THE PATTERN OF CONSULTATION

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THIS paper shows the pattern of consultation by patients attending their family doctor's consulting room. The study covers more than a decade in the first 15 years of the National Health Service: during the period 1 January 1952 to 31 December 1962, continuous recording totalled 65,890 attendances.

The especial advantages of study from within general practice are, among others, those of providing the curious minded with a ready equipped social laboratory. Here the clash and cohesion of interdependent aspects of community needs and professional procedures can be studied at length and at ease. Professional practice, devoted primarily to the well-being of patients, is based on custom and habit of previous decades and differing tempo. It may well be that having looked at what we do, in the light of fresh knowledge we must decide what changes are desirable and how we should make them.

The method

The technique developed for the study has to be simple, effective, and easy to use; not time-consuming, nor must it interrupt trends of thought. The information collected must be capable of easy and speedy tabulation, bulk avoided; and at all times the information must be factual and entirely relevant.

It is based on the principle of marking clearly and quickly a printed sheet, using the 'gate': four separate individual vertical strokes and a fifth transversely across the four, thus: 𝍸 indicate five of a group in the particular column.

As the patient leaves the consulting room a mark is made in the appropriate column in the attendance record which lies on the desk. The age groups are constant and clearly defined:

Infants—up to and including the first birthday
Children—from the age of one year and one day up to and including the fourteenth birthday
Male adult (self-explanatory)—from 14 years and one day

J. COLL. GEN. PRACTIT., 1965, 10, 133

Female adult (self-explanatory)—from 14 years and one day
Father—a male adult who seeks advice about a child or children
Mother—a female adult who seeks advice about a child or children

Particular care was taken when an adult came into the consulting room with a child to determine whether the attendance was for the adult (with the child merely brought along) or for the child. Experience over the years teaches that a child is hardly ever brought into the consulting room without some request for advice being made. In the case of an infant, however, the mother may bring the baby merely because she has no one to leave it with. When a consultation concerning an infant or child was asked for, then on termination a mark is placed in the correct column for the child or infant, and for the parent (either father or mother). Should a parent after seeking advice for the child request advice or treatment for himself or herself, then no further entry on the record is made, since it is considered that the primary reason for consultation was in respect of the child. Care was also required when marking the attendance of parents who seek advice or treatment about a child, without bringing the child with them. The decision was taken some years ago to mark each entry at the end of the consultation rather than when the patient(s) came into the consulting room.

Because family doctors working in the National Health Service are given, quarterly, the number of patients for whom they are at risk, practice populations, for all practical purposes, are known. There is a valid and acceptable scale of measurement, enabling accurate comparison to be made.

ATTENDANCE RECORD

Date		*Male*				*Female*			
		Adult	*Father*	*Child*	*Infant*	*Adult*	*Mother*	*Child*	*Infant*
	Mon. a.m.								
	,, p.m.								
	Tues. a.m.								
	,, p.m.								
	Wed. a.m.								
	,, p.m.								
	Thur. a.m.								
	,, p.m.								
	Fri. a.m.								
	,, p.m.								
	Sat. a.m.								
	,, p.m.								
	Total:								

In each year the winter quarter was the busiest; except for the years 1957 and 1958, the demand for consultations was less in the autumn than in the preceding summer. In 1957 and in 1958, the position was reversed. The autumnal increase for 1957 could be explained on the basis of an increase in demand due to the Asian influenza which made its appearance in this area at that time: in 1958, as a whole, the demand for consultations was less than in previous years, only in the last quarter was the average level of demand reached. The quarterly figures given in figure 1 and table I show that the demand varied in emphasis from year to year, and that the relative ratios between the grouping of patients as men, women and children remained fairly constant. Eighty per cent of the practice population saw their family doctor in his consulting room in each quarter. Of this demand (80.4 per cent), approximately five men (24.9 per cent) and two children (11.3 per cent) consulted their doctor for every nine women consulting (44.2 per cent).

TABLE I
SEEN IN THE CONSULTING ROOM
Average Quarterly Rates (1952–1958)

Year	*All patients (percentage)*	*Men (percentage)*	*Women (percentage)*	*Children (percentage)*
1952	*86.4*	*27.0*	*46.8*	*12.6*
1953	*84.7*	*24.7*	*45.8*	*14.3*
1954	*83.9*	*25.6*	*44.4*	*13.9*
1955	*84.6*	*27.6*	*46.3*	*10.7*
1956	*76.1*	*23.3*	*42.4*	*10.4*
1957	*77.1*	*23.9*	*43.2*	*10.0*
1958	*70.4*	*20.7*	*40.8*	*8.9*
Mean: 1952–1958	*80.4*	*24.9*	*44.2*	*11.3*

Rates: Consultations recorded per quarter / Population at risk per quarter

During the survey, of parents seeking advice, eight mothers, 89.1 per cent, consult for each father, 10.9 per cent (table II). This distribution remains almost constant. Details given in figure 1 and table I confirm that in the winter quarter when men, as a group, have a higher rate of consultation this is not so for those who attend as fathers. (Compare men, figure 1, with fathers, figure 2).

