DESCRIPTION OF A SCOTTISH RURAL PRACTICE 1965

H. J. A. LONGMORE, M.B. (Aberdeen), D.Obst.R.C.O.G.
Lochmaben, Dumfriesshire

THIS IS A description of a single-handed Scottish rural practice in 1965. The practice is based on Lochmaben (population 1,289) and covers about a ten-mile radius. General practice in Lochmaben is in many ways ideal, practising as I do in delightful surroundings with complete co-operation from consultants, open laboratory and x-ray facilities and easy access to hospitals. An excellent course of postgraduate lectures is held every winter in Dumfries. Drawbacks include the lack of general-practitioner beds and the comparative isolation of a single-handed rural practitioner.

The practice

Ten surgeries were held weekly in my home. I had no ancillary help, apart from my wife. Sixty per cent of my patients lived more than three miles away from the surgery. My mileage in 1965 was over 16,000 miles. Apart from 21 days' holiday and, on average, half-a-day weekly, I was on duty every day and night (including week-ends). Ninety-eight per cent of my income came from the executive council.

I undertook this study to ascertain the amount and type of my work and to compare it with that of other practices (*Coll. gen. Practit.*, Report, 1965).

The records kept from 1 January to 31 December 1965 were:

(1) a note of all doctor/patient contacts (including telephone consultations but excluding non-medical contacts and 'double' consultations in the surgery or at home);

(2) an age/sex register;
(3) an E-book;
(4) weekly mileage.

Population. For this study, the population at risk has been found by taking the average of the four quarterly figures supplied by the

executive council. This figure is 1,892. The figure on 31 December 1965 was 1,941, which agrees surprisingly with my own estimate.

During the year, there were 232 (12.5 per cent) additions to, and 146 (8 per cent) withdrawals from, my list. Twenty-five per cent of those who moved went to England. None emigrated.

Of the 44 births, 41 took place in hospital. Nineteen patients died and, of these, 11 died in hospital. Fourteen were aged over 65, and two were neonatal deaths.

The age/sex distribution is shown in table I. Of those aged over 65, eight males and 30 females lived alone.

TABLE I

AGE/SEX DISTRIBUTION

	0–4	*5–14*	*15–44*	*45–64*	*65+*
Male	100	145	373	205	110
Female	87	163	388	227	143
Total	187	308	761	432	253
Percentage ..	*9.5*	*15.9*	*39.2*	*22.3*	*13.0*

The social class distribution of the males of working age is shown in table II. An analysis of their occupations shows that 31 per cent work in agriculture and three per cent in forestry. On the other hand only 2.2 per cent work in the more modern industries of the North British Rubber Works, I.C.I. and Chapelcross Atomic Energy Centre.

TABLE II

SOCIAL CLASS—MALES 15–64

	I	*II*	*III*	*IV*	*V*
Working males ..	12	109	200	183	74
Percentage ..	*2.0*	*19.0*	*34.6*	*31.6*	*12.8*

Findings

The total consultations in 1965, and where they took place, are shown in table III. A comparison with other published results (table IV) confirms the higher rates of consultation and visiting in Scotland but they are not so high as that recorded by Stevenson

(1964) and Waterston (1965). On average a consultation in the surgery lasted six minutes.

TABLE III

CONSULTATIONS

	Surgery	*New visits*	*Revisits*	*Total*
Consultations	5,217	1,490	3,517	10,224
Percentage of total ..	*51.0*	*14.6*	*34.4*	*100.0*
Consultation rate per patient per annum ..	*2.8*	*0.8*	*1.8*	*5.4*

TABLE IV

COMPARISON OF CONSULTATION RATE AND RATIO OF SURGERY TO HOME CONSULTATIONS (S/V RATIO)

	Consultation rate	*Patients seen in surgery*	*S/V ratio*
McGregor 1950	*4.9*	*46.7*	*0.9/1*
Stevenson 1964	*6.5*	*52.3*	*1.1/1*
Fry and Dillane 1964	*3.5*		*4.5/1*
Waterston 1965	*7.0*	*65.5*	*1.9/1*
Posner 1965	*5.2*		*5.4/1*
Wilson 1966		*41.0*	*0.7/1*
Present review	*5.4*	*51.0*	*1.1/1*

A night call to me means a call undertaken after evening surgery, i.e. from about 7.30 p.m. onwards. During the year there were only 31 calls after 11 p.m. Table V shows the rates per 1,000 patients. Comparison with other studies shows the rate to be less than the usual Scottish ones and more than English ones.

One hundred and sixty-five patients were referred for a second opinion (including two domiciliary visits). There were 67 acute admissions. The rates per 1,000 patients are shown in table VI along with other published results.

Discussion

Exact comparisons are difficult, as has been pointed out by Lees

and Cooper (1963). Only McGregor (1950), Waterston (1965) and Wilson (1966) have described the work of single-handed Scottish rural practices. Both McGregor and Waterston had trainee-assistants for a time. Differences between these practices have been noted. Greater differences are noticed when comparisons are made with urban practices.

TABLE V

NIGHT CALLS

	Total	*Rate per 1,000 patients*
7.30 p.m.—11 p.m.	68	36
11 p.m.—8 a.m.	31	16

TABLE VI

COMPARISON OF REFERRAL RATES PER 1,000 PATIENTS

	Outpatients	*Inpatients*
Fry 1959	98	30
Wood 1964.. ..	99	37
Waterston 1965 ..	38	37
Present review ..	87	35

An urban practitioner with a list of 2,900 and a consultation rate of 3.5 (Fry and Dillane 1964) would do a similar amount of work. The rural practitioner, however, takes longer to do it because of the greater visiting rate and greater mileage involved. He is also at a disadvantage because of the lack of time and opportunity for medical work outside his N.H.S. practice.

I believe there must be changes in general practice. With more efficient use of doctors and their time, more co-operation between doctors, more ancillary help and a lower visiting rate, even rural practitioners could look after more patients, more efficiently.

Summary

This article describes some aspects of a Scottish rural practice in 1965. The higher consultation and visiting rates in Scotland are re-emphasized.

REFERENCES

Coll. gen. Practit., Reports from general practice No. 1 (1965).
Fry, J. (1959). *Brit. med. J.*, **2**, 1322.

Fry, J., Dillane and J. B. (1964). *Lancet*, **2**, 632.
Lees, D. S. and Cooper, M. H. (1963). *J. Coll. gen. Practit.*, **6**, 408.
McGregor, R. M. (1950). *Edin. med. J.*, **57**, 433.
Posner, B. H. (1965). *Practitioner*, **195**, 799.
Stevenson, J. S. K. (1964). *Brit. med. J.*, **1**, 1370.
Waterston, J. F. C. (1965). *J. Coll. gen. Practit.*, **10**, 18.
Wilson, J. B. (1966). *Lancet*, **1**, 144.
Wood, L. A. C. (1963). *J. Coll. gen. Practit.*, **5**, 379.

MINISTRY OF HEALTH RESEARCH GRANTS

For some time the Ministry of Health have been anxious to implement a policy in which small research projects by general practitioners could be included in the Decentralized Research Scheme administered by the department through regional hospital boards.

Considerable progress has now been made in this matter, in that all 15 regional hospital boards are willing to consider general practitioners' projects on the same footing as projects from within the hospital service, allocations being made according to the merit of the project irrespective of its source; 14 are able to put this into operation straight away, the remaining one from 1968/69. Some of the boards have a general practitioner co-opted to their research committee, so that the general practitioner point of view can be put in assessing the projects.

Therefore, in most areas, general practitioners who wish to undertake a research project in their practice, may now make a formal submission to their local regional hospital board.