THE CONSULTATION IN GENERAL PRACTICE

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TODAY is a stimulating time for general practice because, more than ever before, doctors and related workers are thinking how this branch of medicine must progress and develop in the next few years. There are those who are sceptical of any need for change, and yet we imagine very few general practitioners are entirely satisfied with the state of affairs as it exists today. And if we are not satisfied then it behoves us to enquire why, and moreover to enquire further in what way we can constructively take steps to improve it. It is important therefore that we endeavour to look objectively at what we are doing.

We propose in this paper to examine the consultation that takes place in general practice, considering it in terms of place, time, and personnel. The conclusions drawn are based on the statistics from our practice obtained over the last two and a half years. The partnership is one of six doctors, who work in two independent groups of three. It is with only one of these groups we are concerned, and therefore the figures relate to three doctors.

These three doctors look after approximately 6,200 patients plus a further 200 pupils at a boarding school (*see* tables I, II and V). At the present time they are assisted by two full-time secretary-receptionists and one part-time nurse and receptionist. Attached local authority staff consists of one health visitor and one district nurse (see below). There is a separate district nurse-midwife who is not formally attached. The premises consist of two consulting rooms, a waiting room, an office and a dispensary. This is already inadequate. Approximately one third of the patients are on the dispensing list. The population is nearly all in Social Classes I, II

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and III, and the area is semi-urban and rural.

The place of consultation

One of the controversial issues today is where ideally the consultation between patient and doctor should take place—Should we adopt the pattern in many other civilized countries and actively discourage home visiting, or should we be eager to see our patients at home when they desire it? Eimerl and Pearson (1966) have asked "Can the community afford the luxury of having the doctor acting merely as a chauffeur for so much of his time?" We do not think it can, nor do we think it necessary.

Family doctors spend an excessive amount of time driving to see patients who request home visits for no particular medical reason but purely because of convenience. They have come, not unnaturally, to expect it as a right. But, to be fair to these patients, if we

TABLE I

SUMMARY OF WORK DONE IN NORMAL WORKING HOURS IN SIX-MONTHLY PERIODS FROM 1 OCTOBER 1964 TO 31 MARCH 1967

Period	*Practice size middle of 6/12*	*New calls*	*Surgery consultations*
October 1964/March 1965 ..	3,324	761	5,208
April 1965/September 1965 ..	4,320	757	5,428
October 1965/March 1966 ..	5,440	1,135	6,300
April 1966/September 1966 ..	5,732	712	6,372
October 1966/March 1967 ..	6,061	1,172	7,296

TABLE II

PERCENTAGE INCREASE OF WORK DONE DURING LAST TWO 12-MONTH PERIODS IN NORMAL WORKING HOURS

Year	*Average list size*	*New calls*	*Surgery consultations*
April 1965/March 1966 ..	4,892	1,892	11,728
April 1966/March 1967 ..	5,794	1,884	13,668
Percentage change ..	*18.4+*	*0.4 −*	*16.6+*

Notes for tables I and II.

1. Normal working hours are 0900 hours–1800 hours Monday to Friday, 0900 hours–1230 hours Saturday.
2. On 1 July 1965, approximately 1,740 patients were added from a retired partner. The figures have been adjusted in table I to show an average for the 6/12.
3. Surgery consultations do not include a small branch surgery which remains fairly constant.
4. List numbers do not include a boarding school of 215 approximately.

offer them a good service at the consulting room, many of them are only too prepared to come in: some prefer it. We started an appointment system two and a half years ago and now consult throughout the majority of the working day by rota. In the last two years, although the list numbers have increased rapidly, the demand for new home visits has remained static (*see* tables I and II). This was not due to any positive action on our part but, we think, has come about because the patient can now be seen throughout the day without waiting. Furthermore, by screening requests more carefully, and by asking our receptionists to put through more doubtful calls, we find we can deal with many of them adequately over the telephone, or can arrange for them to have appointments.

Let us be quite clear about this problem, because for every patient seen at home we can see at least two in our consulting rooms: at a time when most doctors are endeavouring to allocate more time to their patients, this is no small thing. Two criticisms are commonly heard. It is said that ill patients are dragged from their beds to come to the consulting room. This is not our experience. No one is denying that many people need to be seen at home, but it is another matter when the person is wandering round the house, or the patient is a small child who can often be brought by car wrapped up, seen immediately (not 20 minutes later) and taken home again, with treatment probably started much earlier. Diagnosis is often easier with instruments and lights to hand. Similarly elderly patients who really need seeing regularly could often be brought in by transport, and certainly we shall be doing this in the future, as is done in one or two places already. So we are not ceasing to visit at home; we are being more selective.

The other common criticism of encouraging consulting-room attendances, is that the general practitioner needs to know the social background of his patient which he can only get from the home. This is often true, but how many times does he need to visit a house to acquire this information? And are we, as doctors, very efficient at it? When we need a social assessment on a family, our attached health visitor can often bring back a fuller picture than we obtain. It is sometimes salutary to discover what has been missed.