It would appear that the breadwinner of the family will seek his doctor's advice more readily about himself during the winter than he will about his children.

Conversely, mothers consult more often in the winter quarter: (figure 4). It is probable that at this time of the year there is an

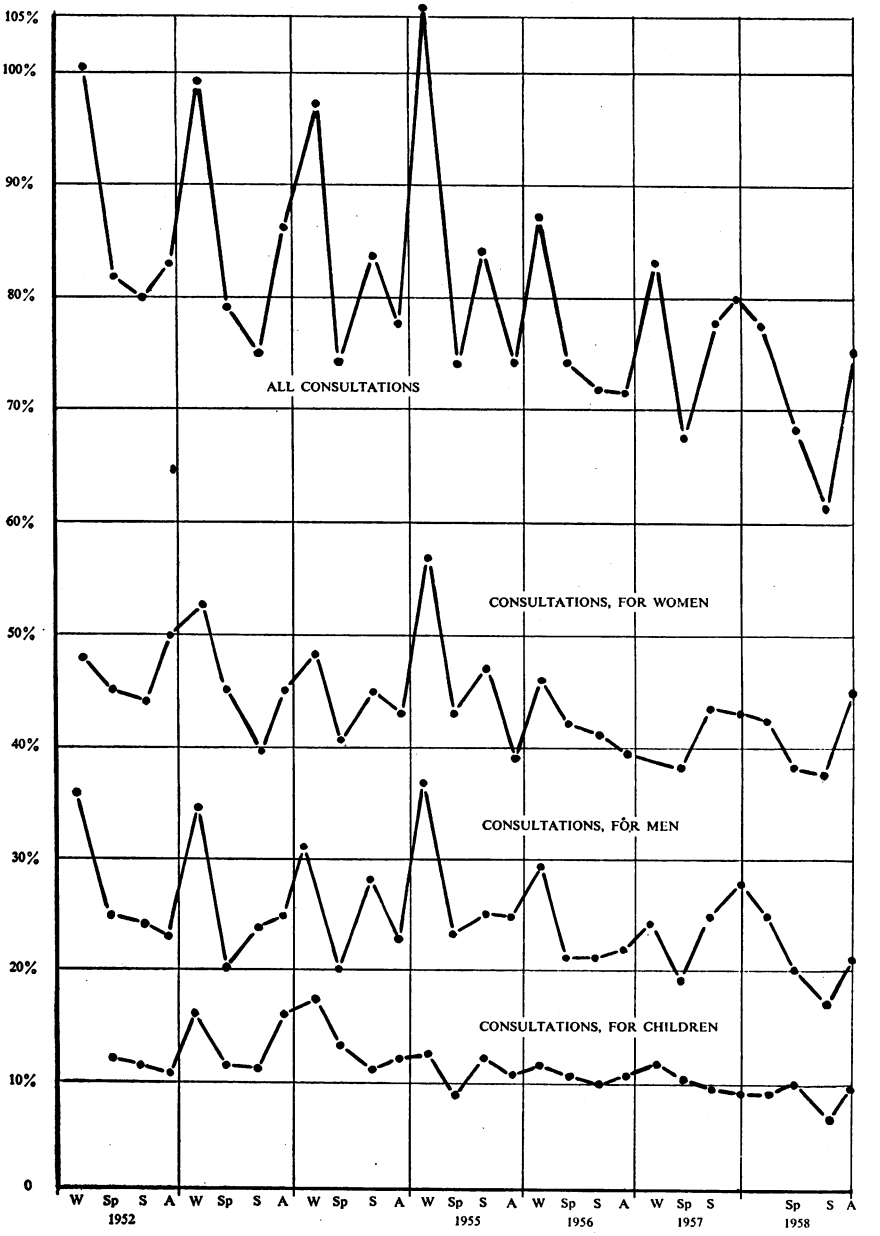

Figure 1
Patients seen in the consulting room. 1952–1958
(percentage, mean population at risk; estimated quarterly)

increase of sickness in the home which despite the extra demands on their time and energy cause mothers to consult their family doctor more frequently.

