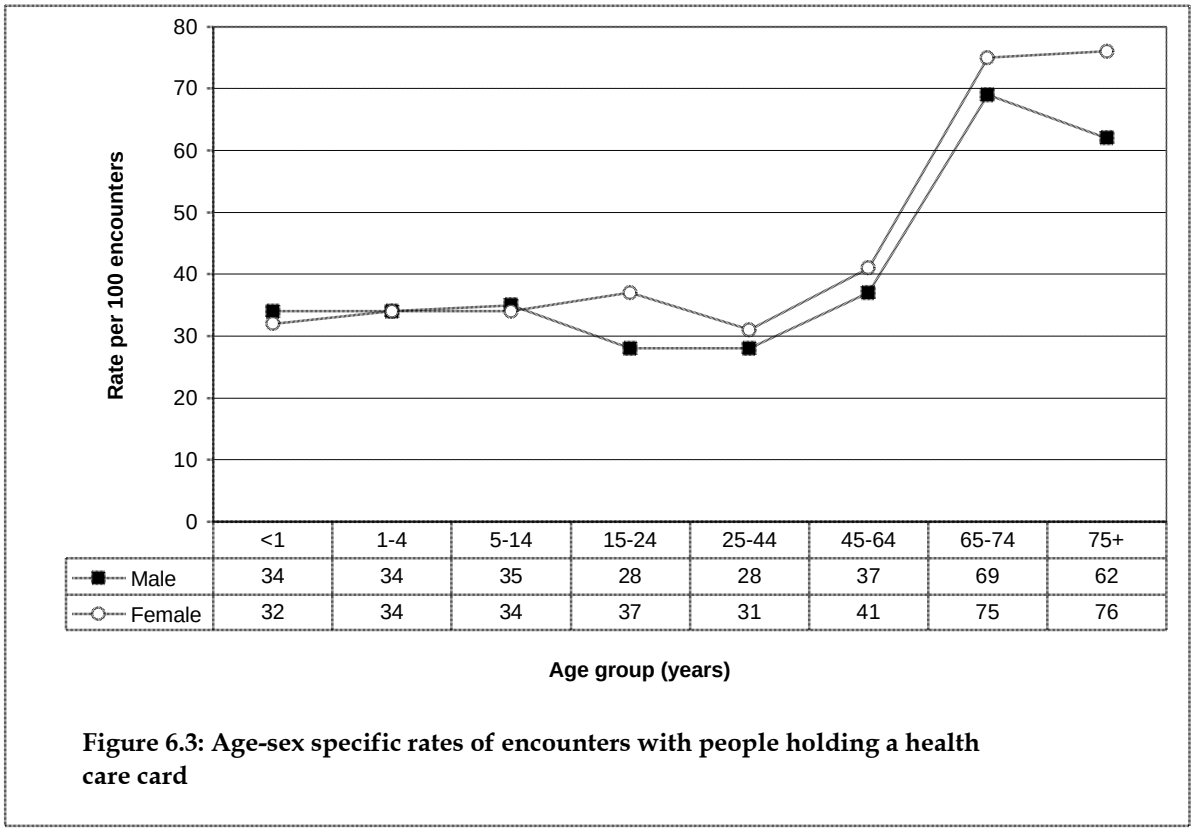


Figure 6.3: Age-sex specific rates of encounters with people holding a health care card

