

TRANSPORT OF PATIENTS IN GENERAL PRACTICE

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THE general practitioner in this country is an independent contractor under the National Health Service who visits and is visited by people who require their doctor's attention. The rate at which a family doctor is consulted varies from practice to practice, but in England and Wales the average rate of consultation per patient per year is between four and five; of these consultations nearly one quarter take place in the home.

Many general practitioners have expressed the view that under present conditions the continuous care of an average-sized list with this sort of consultation rate does not permit one to practise adequate medicine. This has resulted in a demand for a smaller list size. A more realistic approach to this problem, at a time of an increasing shortage of general practitioners, would be to examine ways in which a doctor's time can be saved, or more efficient use made of his time without curtailing the service to the patient or introducing a financial discouragement.

We are encouraged to employ nurses and other ancillary staff and delegate work to them. Perhaps our greatest obstacle to delegation is the patient—many feel less satisfied when visited by other than his or her doctor, although the content of the visit may well be more social than medical and performed more efficiently by social workers than doctors. Similarly, the climate of opinion amongst patients is not sufficiently ripe to permit primary visits by nurses.

In what other ways could the doctor save time without detriment to the patient or without putting up a barrier of some sort to deter the patients?

In this country we visit patients far more frequently in their home than in other countries with advanced systems of medical care. Is this necessary? These customs have been handed down to us.

Customs, however, can be changed, and the time is ripe for change. We can encourage the patient to use the surgery by making it more attractive and reducing waiting time with an appointments system and by making the surgery more comfortable and pleasant. There is a limit to the success of such a venture. Patients may be too infirm to use public transport. In rural areas public transport may be inadequate, and even in suburban areas there are patients who take the attitude that it is more convenient for the doctor to use his car than it is for themselves to use public transport.

Our practice is an urban one but rather scattered, partly because the borough is a seaside resort and tends to stretch along the coast, and partly because this two-doctor practice was formerly two separate practices two miles apart. There is now a central surgery situated 100 yards from a hospital. This hospital provides us with outpatient facilities and direct access to radiology and pathology. We regard it as a paradox that whilst transport can be provided at our request to bring our patients to within 100 yards of our surgery for various purposes, to use the same transport to bring such patients to our surgery would not be looked on favourably by the transport authority.

If the use of a sitting ambulance is regarded as usual procedure to supplement the workings of an outpatient department, why should it not succeed in general practice? A visit to a patient's home, including travelling time, may take two or three times as long as a consultation at the surgery with the same medical content.

Is it feasible for a sitting ambulance car to bring suitable patients to the surgery and thus save travelling time, and the time so saved used for more leisurely examination of existing patients or used in other medical work?

An experiment was commenced on 1 October 1965 in which transport was provided by the practice to bring patients to the surgery instead of visiting them at home, with the object of exploring the scope and cost of such a venture.

We have 5,000 N.H.S. patients, 27 per cent of whom are over 65 years of age. We have secretarial help equivalent to two and a half full-time workers and a part-time nurse. For the experiment we engaged a part-time driver, but later used a receptionist-driver. The driver was engaged three half-days per week, each time for three hours. It was estimated that a maximum of 12 patients could be ferried each session and the appropriate number of appointments were allocated in the appointments book. In practice, if these were not filled in by 10 a.m. on the same day the appointments were given to ordinary surgery patients. The appointments were so grouped in

order that patients could be brought in groups with a maximum of three.

Results

Our particular problem is the high proportion of elderly people who make the visiting list long. Many of these visits are of a social kind, with the occasional addition of a small medical content such as repeat prescriptions of digoxin. Amongst those visited are a proportion who are not bedfast but are for most of their time tied to the house. These are the patients for whom the service was principally employed. At the start of the scheme a number of such patients were put on the transport list. They included those with mild but controlled cardiac failure, moderate rheumatoid arthritis, severe angina, frail and blind people. Whereas 25 per cent of the patients attending the surgery are over 65 years of age, 75 per cent of those using transport were of that age group. The bulk of these fell into the semi-ambulant group who were formerly receiving regular visits. In addition there were a small number of individuals who were either convalescent after acute illnesses (particularly chest infections and cardiac infarcts), and a small number who had requested visits that day or the day before. These were largely elderly or babies.

