HOW MANY PATIENTS?

THE number of patients a doctor can look after properly is a key index of care. As the basis of medical care in Europe, and other parts of the world, is fast centring on the primary physician, the population that he can care for now interests both doctors and governments.

List size

For historical reasons data are best obtained from the United Kingdom. The introduction of the National Health Service in 1948 led to over 98 per cent of the British population registering with a general practitioner. The list concept thus became established and average numbers of patients per doctor began for the first time to be discussed. The national average list size has always been about 2,500. Periodically, limits have been introduced and currently British doctors are discouraged from having more then 3,500 patients on a single list. Rarely do doctors care for more than 4,500.

Such accurate numbers are not always known in general practice in other parts of the world and in Europe, in Australasia, and in the north American continent general practitioners still may not know the exact number of patients for whom they are responsible.

In countries where numbers are known, 2,500 patients seems low. In Scandinavia, for example, it is common for general practitioners with their health teams to care for over 5,000 patients.

Compared with other indices of medical care, the list size has moved within surprisingly narrow limits although such figures include wide variations among practices. Nevertheless it has only varied from 2,257 in 1961 to 2,400 in 1971—a change of a mere 143, during a decade of unparalleled change in the organisation of general practice.

Attitudes to list size

In the early years of the National Health Service considerable emphasis was placed on the list size. The financial basis of health service general practice at that time hinged on the capitation fee, which was then almost the sole source of income.

General practitioners have hitherto been somewhat sensitive in discussing or even disclosing the exact size of their practices. Even ten years ago it was rare to hear principals reveal the size of their own list.

At that time there was much discussion about optimum and maximum list sizes: nowadays, there is less. Much more emphasis is now being placed on the quality of the practitioner, his training, his tools, and his team, and secondly, the financial significance of the capitation fee as a proportion of general practitioners' income has progressively declined.

As a result, the *status quo* of the list size has come to be accepted—almost unquestioned. Much of the current organisational planning for and in general practice is being devoted to methods of improving the delivery of care with the implicit assumption that 2,500 patients per doctor is about right. Elaborate costings, carefully contrived attachment ratios, plans for future vacancies, teaching requirements, and a host of other projections are being constructed—yet all rest on this one fundamental assumption.

Surprisingly little objective work has been done to test if 2,500 is indeed the optimum number. How many patients can a general practitioner look after? By varying the size or the skills of the supporting team, the premises, or the organisation, can a doctor look after more patients equally well?

Caring for more patients

This issue of the *Journal* contains a paper by Dr John Fry which provides much food for thought. He believes that during his last 21 years in practice, he has become able to look after many more patients. He currently cares for 4,500 and believes he provides better care than when his list was smaller.

Data are given for 21 years to show this trend, and emphasis is given to the falling number of home visits.

Such a very personal approach is certain to arouse interest; it may attract criticism. Such criticism could take three forms: firstly, the accuracy of the data; secondly, the possibility of bias; and thirdly, the suggestion that quantity and quality of care might be inversely proportional.

Accuracy of the data

Accuracy of the data is not likely to be seriously disputed. Few practices have kept such records, and even fewer for so long a time. Furthermore, some of these figures have already been published (*Present State and Future Needs*, 1970).

Possibility of bias

Secondly, comment could occur about the possibility of bias. Is this a special practice? Could these patients be abnormally fit, abnormally young, or have an unusual social class distribution? Are the doctors themselves different?

Certainly it would be interesting to know the age-sex and social class structure of this practice and the boundary of the practice area. It seems improbable, however, that this practice population differs markedly from the average in that part of England. On the other hand, there is certainly evidence that Drs Fry and Dillane are more active than many of their colleagues. Both are well known for the work they have published and Dr Fry himself takes part in a particularly wide range of professional activities.

However, the question remains, if care for 9,000 can be provided by two doctors with such other commitments, why is it not possible for others?

Quality of care

The third potential criticism is the question of quality. If a practice of 9,000 patients is only generating three visits a day, including re-visits, are patients receiving adequate care in the home? What pressures are placed on those who request home visits? What kinds of condition are brought to the surgery? Do any patients suffer? Do patients like it?

At first sight, it appears that coronary thrombosis, pneumonia, prolapsed intervertebral disc, measles and miscarriages might alone account for more than this number of home visits. Many may wish to know how common clinical conditions are managed in this practice.

Apart from the low home visiting rate, a falling surgery consultation rate is reported as well. Questions will arise as to the kind of consultation that does occur. What work is done, how much is delegated, what is referred? In this context the simultaneous reduction of the consultant referral rate both at outpatients and domiciliary visits is even more interesting.

Revolution in organisation

During the last 15 years there has been an organisational revolution in general practice. Although reports of major changes in list size may seem surprising, perhaps they are only to be expected.

The mass introduction of new administrative methods, such as appointment systems and the introduction of new members of the general-practitioner team have occurred on a previously unprecedented scale. All these changes, if they are improvements, ought to lead to changes in efficiency and be measurable in the indices of general-practitioner care.

Some of the improvements may have led to a reduction in the excessively long hours of duty previously worked, some to improvements in the quality of care provided—but it does not seem *prima facie* absurd that some should also have led to care for increased numbers of patients. Delegation to the practice team should in theory free the doctor, and make him able to look after more patients.

Comparative studies

Some other published papers support Fry's central thesis that general practitioners are progressively becoming able to care for larger populations, although they may not always choose to do so. Marsh (1968) has convincingly shown the fall in home visiting, and *Present State and Future Needs* (1970) of which Fry was himself a co-author includes data confirming that consultation rates per person at the surgery are at least static if not falling. Wright (1968) in his survey in South-west England showed that consulting rates were inversely proportional to list size and doctors with less than 2,000 patients averaged 4·8 consultations per patient per year compared with 3·4 consultations per patient per year for those with list sizes of more than 3,000.

It is clear that Fry is not now alone; his thesis needs careful and critical examination. Quantity and quality are inextricably linked. Does more mean worse? Can quantity and quality simultaneously be improved? Showing an increase in quantity may not by itself be enough; it must also be shown that quality of care is at least constant if not improving. Furthermore, the measurement of quality should include some objective assessment of patient satisfaction.

These considerations thus lead increasingly to more attention being paid to the difficult problem of the assessment of quality in general practice.

Need for further research

Dr Fry, by caring for 4,500 patients and still being able to take Thursdays away from the practice each week, challenges his contemporaries—especially those who still believe that about 2,000 patients per doctor is the optimum number.

This paper raises more questions than it answers. Further information and further research are clearly needed. It is encouraging that Marsh (1972) is already working on this subject.

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