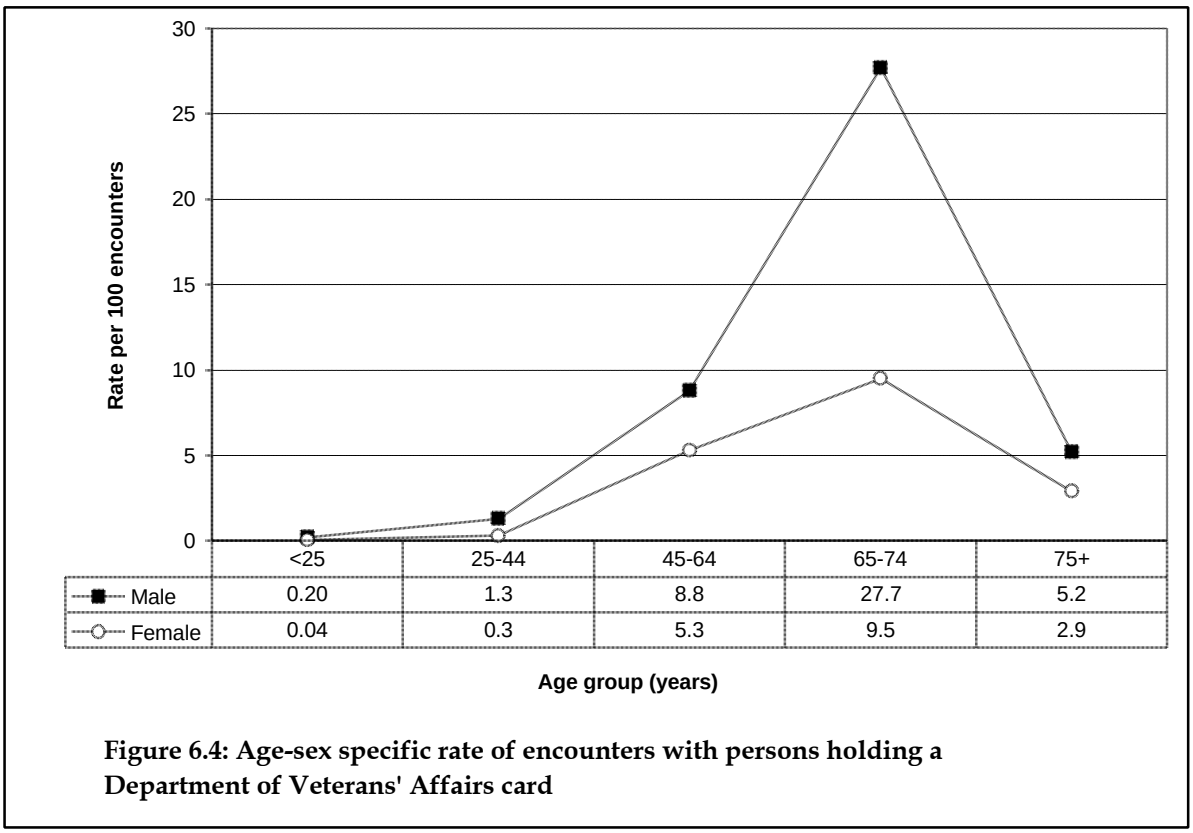


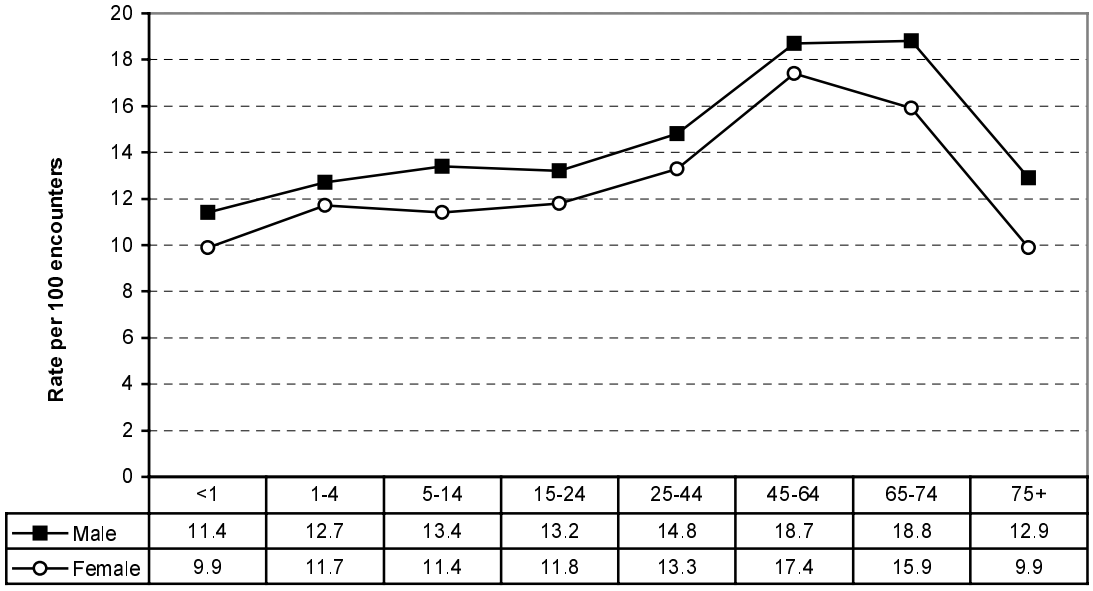
Figure 6.4: Age-sex specific rate of encounters with persons holding a Department of Veterans' Affairs card

6.1.5 Age–sex specific rates of encounters with persons holding a Department of Veterans' Affairs card

As could be expected men were more likely than women to hold a Department of Veterans' Affairs card. At very few encounters with patients aged under 44 years did the patient hold a card of this type but more than a quarter of all encounters with men in the 65–74 years age group held a Veterans' Affairs card (Figure 6.4).

6.1.6 Age–sex specific rates of encounters with persons from a non-English speaking background

Patients were defined as being from a non-English speaking background (NESB) if they reported usually speaking a language other than English in their home. The relative rate of encounters with people from a non-English speaking background is shown in Figure 6.5. Males in all age groups were slightly more likely to be from a non-English speaking background than were females and the proportion of encounters with such people ranged from about one in ten for children aged less than one year and for elderly persons over 75 years old, to a peak of 19 encounters per 100 for males of 45–74 years.