Our requests for new visits are low. During the 12 months ending 31 March 1967, our practice list rose from 5,566 to 6,022 and the number of new visits was 1,884 (table II). Stevenson (1966) found 7,644 new visits in one year with 9,252 patients. Unlike his, our figure does not include night and weekend work after Saturday 1 p.m., so the figures are not strictly comparable. Even allowing for this, there is still a large difference. Unfortunately we have no records for revisits but they are very low, partly because we are very selec-

tive, and partly because our attached district nurse is now doing some (see below). Revisits are certainly fewer than new calls.

The length of the consultation

Now that appointment systems are becoming common in general practice, we need to know how much time to allocate per patient, and how much consulting time to provide per week. The time per patient varies with the individual doctor, but we find we now see six to eight patients an hour. Since a nurse has taken over many of the routine tasks we previously performed (*see* tables III and IV),

TABLE III

MONTHLY WORK-LOAD PERFORMED BY SURGERY NURSE

Work	*Nov.*	*Dec.**	*Jan.*	*Feb.*	*Mar.*	*Total*
Nursing procedures ..	90	40	77	94	117	418
Antenatal clinic numbers ..	97	48	77	91	84	397
Items dispensed	180	101	159	131	184	755

*Away one week

TABLE IV

DETAILED NURSING PROCEDURES PERFORMED BY SURGERY NURSE

Procedure	*Nov.*	*Dec.**	*Jan.*	*Feb.*	*Mar.*	*Total*
Immuniz. injection	18	8	17	12	18	73
Vit. B_{12} injection	19	6	11	13	15	64
Desensit. vaccine	10	6	8	22	56	102
Influenza vaccine	12	1	—	—	—	13
Other injection	6	2	4	7	12	31
Oral polio	12	8	19	8	13	60
Vaccination inspection ..	—	1	—	—	—	1
Suture removal	3	—	1	5	1	10
Dressings	9	8	13	25	10	65
Ear syringing	7	3	11	2	4	27
Strapping etc.	1	1	4	1	1	8
Venepuncture	—	—	—	—	1	1

*Away one week

At the moment the doctors do vaccinations. The infant welfare clinic which one of the doctors also runs does many of the immunizations which otherwise would be done by the nurse.

a higher percentage of patients need ten minutes rather than five minutes (used for consultations that we know will be quick). We used to consult faster, but we feel that both the patients and ourselves have benefitted by the change.

This seems to be a much more leisurely rate than that of many

doctors. An average of eight to nine per hour is often quoted. Eimerl and Pearson (1966) with the Royal College of General Practitioners in February 1965 report an average of 210 patients seen at the 'surgery' in just under 19 hours (11 patients an hour). Hattersley (1967) states ten consultations per hour is successful.

The total consulting time required per week is another factor. Stevenson found 1¼ hours/week/200 patients was satisfactory. We prefer to allocate 1½ hours/week/200 patients at risk, presumably partly explained by the slower rate of seeing patients. This figure includes antenatal clinics but not the nurse's sessions. At a lower rate, several patients were having to be fitted in at the end of many sessions as emergencies. Now the figure is one or two at the most, and life is less harassing. The patients make fewer complaints about being unable to obtain appointments quickly.

The consultation rate at the consulting room per patient per annum is much lower than Stevenson's. For October 1964 to September 1965 he quotes 29,896 attendances per population of 9,252 (3.2 per patient per annum). From April 1966 to March 1967 we had 13,668 attendances per population of 5,794 (2.3 per patient per annum). A small branch surgery number has to be added to this, but it would raise our figure only by about 0.1 per patient per annum.

It is tempting to guess at the reasons for these differences. Perhaps it is because we have a relatively young practice, although paediatrics and obstetrics can be just as time-consuming as geriatrics (table V). Perhaps by seeing patients at the slower rate of six to eight per hour, the patients do not need to return so often. Can we afford to be so leisurely? Admittedly between three doctors we only have an average list of just over 2,000. But in addition to this work, we do six hospital sessions per week and have several other regular commitments. We find no difficulty in fitting in the required consulting time, provided we see patients throughout the day on a rota. The last appointments are made at 5.50 p.m. and there are rarely any extras to be seen.

TABLE V

PROPORTIONS OF THE PRACTICE IN TEN YEAR AGE GROUPS

Year of birth	*Percentage*
1958–57	*17*
1948–57	*13*
1938–47	*13*
1928–37	*14*
1918–27	*14*
1908–17	*12*
1898–07	*9*
1888–97	*5*
1878–87	*2*
1868–77	*0.4*
Unknown	*0.6*

These figures do not include a boarding school of approximately 215 pupils.

Who shall see the patient?

In the majority of traditional British practices, this question has

been only infrequently, if ever, asked, at least until recently. The family doctor has always seen everything, be it a cut or a child with a feeding problem. But should this be so? Is it necessary, and, more important, are we always the best people to do it?