TABLE II

PARENTAL CONSULTATIONS

Average quarterly rates, each year 1952–1958

Year	*Parental consultations*		*Parents consulting: as percentage of all communications*
	Fathers percentage	*Mothers percentage*	
1952	*8.3*	*91.7*	*13.9*
1953	*9.5*	*90.5*	*18.4*
1954	*10.6*	*89.4*	*18.5*
1955	*11.9*	*88.1*	*16.3*
1956	*12.9*	*87.1*	*21.3*
1957	*11.9*	*88.1*	*19.0*
1958	*11.4*	*88.6*	*19.2*
Mean: 1952–1958	*10.9*	*89.1*	*18.1*

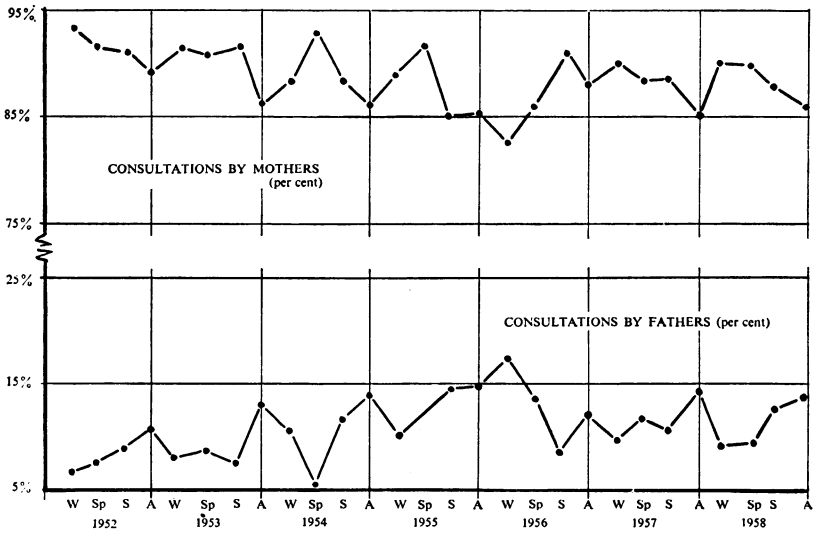

Figure 2

Parents seen in the consulting room. 1952–1958

(percentages, consultations by *Mothers* and by *Fathers*, quarterly, each year)

Table III provides evidence that the mothers in one general practice at least are more likely to seek advice in the months of March and September than in other months of the year. January, June, October and December show higher rates than April, July and August. The high attendance in March can be accounted for by increased family sickness at the end of the winter; August provides the lowest, and September the next highest rate of attendance. An

explanation of the September increase could be the rise in children's sickness following on the return to school at the beginning of the school year.

TABLE III

CONSULTATIONS BY MOTHERS—by month 1952–1958

Month	*1952*	*1953*	*1954*	*1955*	*1956*	*1957*	*1958*	*Total*
Jan. ..	29	87	102	91	74	102	68	553
Feb. ..	78	81	78	87	77	95	82	578
Mar. ..	81	105	116	106	72	94	108	682
Apr. ..	57	85	81	52	67	53	85	480
May ..	72	67	112	42	74	82	74	523
June ..	61	89	60	87	76	84	98	555
July ..	46	31	67	51	85	81	82	443
Aug. ..	57	66	65	60	84	65	41	438
Sept. ..	84	97	75	122	88	133	75	674
Oct. ..	65	101	70	69	68	86	87	546
Nov. ..	60	88	72	60	106	71	81	538
Dec ..	70	94	95	64	81	82	70	556
Totals ..	760	991	993	891	952	1028	951	6566

The two months with the highest consultations are MARCH and SEPTEMBER

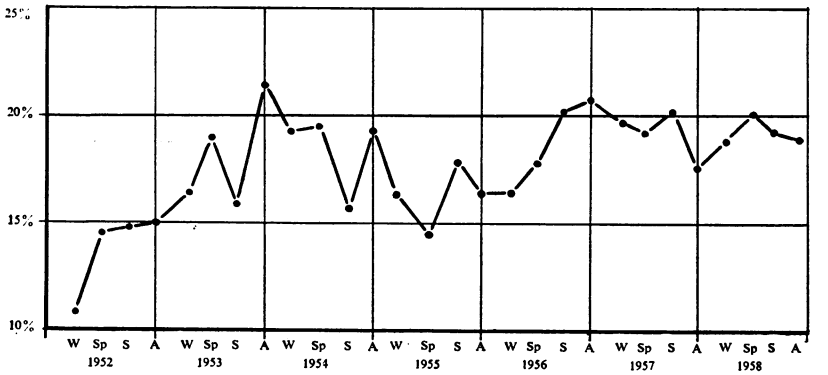

Figure 3
Parents seen in the consulting room. 1952–1958
(percentage of all consultations, quarterly each year)