	<1	1-4	5-14	15-24	25-44	45-64	65-74	75+
Male	11.4	12.7	13.4	13.2	14.8	18.7	18.8	12.9
Female	9.9	11.7	11.4	11.8	13.3	17.4	15.9	9.9

Figure 6.5: Age-sex specific rates of encounters with NESB patients

6.2 Patient reasons for encounter

Reasons for encounter (RFEs) are those concerns and expectations which patients bring to the doctor. They may be symptoms or complaints (headache or fear of cancer), known diseases (flu or diabetes), requests for preventive or diagnostic services (a blood pressure check or an ECG), requests for treatment (repeat prescription), to get test results, or request an administrative action (e.g. a medical certificate). These reasons are usually related to one or more underlying problems which the doctor formulates during the encounter as the conditions that have been treated, and those may or may not be the same as the reasons for encounter.

International interest in RFEs has been developing over the past two decades. They reflect the patient's demand for care and can provide an indication of service utilisation patterns, which may benefit from intervention on a population level.

Balint's work in the 1950s led to a strong shift in approach by many practitioners, towards a 'patient-centred' rather than a 'disease-centred' approach (Balint, 1961). McWhinney has continued to promote this concept. He feels that the traditional disease-centred approach aims 'to interpret symptoms and signs in terms of physical pathological findings'. In contrast, the patient-centred method aims to see the patient's illness through the patient's eyes, relying on empathy, reflective listening and self knowledge on the part of the practitioner (McWhinney 1986).

The movement towards the patient-centred approach in turn stimulated increasing interest in the patient's role in the primary care setting, the way he/she reacts to pain, discomfort and stress; his/her attitudes to illness and disease and the factors which influence his/her decision to attend a medical practitioner (Barsky 1981; Stewart et al. 1975; Weyrauch 1984).

The importance of the patient's reason for attending the practitioner was emphasised by Morrell in 1971, who saw it as 'the logical point at which to start prospective studies into the natural history of illness and of the diagnostic method in general practice' (Morrell et al. 1971).

Clearly the collection of morbidity data based solely on the doctor's diagnostic decision is insufficient, especially in view of the difficulties in 'labelling' noted earlier in this report. The whole process of care needs to be described. A large part of the resources spent on health is applied to primary care and the efficient application of these resources requires greater knowledge of the reasons people decide to attend a general practitioner; why they move from self care to the primary care stage; and the economic costs related to different symptomatology.

Participating GPs were asked to record at least one and up to three patient reasons for the encounter (RFEs). These reflect the patient's view of the reasons s/he has for consulting the GP. RFEs can be expressed in terms of one or more symptoms (e.g.' itchy eyes ', 'chest pain'), in diagnostic terms (e.g. 'about my diabetes', 'for my hypertension'), a request for a service, ('I need more scripts', 'I want a referral'), an expressed fear of disease, or a need for a check-up.

RFEs were coded using ICPC-2 PLUS. The bi-axial structure of ICPC-2 has been used to formulate the analytical structure presented in this Chapter. GPs were instructed to record the reasons for the encounter in words as close as possible to the patients, prior to the commencement of the diagnostic or management process.

6.2.1 Number of RFEs at encounter

There were 141,766 patient RFEs recorded at a rate of 146.3 per 100 encounters. For almost two-thirds of encounters (63.4%) only one RFE was recorded, while at almost 10% of encounters the maximum of three RFEs were noted (Table 6.2).

Table 6.2: Number of patient reasons for encounter at an encounter

Number of RFEs at encounter	Number of encounters	Col %	95% LCI	95% UCI
One RFE	61,480	63.4	62.3	64.59
Two RFEs	25,977	26.8	26.1	27.51
Three RFEs	9,444	9.7	9.15	10.35
Total	**96,901**	**100.0**	. .	. .

Note: Abbreviations: UCI – Upper confidence interval, LCI – Lower confidence interval.

6.2.2 Age–sex specific rates of RFEs

For encounters with children aged less than 15 years the age–sex specific rate of RFEs per 100 encounters was steady at 130-133. It then gradually increased with patient age for both males and females reaching its maximum of 163 RFEs per 100 encounters for females of 65–74 years. Women of 15 years or more consistently had more RFEs than their male counterparts, though the difference decreased in patients aged 75 years or more (Figure 6.6).