The modern concept is of a health team in the community, and if it is to be more than merely a concept, then we must get down to making it a function. There is no doubt that attachments of health visitors and nurses are proving of enormous value, but we believe there are practices with attachments, in which the personnel are only making superficial contact. This is partly because these health visitors and nurses have full commitments before they start, and partly because we as doctors are often reluctant to share our problems. We have found, in common with many other group practices, that the first important thing in running a team is good communication. So we have our coffee break in the morning, with all the clinical staff present, and all overlapping problems are dealt with.

The health visitor has inevitably acquired a medicosocial aspect to her work. She assists with all social matters, and takes a great load off our shoulders (*see* table VI). Similarly, she deals with

TABLE VI

MAIN GROUPS OF CASES REFERRED TO OR DISCUSSED WITH HEALTH VISITOR DURING FIRST NINE MONTHS OF ATTACHMENT

Age group	*Problems*	
	Referred	*Discussed*
Geriatric	Re-housing Sanitation Arranging dental, chiropody and opticians treatment Home helps	Emergencies, hospital admissions etc.
Middle age		Newly widowed Depressed states
Young couples ..	48 hour discharge Home helps	Poor home managers Puerperal depression
Children	Heaf tests and BCG Domiciliary immunization Feet exercises Dietary problems	Enuresis management Behaviour problems

many infant welfare problems that we would otherwise see, but because of the closeness of contact, we remain in touch with the

situation. As the patients come to realize she is one of us, they approach her more often. Between us we are planning an active programme of health education: already she runs relaxation and mothercraft classes and together we run a regular evening session for all the couples expecting their first babies. Whether the health visitor's work will remain in its present form is a matter for debate. Much of her traditional work would appear to be unnecessary, or capable of being done by someone less well qualified.

The nurses who work with us at the moment are of two kinds. First, we employ our own nurse in the consulting rooms who deals with all nursing procedures, and a considerable amount of dispensing. She also runs the antenatal clinics: this will alter somewhat when a new district nurse-midwife is attached. Eventually when there is a treatment room, a rota of nurses will, in addition to nursing procedures, collect pathological specimens and deal with all minor injuries. Marsh (1967) has analysed his surgery nurse's work and ours performs a similar task (*see* table III and IV). She is employed for only three hours a day because our present building is inadequate and the rooms are required by the doctors for most of the day. Naturally her scope will increase considerably when we have full-time cover. Her role may alter when we have further local authority attachments.

The attached district nurse, in addition to a certain amount of traditional work, is employed in special work for and with the doctors on the district. This is in the experimental stage, and is probably the field in which the biggest changes will come. We hope to publish a detailed analysis of this work at a later date. Again, first class communication is essential. The nurse becomes more of a 'ward sister' on the district rather than, what usually happens, just a person who gives bed baths and enemas. These are jobs for state enrolled nurses and nursing auxiliaries. Lisbeth Hockey (1966) has said that much of the nurse's present work does not require professional skills, and she comments on the very little contact with general practitioners, hospitals, health visitors, and other workers. She also says that most doctors are ignorant about district nurses' qualifications and the help they could give.

It is often stated there is no substitute for the doctor. This is not our experience. Patients know full well a competent nurse or technician is much better at many procedures than a doctor, and they appreciate the doctor has more time to talk to them. They are coming to accept that the nurses, midwives and health visitors work very closely with us.

Discussion

Any enterprise that is to flourish in our modern society must keep pace with the times. We must move forwards or we retreat. Gen-

eral practice has remained static for too long, and the ball is in our court. What do we really want? Surely much of the answer must be more time to devote to diagnosis and presymptomatic diagnosis of disease, and more time to listen to our patients' problems. It must be the chance to do the work we trained to do, and some work that as yet we have not been trained to do. It need not include unnecessary work, or work someone else can do for us. Only by thinking carefully about what we do, why we do it, and what we can delegate, will we increase this vital commodity of time. And this is important if we are to keep our professional standards, to teach students, and to perform preventive medicine in the community. It may be that we shall want to return to some hospital work—we find this stimulating, not detrimental to our practice. Are all these things bad for the 'doctor–patient relationship'? On the contrary, they cement it more firmly together.

Eimerl and Pearson (1966) say there are signs of change in the way younger men practise but "wonder if this is fast enough for the challenge of our time". They say "we must learn how to use scarce medical skills to full advantage". They mention "factors of surprising rigidity in the ways of working".

We hope general practice will flourish and grow in the years ahead. It may be a rather different picture from what we know today. It may be that if we do not change, we shall die out altogether. This, neither we, nor the community we serve, can afford.

Summary

The trend towards reducing home visits is discussed and a reduction in requests is shown when a satisfactory appointments system operates.

The length of time needed for consultations is discussed and the possibility that a more leisurely rate may reduce the overall numbers of consultations is mentioned.

The need for an active approach to the health team is stressed and some of the members' work is discussed.

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