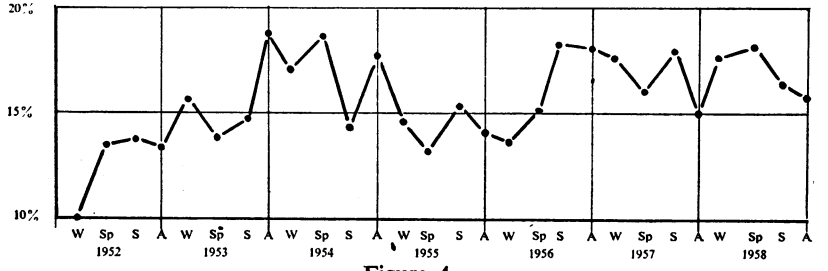

Figure 4
Mothers seen in the consulting room. 1952–1958
(percentage of all consultations, quarterly each year)

The ratio of parental consultations to all consultations has remained reasonably constant around 18.0 per cent during the seven years 1952–1958 (table II).

Of greater interest is the pattern of maternal consultations continuously recorded over 11 years (1952–1962) shown in table IV. The constancy of the share of professional attention devoted to mothers, 16.1 per cent or one consultation in every six or seven is remarkable.

TABLE IV
CONSULTATION BY MOTHERS, 1952–1962
Average quarterly rates, proportion of all consultations: in each year

Year	*Maternal consultations (percentage)*
1952	*12.6*
1953	*16.8*
1954	*16.5*
1955	*14.3*
1956	*16.4*
1957	*16.8*
1958	*17.0*
1959	*16.2*
1960	*16.1*
1961	*18.6*
1962	*15.9*
Mean: 1952–1962	*16.1*

A comparison is offered in table V between the results of this study and some reported in Logan's 3-year survey in eight practices (Logan, 1953, No. 7 and continuation No. 9).

The pattern of use is broadly similar, with the exception of a much higher attendance of women in my series.

TABLE V
USING THE CONSULTING ROOM

Consultations per 1000 List				
	Logan			*Eimerl*
	Year 1	*Year 2*	*Year 3*	
Men	793	795	753	981
Women	1246	1178	1222	1765
Children	524	463	476	465

When one considers the reports of studies in other practices often little evidence of this particular demand made on the practitioner by the parents in the practice population is provided. It would be incorrect to assume that because of the lack of evidence the demand does not exist. Young and Willmott (1957) stressed the importance of the mother in the life of the family especially where families are rehoused on new estates; they found that the mother is the head and centre of the extended family and her home its meeting place. Particularly when the children are grown up and have youngsters of their own does the influence of the older mother become more manifest; it is she who looks after the home when her daughter is confined, who helps with domestic and social problems, and who carries the load when children are sick whether they are her own or her children's progeny. Kerr (1953) made a comparative study of both Jamaica and Liverpool and observed that both Jamaica and

'Ship Street' " are flourishing matriarchies where lip service is paid to the male but the chief female in the family is the pivot and boss".

The significance of these observations is reflected in the work of all family doctors. They, above all others, are most aware of the mother's importance in the community they serve. In the welfare state there is an increasing relationship between the mother and her family doctor. A cause for speculation is that little has been recorded by him on this subject.

More of this aspect requires study and comment. For example, if in other practices, one in every six or seven consultations is for the mother in a family the effect of long waits, especially when accompanied by children, is both undesirable and unnecessary. Moreover, in present day conditions, mothers may not wait but instead request a home visit, thus increasing the work-load of the doctor. There is an increasing need for better means to enable mothers to see their family doctor more speedily and less wearisomely. This is a matter of social policy which with increasing marriages, earlier childbirth, and an increasing birth rate, affects the community as much as if not more than the family doctor.

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The Best is Yet to be. P. J. SHIELDS. *Brit. med. J.* 1965. **1**, 49.

In this article based on his presidential address to the Yorkshire Branch of the British Medical Association, Dr Shields reviews the various methods by which general practitioner services are organized in different countries; the different methods of remuneration, capitation fee, salary and fee for service and the problems arising therefrom. He expresses the hope that by making a comparison with other people's ways of doing things the British system of medical services can benefit, but as he says in his summing up, " what do we want, I do not think we know exactly ".