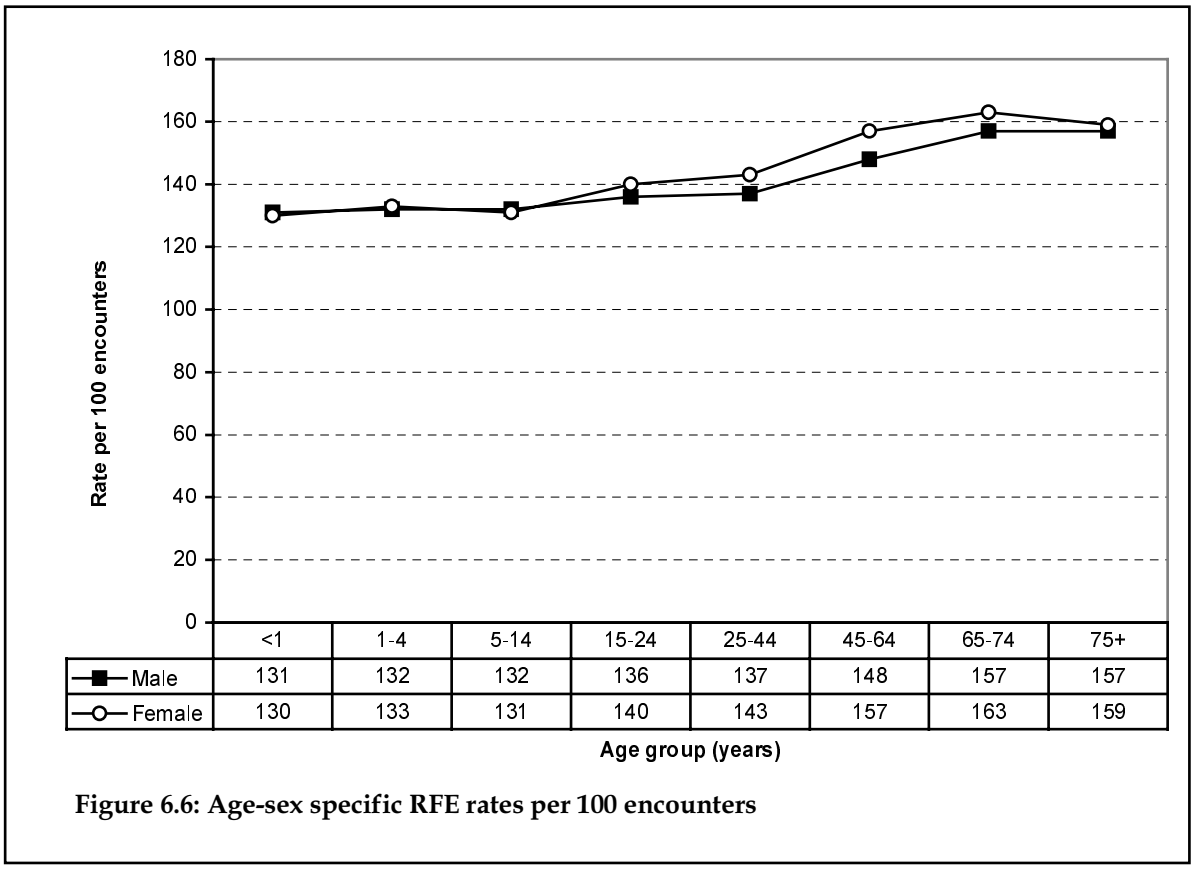


Figure 6.6: Age-sex specific RFE rates per 100 encounters

6.2.3 Nature of reasons for encounter

Reasons for encounter by ICPC-2 chapter

The distribution of patient RFEs by ICPC-2 chapter and the most common RFEs within each chapter are shown in Table 6.3. Each chapter and individual RFE is expressed as a percentage of all RFEs and as a rate per 100 encounters with 95% confidence intervals.

More than half the RFEs related to the respiratory, musculoskeletal, skin, circulatory and digestive systems. Less common were RFEs of a psychological or social nature and reasons related to the blood, ear, eye, urological, endocrine and genital systems.

Eighteen per cent of RFEs did not relate to a specific body system and were classified in the **general** chapter. The most common general RFE was a request for a prescription (of unspecified type), followed by a request for a check-up and a need for immunisation or vaccination. Other general RFEs that also arose relatively frequently were of a symptomatic nature. These included fever, weakness/tiredness and chest pain (of unspecified origin).

Respiratory problems arose at a rate of 24.8 per 100 encounters, the most common being cough, throat complaints and URTI (often expressed as a 'cold'). Requests for influenza vaccines presented at a rate of 2.3 per 100 encounters while asthma, nasal congestion and acute bronchitis were also relatively common.

RFEs related to the **musculoskeletal system** were described at a rate of 16.7 per 100 encounters and were most commonly for symptoms and complaints of specific skeletal body parts. Complaints related to the back were by far the most common (3.6 per 100 encounters), followed by those related to the knee, the foot/toe, the neck, shoulder and leg.

Reasons associated with the **skin** were described at a rate of 15.1 per 100 encounters, rash being the most frequent problemn followed by skin compaints (not othersie classified). Requests for a skin check-up were also in the most frequent list of RFEs related to the skin.

Requests for a cardiovascular check-up accounted for almost half of all RFEs associated with the **circulatory system** which arose at a rate of 11.4 per 100 encounters. Patients also frequently presented for their hypertension or 'high blood pressure' problem.

Digestive problems accounted for 7.2% of all reasons described, arising at a rate of 10.6 per 100 encounters. Abdominal pain was most common, followed by diarrhoea and vomiting Together these three symptoms represented approximately half of all digestive related RFEs.

Less frequently recorded were RFEs of a **psychological** nature (7.6 per 100 encounters) and these were frequently described in terms of depression, insomnia and anxiety. The relative frequency of the remaining ICPC-2 chapters for patient reasons for encounter is demonstrated in Table 6.3.