Advantages

The principal advantage is the saving of time. This, of course, has to be laid against cost, considered below. Surgery consultations are booked at the rate of eight per hour, whereas our visiting rate is three to four per hour, even with chronic visits. Both can be speeded up as demand dictates. However, in our particular experience four visits an hour would compare to eight surgery consultations per hour (in terms of comfort). Thus each visit converted to a consultation saves on average seven and a half minutes. This saving factor will, of course, vary widely, being highest in practices with a scattered population. Although we had allowed for a maximum of 36 consultations by transport, the number of suitable patients averaged 20 per week, thus saving the practice two and a half hours.

The second advantage is that of efficiency. Although patients appreciate a doctor's visit, it can be very inefficient at times. The small nuisances of dogs and television, and often lack of privacy because other people are in the same room may be magnified out of proportion when under pressure. Worse still when visiting the elderly chronic patients, one is occasionally faced with the situation where the usual chitchat and pulse-taking are insufficient but because the patient is alone and fully dressed we have the choice of waiting whilst painstaking slow disrobing takes place (followed by an examination on a low easy-chair), or returning at a later date with the patient in bed. In the surgery with a separate room and ancillary

help this presents no problem, similarly with simple procedures such as ear syringing, collection of midstream urine and vaginal examinations.

A third advantage not foreseen is the ability to change the attitude of patients. Some of our elderly patients were formerly private patients and "were not used to attending the surgery". Having undergone such an unpleasant experience, they are converted when the advantages are explained to them. Others, on discovering it is possible to be transported to the surgery, then make their own arrangements with relatives or taxis. In a few instances, the journey itself has been therapeutic; some of our patients had not been out for many months, and thoroughly enjoyed the trip.

Effect on work load

During the first six months 504 patients were carried. Table I shows the effect of reorganization on items of service. Clearly this change cannot be accounted for only by the transport service. At the start of this period one of the two surgeries was closed and a full-time appointments system spread across morning and afternoon was introduced. Also during 1965 one partner left and was replaced by a new doctor. The greatest impact of all the changes has been on re-visits and very little in new calls. The practice did, however, increase by 5 per cent in the 12 months, and the expected slight increase in new calls has been kept down by the small number of patients requiring a new visit who were persuaded to come to the surgery in the car provided.

TABLE I

	<i>New visits</i>	<i>Re-visits</i>	<i>Surgery consultations</i>
August 1964/January 1965 ..	1,038	1,769	11,995
August 1965/January 1966 ..	1,052	877	9,826

Disadvantages

Such a service requires organization and mistakes can be made. Transport appointments for the regular attenders are booked up to two months in advance and occasionally such patients are taken ill and are visited in bed before the appointment is due; the original appointment is not cancelled and the chauffeuse calls on a patient who is in bed or in hospital. On one occasion, a patient had died between appointments but the driver was unaware of this and called at the house. These mistakes have been made for some time in the hospital service since no one had informed the transport office or the

outpatient clerks that a patient had died. They could have been avoided by the simple procedure of vetting the list personally on the day of the transport.

This service was introduced to the practice at a time when re-organization was about to take place and all households received a letter. Patients were invited to make use of it when they were unable to use public transport and were told that it would be for an experimental period of 12 months. It was suggested by colleagues that this was inviting abuse. They know that misuse of local authority transport takes place. Were we inviting similar misuse? In practice this presented no problem. Nearly all the patients who used it did so at our request or that of the receptionist. Few actually asked for it and fewer still who were capable of using public transport, used it. The few patients who did so were those who would have requested a visit anyway.

Cost

The costing of the service was important. In the six months October/March 1966 one car, a Singer Vogue Estate, was used. This car was new in April 1965 and covered 12,000 miles in one year. Even with the relatively low mileage, and allowing for first year depreciation, the cost per mile was sevenpence.

TABLE II

Number of patients using the car	504
Miles travelled	1,500
Estimated additional mileage assuming each patient would have required a visit	900
	£ s. d.
Costs: Car expenses 900 x 7d	26 5 0
Labour	84 0 0
TOTAL	110 5 0
Estimated time saved	63 hours
Cost of one hour saved	35s. 0d.

In the period of six months, 504 patients were brought to the surgery in groups. The total mileage of the car for this service was 1,500. Only part of this, approximately half, was mileage over and above that which would have been necessary to visit these patients. By and large we believe that this transport has been as well organized as our usual visiting, but for the purpose of this experiment we have allowed a margin for mismanagement and estimated that additional mileage was 900. The cost to the practice of this service amounts to 35s. 0d. for every hour saved. Three quarters of the cost of this service are labour charges. By operating below maximum capacity,

the costs have risen. If 36 patients per week had been carried the cost would have been 24s. 0d. for each hour saved.