Table 6.3: Distribution of patient reasons for encounter by ICPC-2 chapter and most frequent individual reasons for encounter within chapter

Patient reasons for encounter	Number	% total RFEs	Rate per 100 encs[(a)]	95% LCI	95% UCI
General & unspecified	**25,739**	**18.2**	**26.6**	**25.7**	**27.4**
Prescription NOS	5,452	3.9	5.6	5.2	6.0
Check-up NOS*	3,032	2.1	3.1	2.9	3.4
Immunisation/vaccination –general	2,003	1.4	2.1	1.9	2.3
Fever	1,768	1.3	1.8	1.5	2.1
Weakness/tiredness	1,515	1.1	1.6	1.4	1.7
Chest pain NOS	1,269	0.9	1.3	1.2	1.4
Administrative procedure NOS	819	0.6	0.9	0.7	1.0
Blood test NOS	719	0.5	0.7	0.4	1.0
Trauma/injury NOS	717	0.5	0.7	0.6	0.9
Respiratory	**24,027**	**16.9**	**24.8**	**24.0**	**25.6**
Cough	6,019	4.3	6.2	5.8	6.6
Throat complaint	3,696	2.6	3.8	3.5	4.1
URTI	2,794	2.0	2.9	2.5	3.3
Immunisation/vaccination –respiratory	2,271	1.6	2.3	1.2	3.4
Asthma	1,327	0.9	1.4	1.2	1.5
Nasal congestion/sneeze	1,307	0.9	1.4	1.1	1.6
Acute bronchitis/bronchiolitis	975	0.7	1.0	0.7	1.3
Shortness of breath, dyspnoea	761	0.5	0.8	0.6	0.9
Musculoskeletal	**16,236**	**11.5**	**16.7**	**16.1**	**17.4**
Back complaint*	3,435	2.4	3.6	3.3	3.8
Knee complaint	1,200	0.9	1.2	1.1	1.4
Foot/toe complaint	1,162	0.8	1.2	1.1	1.3
Neck complaint	1,141	0.8	1.2	1.0	1.4
Shoulder complaint	1,055	0.7	1.1	0.9	1.2
Leg/thigh complaint	1,014	0.7	1.1	0.9	1.2
Skin	**14,584**	**10.3**	**15.1**	**14.6**	**15.5**
Rash*	2,539	1.8	2.6	2.4	2.8
Skin complaint	1,192	0.8	1.2	1.1	1.4
Swelling*	1,080	0.8	1.1	1.0	1.2
Check-up*	793	0.6	0.8	0.6	1.0
Circulatory	**11,085**	**7.8**	**11.4**	**10.9**	**12.0**
Check-up*	4,986	3.5	5.2	4.7	5.5
Hypertension/high BP*	2,452	1.7	2.5	2.1	3.0

(continued)

Table 6.3 (continued): Distribution of patient reasons for encounter by ICPC-2 chapter and most frequent individual reasons for encounter within chapter

Patient reasons for encounter	Number	% total RFEs	Rate per 100 encs[(a)]	95% LCI	95% UCI
Digestive	**10,265**	**7.2**	**10.6**	**10.3**	**10.9**
Abdominal pain*	2,174	1.5	2.2	2.1	2.4
Diarrhoea	1,355	1.0	1.4	1.3	1.5
Vomiting	1,031	0.7	1.1	0.9	1.2
Psychological	**7,374**	**5.2**	**7.6**	**7.2**	**8.0**
Depression*	2,047	1.4	2.1	1.9	2.3
Insomnia	1,149	0.8	1.2	1.0	1.3
Anxiety*	1,093	0.8	1.1	1.0	1.3
Endocrine & metabolic	**5,429**	**3.8**	**5.6**	**5.3**	**5.9**
Diabetes *	1,033	0.7	1.1	0.9	1.3
Blood test endocrine/metabolic	723	0.5	0.8	0.5	0.9
Lipid disorder	677	0.5	0.7	0.4	1.0
Female genital system	**5,171**	**3.6**	**5.3**	**5.0**	**5.7**
Check-up/Pap smear*	1,652	1.2	1.7	1.5	1.9
Menstrual problems*	830	0.6	0.9	0.7	1.0
Neurological	**5,136**	**3.6**	**5.3**	**5.1**	**5.5**
Headache	1,876	1.3	1.9	1.8	2.1
Vertigo/dizziness	1,061	0.8	1.1	1.0	1.2
Ear	**4,379**	**3.1**	**4.5**	**4.3**	**4.7**
Ear pain	1,882	1.3	1.9	1.8	2.1
Pregnancy & family planning	**3,576**	**2.5**	**3.7**	**3.4**	**4.0**
Pre/post natal check*	1,149	0.8	1.2	0.8	1.6
Oral contraception*	871	0.6	0.9	0.7	1.1
Eye	**2,741**	**1.9**	**2.8**	**2.7**	**3.0**
Eye pain	545	0.2	0.6	0.4	0.7
Urology	**2,375**	**1.7**	**2.5**	**2.3**	**2.6**
Blood	**1,739**	**1.2**	**1.8**	**1.6**	**2.0**
Male genital system	**1,031**	**0.7**	**1.1**	**0.9**	**1.2**
Social problems	**877**	**0.6**	**0.9**	**0.7**	**1.1**
Total RFEs	**141,766**	**100.0**	**146.3**	**144.6**	**148.0**

(a) Figures do not total 100 as more than one RFE can be recorded at each encounter. Also only frequencies >0.5 are included.

* Includes multiple ICPC-2 or ICPC-2 PLUS codes (see Appendix III).

Note: Abbreviations: UCI – Upper confidence interval, LCI – Lower confidence interval, NOS – Not otherwise specified.

Reasons for encounter by ICPC-2 component

Almost half of the RFEs presented were expressed in terms of a symptom or complaint (e.g. feeling tired, sore feet, pain in back), described by patients at a rate of 71.1 such symptoms per 100 encounters. Diagnostic terms represented almost one-quarter of all RFEs and were described at a rate of 33.6 per 100 encounters. Requests for diagnostic and preventive procedures were made at a rate of 22.4 per 100 encounters and (as demonstrated in later Tables) these were most commonly requests for check-ups and vaccination/immunisation. Patient requests for medication and other treatments were made at a rate of 10 per 100 encounters while requests for referral, results, and administrative procedures were relatively few (Table 6.4).

Table 6.4: Distribution of RFEs by ICPC-2 component

ICPC-2 component	Number	% total RFEs	Rate per 100 encs[(a)]	95% LCI	95% UCI
Symptoms & complaints	68,933	48.6	71.1	69.4	72.9
Diagnosis, diseases	32,540	23.0	33.6	31.9	35.2
Diagnostic & preventive procedures	21,721	15.3	22.4	21.5	23.3
Medications, treatments & therapeutics	10,011	7.1	10.3	9.8	10.9
Referral & other RFE	4,231	3.0	4.4	4.0	4.7
Results	3,306	2.3	3.4	3.1	3.7
Administrative	1,023	0.7	1.1	0.9	1.2
Total RFEs	**141,766**	**100.0**	**146.3**	**144.6**	**148.0**

(a) Figures do not total 100 as more than one RFE can be recorded at each encounter.

Note: Abbreviations: Encs – encounters, UCI – Upper confidence interval, LCI – Lower confidence interval.

Table 6.5: Most frequent patient reasons for encounter

Patient reason for encounter	Number	% total RFEs	Rate per 100 encs[(a)]	95% LCI	95% UCI
Check-up (all)*	13,223	9.3	13.7	13.0	14.3
Prescription (all)*	7,946	5.6	8.2	7.7	8.7
Cough	6,019	4.3	6.2	5.8	6.6
Immunisation/vaccination (all)*	4,742	3.4	4.9	4.4	5.4
Throat complaint	3,696	2.6	3.8	3.5	4.1
Back complaint*	3,435	2.4	3.6	3.3	3.8
Test results*	3,306	2.3	3.4	3.1	3.7
URTI	2,794	2.0	2.9	2.5	3.3
Rash*	2,539	1.8	2.6	2.4	2.8
Hypertension/high BP*	2,452	1.7	2.5	2.1	3.0
Abdominal pain*	2,174	1.5	2.2	2.1	2.4
Depression*	2,047	1.4	2.1	1.9	2.3
Ear pain	1,882	1.3	1.9	1.8	2.1
Headache	1,876	1.3	1.9	1.8	2.1
Fever	1,768	1.3	1.8	1.5	2.1
Weakness/tiredness	1,515	1.1	1.6	1.4	1.7
Diarrhoea	1,355	1.0	1.4	1.3	1.5
Asthma	1,327	0.9	1.4	1.2	1.5
Nasal congestion/sneeze	1,307	0.9	1.4	1.1	1.6
Chest pain (NOS)	1,269	0.9	1.3	1.2	1.4
Knee complaint	1,200	0.9	1.2	1.1	1.4
Skin complaint	1,192	0.8	1.2	1.1	1.4
Foot/toe complaint	1,162	0.8	1.2	1.1	1.3
Insomnia	1,149	0.8	1.2	1.0	1.3
Neck complaint	1,141	0.8	1.2	1.0	1.4
Anxiety*	1,093	0.8	1.1	1.0	1.3
Swelling*	1,080	0.8	1.1	1.0	1.2
Vertigo/dizziness	1,061	0.8	1.1	1.0	1.2
Shoulder symptom/complaint	1,055	0.7	1.1	0.9	1.2
Diabetes*	1,033	0.7	1.1	0.9	1.3
Subtotal	*76,689*	*54.1*	. .	. .	. .
Total RFEs	**141,766**	**100.0**	**146.3**	**144.6**	**148.0**

(a) Figures do not total 100 as more than one RFE can be recorded at each encounter.

* Includes multiple ICPC-2 and ICPC-2 PLUS codes (see Appendix III).