However, on an average only 20 patients were carried per week because of an insufficient number of suitable patients on certain days. Originally a driver was employed for three-hour sessions and would be idle part of the time in some sessions. We now employ a driver/receptionist (at 6s. 8d. per hour) who when she has free time in these sessions can perform office work. More recently she has been employed to do ECGs in the patient's home when not fully occupied in the transport sessions.

Comment

This transport scheme was introduced for an experimental period of 12 months. If too expensive or impracticable it would be withdrawn. After six months we feel we have sufficient experience to say that it does work satisfactorily and can be a help in the management of a practice. Apart from the question of time saved, it is more efficient to see certain patients in the surgery than at home, and for this reason alone this scheme will become a permanent feature of our practice.

The financial aspects are more satisfactory than anticipated but could be better. We save two and a half hours per week at a gross cost of £4. 7s. 6d. In practice we earn this from a clinical assistantship in the time so provided. Equally well we could take on an increased number of patients. The net effect is thus to increase one's productivity by three per cent without cost. On this basis can we recommend other practitioners to adopt this scheme? Clearly not. There is no incentive to increase one's productivity without benefit, and to be financially satisfactory the scheme depends on the existence in the practice of a suitable car and a willingness on the part of the practitioner to expose what he may regard as a very personal possession to a hired driver and his practice population.

A recent pronouncement has affected the financial prospects. In the Third Report of Negotiations on Family Doctor Service, Appendix C, the duties of ancillary help which would qualify for the 70 per cent refund do not include that of driving. It is in the country's interest to improve our productivity and largely because the use of a driver has not been anticipated, we are losing an incentive to the encouragement of such a scheme. If our driver were henceforth to qualify for the ancillary help rebate the cost of saving one hour's time would fall from 35s. 0d. to 16s. 0d.

We would urge that this situation be rectified and we should then be in a position to encourage other practitioners to adopt similar schemes in the belief that they would suffer no financial disadvantage.

We believe that the time is ripe for experiments of a similar nature

in different types of practice, and if shown to be successful under differing conditions, a plea may be made for the provision of transport by the appropriate authority on a sessional basis. In particular we would suggest that practices using premises provided by the local authority are in a good situation to experiment with local authority transport.

If it could be demonstrated that a similar service operating in different practices also increased the medical content of the doctor's work by three per cent, the universal adoption of such a service would result in the saving of medical manpower equivalent to 600 whole time doctors in general practice.

General medicine in the danger zone?

Tidsskrift for den Norske lægeforening for 15 February 1967 reports on a meeting of the Norwegian Medical Society on this theme. The number of general practitioners in Norway has decreased by 15 per cent between 1956 and 1966; at the same time the average age has increased by five to ten years (according to the district). The Norwegian Medical Society is no alternative to the general practitioner who knows the patient and his family and has not to start every time afresh, who sees the whole man. "It is unhealthy for patient and doctor alike if it is not one and the same physician who treats the patient in all stages of his disease" (L. Eitinger).

Why are doctors leaving general practice? First of all it is much easier just to continue working in hospital, than to enter the competition and irregular hours of family practice. Students are trained by specialists, who are their example; and, most important, there is the low status of the general practitioner compared with the specialist and research worker who have ample chances for easy living and a sufficient income. The satisfaction of the general practitioner who knew every one of his patients in all stages of his disease and of his life is missing at a time when the patient is apt to 'disappear' in hospital, or to wander from clinic to clinic without much 'communication' with the general practitioner.

General practice is more exacting than at former times, and many feel that they just do not know enough for our work, and last but not least, there is the increasing paperwork.

The remedies suggested are (1) general practice should become a specialty, or, at the very least, continuous additional training. (2) Choosing the medical student not only according to school certificates. (3) Organization of general practitioner research. (4) Group practice in a form adapted to local conditions. (5) Modernization of methods, including reduction of the paperwork. (6) Decrease of the unnecessary subdivisions of medical work which can be done by the general practitioner.

Karl Evang stressed the good results of a specific Norwegian form of general practitioner, the family doctor plus the medical officer of health, which has remained attractive, in the more isolated districts.