Note: Abbreviations: Encs – encounters, UCI – Upper confidence interval, LCI – Lower confidence interval.

Most frequent patient reasons for encounter

The 30 most commonly recorded RFEs are listed in order of frequency in Table 6.5. In this analysis the specific ICPC-2 chapter to which an across chapter RFE concept belongs is disregarded, such that 'check–up (all)' includes all check-ups from all body systems irrespective of whether the type was specified (e.g. 'BP check') or whether the request was very general. Equally, 'immunisation/vaccination (all)' includes flu vaccination requests as well as those for childhood immunisation, hepatitis, etc.

The need for a check-up was by far the most common RFE, accounting for almost 10% of all RFEs recorded at a rate of 13.7 per 100 encounters. Requests for medication were also frequent (8.2 per 100 encounters). It is notable that RFEs described as 'hypertension' and 'high BP' also arose at a rate of 2.5 per 100 encounters and these are likely to be closely associated with the need for a check-up and/or medication. RFEs associated with the need for immunisation or vaccination were the fourth most often expressed RFE (4.9 per 100), perhaps reflecting an increasing understanding of the advantages of such preventive care.

The remaining RFEs in the top 30 were largely symptom based, led by cough (6.2 per 100) and throat complaints (3.8 per 100), back complaints, URTI (often described as 'a cold') and rash. Undifferentiated symptoms such as weakness/tiredness, headache, fever, abdominal pain, diarrhoea, chest pain and vertigo were also common. Many musculoskeletal symptoms also appeared in the top 30 RFEs. It is notable that chronic conditions such as asthma, depression, insomnia, anxiety and diabetes were also frequently described in diagnostic terms by patients in describing their reasons for encounter.

6.2.4 The inter-relationship of RFEs with other variables. Example: Weakness/tiredness

An RFE was classified as 'weakness/tiredness' if the patient described their reason for the encounter in terms of any of the labels classified under the ICPC-2 rubric A04 (General weakness/tiredness). In ICPC-2 PLUS this rubric includes a number of more specific symptoms and complaints codes, such as 'rundown' (ICPC-2 PLUS code A04018) and 'feeling weak' (ICPC-2 PLUS code A04011). As multiple ICPC-2 PLUS codes fall into the general weakness/tiredness rubric in cases where a patient described more than one of these terms at an encounter, the RFE would have been classified twice to A04.

General weakness/tiredness was one of the most frequently described patient RFEs (Table 6.3). It was described on 1,515 occasions, representing 1.1% of all RFEs and occurring at a rate of 1.6 per 100 encounters. Encounters involving at least one RFE of this type numbered 1,433 (1.5% of all encounters).

Figure 6.7 illustrates the relationship of an RFE of weakness/tiredness with other variables that are collected at the general practice encounter. Weakness/tiredness can be directly linked to patient characteristics such as age and sex (solid arrows); however, a RFE can only be indirectly linked (dotted arrows) to the problems and managements (i.e. Prescriptions written, tests and investigations ordered, and referrals transcribed) provided at the encounter. In addition, other RFEs presenting with weakness/tiredness have also been included to give an indication of other reasons why the patient attended the encounter.

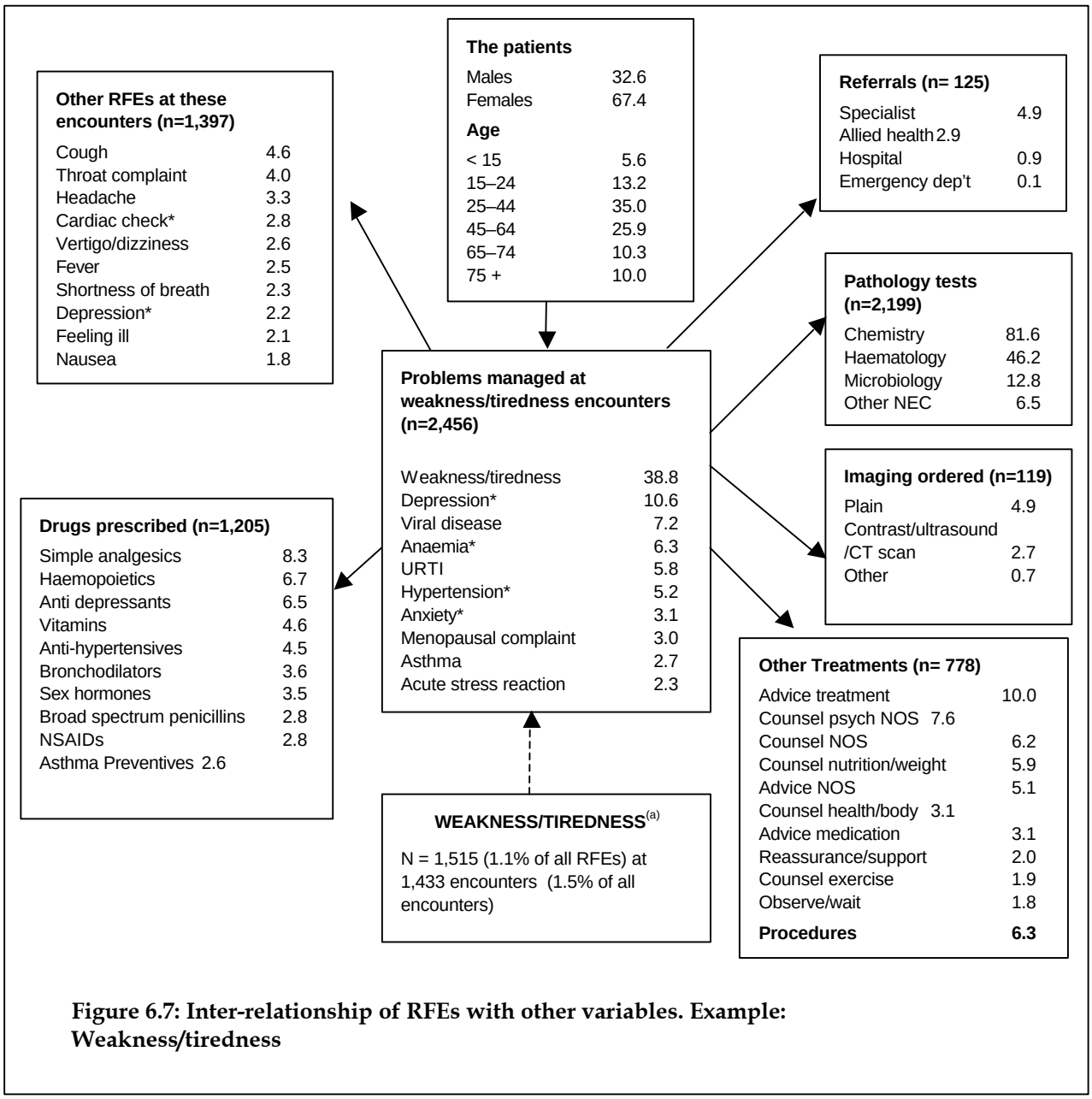


Figure 6.7: Inter-relationship of RFEs with other variables. Example: Weakness/tiredness

Other reasons for encounter

At each encounter where a RFE of weakness/tiredness was described, a number of other patient RFEs were also presented to the GP. A total of 1,397 other RFEs were described at these encounters, the most frequent being symptoms of cough (4.6 per 100 encounters), throat complaints (4.0) and headache (3.3).

Problems managed

At the 1,433 encounters where tiredness/weakness presented as an RFE, more problems (171 per 100 encounters) were managed than in the total dataset (145 per 100). The most common problem managed at these encounters was described in the same symptomatic terms as the RFE, demonstrating that in 38.8 per 100 encounters no further definition of the underlying problem could yet be determined. This was followed by depression (10.6 per 100 encounters), viral illness (7.2) and anaemia (6.3). The inclusion of hypertension in the top ten problems managed at weakness encounters could purely reflect the high rate of management of this problem throughout the total dataset. Alternatively some of these cases of hypertension may be associated with symptoms, such as weakness/tiredness, which present as side effects of anti-hypertensive medication. Anxiety, menopausal complaints, asthma and acute stress were also common problems managed at these encounters.

Prescriptions and other treatments

Prescriptions given at these encounters numbered 1,205 (84.1 per 100 encounters). This was somewhat less than the rate for the total data (93.6 per 100). Simple analgesics were the most frequently prescribed drug group and these were more likely to be given than usual (8.3 per 100 encounters compared with 4.7). Haemopoietics were prescribed at a rate of 6.7 per 100 weakness encounters (compared with <0.5 per 100 in the total dataset). Almost half of these were Vitamin B12 injections (cyanocobalamin). Anti-depressants were 2.5 times more frequently prescribed at the encounters compared with the total dataset and vitamins were almost 10 times more frequent. Bronchodilators, anti-hypertensives, broad spectrum penicillins and NSAIDS were less frequently prescribed than usual while prescription rates for hormones paralleled the total findings.

Referrals, tests and investigations

Other clinical treatments were provided at 778 of these encounters (53 per 100) and again this was more frequent than usual (31 per 100). Advice about treatment for the problem being managed was most common, followed by psychological counselling and counselling of an unspecified nature. Other forms of counselling and advice provided to these patients covered nutrition and weight, exercise and advice about medication.

Referrals numbered 125 (8.7 per 100 weakness encounters). While specialist referrals were relatively less frequent than in the total dataset (4.9 per 100 encounters compared with 7.4), referrals to allied health professionals were consistent with usual levels (2.9 compared with 2.8 per 100 encounters).

Encounters involving a RFE of weakness/tiredness generated very high pathology test ordering rates. There were 2,199 pathology tests (or groups of tests such as FBC) placed at these encounters, a rate of 153 per 100 encounters. This compares with an overall rate of 24.6 orders per 100 encounters. Orders of imaging were only made at a rate of 8.3 per 100 encounters, a similar rate to the average (5.2) and the majority of these orders were for plain X-rays.