OUTPATIENT FOLLOW-UP

OUTPATIENTS have often caused conflict between consultants and general practitioners. Originating from the dispensaries for the poor and intended for those unable to afford even the lowest fee, outpatients became astonishingly overcrowded in the last century. In 1879 at St. Bartholomew's Hospital, London, " 120 patients were seen by the physician and dismissed in an hour and ten minutes at the rate of 35 seconds each " (Rivington, 1879). In another London hospital three casualty officers dealt with 500 patients in a morning and the hall-porter, whose task was to keep order, " often had to shout to make himself heard ". The crowds, however, consisted not only of the " deserving poor ", but also of large numbers of the middle classes (who would even come in their servant's clothes as a disguise), who could well afford to pay. Thus in 1870 of 641 outpatients who attended the Royal Free Hospital " 231 were well enough off to pay and 103 gave false addresses ".

Outpatients became such a threat to their income that general practitioners insisted on the rule that no patient should be seen in outpatients without the passport of a general practitioner's letter. This—the principle of referral—had far-reaching consequences: " The physician and the surgeon retained the hospital, but the general practitioner retained the patient " (Stevens, 1966).

The crowds diminished, but with the introduction of the National Health Service began to return again. Between 1949 and 1971 the population of England and Wales increased by 11 per cent, but the outpatient population increased by 35 per cent. In England in 1973 the total number of outpatient attendances was 33 million for a population of 48 million—a ratio of approximately 2 : 3. But a majority of these attendances were follow-ups, whose ratio to new appointments for all specialties was 3·2 to 1 and varied from 1·8 to 1 for gynaecology, 2·2 to 1 for E.N.T., 2·4 to 1 for general surgery and 5·1 to 1 for general medicine up to 6·5 to 1 for mental illness (Department of Health and Social Security, 1974). A reduction of the follow-up/new attendance ratio for general surgery alone from 2·4 to 1, to 1 to 1, would, in England in 1973, have saved nearly 1,500,000 attendances. How many follow-up appointments are really necessary?

Many, of course, are. Outpatient clinics providing continuing care are essential for many disorders, including, for instance, the leukaemias or renal failure. For other serious but more common diseases such as diabetes and hypertension, continuing care clinics are certainly desirable for some patients, notably those presenting particular difficulties.

Apart from clinics for continuous care which account for most medical follow-up attendances, some follow-up appointments are needed for educational reasons (education, that is, of the hospital—particularly the junior staff), and some for research. Beyond these, however, there is a large number of routine thoughtless follow-up appointments for conditions such as straightforward appendicitis, hernia operations, and cholecystectomy, which cannot be justified. Most of them are surgical and Coggon and Goldacre (1976) have shown that for appendicectomy routine follow-up is unnecessary, and also that it is not even effective as a guard against late complications, which was the only possible argument in its favour. The routine unnecessary follow-up removes the incentive from the general practitioner to undertake care after discharge from hospital. Often it discourages the patient from consulting his own doctor for much needed advice. Instead, advice is often given in outpatients by an inexperienced house officer who may not have seen the patient before; moreover, the house officer may feel he dare not discharge the patient from the clinic and perpetuates the follow-up system by saying, illogically, " Everything is fine; but come back in six months."

Faced with an overcrowded outpatients, the hospital staff are then apt to blame the general practitioner for failing to undertake care after hospital discharge, although they themselves are operating a system that prevents him from doing so. A way out of this muddle must be found, because routine follow-up appointments devalue the practitioner in the eyes of both the patient and the hospital staff, who wrongly assume that he is unwilling to undertake after-care. Recently, an editorial in *The Lancet* (1976) drew attention to the need to reform this system.

Unless there are good reasons to the contrary, the follow-up of patients who have been to hospital—either as inpatients or outpatients—should be the province of the general practitioner and his team. What other simple measure could reduce the workload of the hospital service so much and also improve the relationship between general practitioner and consultant?

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FOLLOW-UP APPOINTMENTS

" The clinical necessity of follow-up appointments, or the variation between hospitals, or between consultants in the same hospital does not seem to have been investigated. Some patients must be followed up at outpatients, but my guess is that more co-ordination between hospital and general practice in the care of convalescent patients could reduce the ratio of old attendances to new to one to one in the case of general surgery.

" Much attention has been given to the dire need for economy and 'redeployment of resources'. Follow-up appointments seem to have escaped attention, perhaps because they do not appear at first sight to offer any scope for appreciable saving. This may be so, but reducing the time wasted by doctors and patients alone seems worthwhile, and the cost of nine-and-a-half million unnecessary outpatient appointments is unlikely to be negligible. If letters sent after each outpatient visit went by second-class mail £617,500 would be saved.

" It is commonly believed that the vast legions of outpatients are due to the increasing clamour of the public for hospital care, and that demand is open-ended. I believe this is nonsense. As Professor A. E. Bennett pointed out (unpublished), it is general practitioners and not patients who use hospitals. If this is true for new outpatient attendances, follow-up appointments must be created by hospital staff. Evidence suggests that, to a great extent, general practitioners create their own workload, and also shows that there can be a 15-fold variation in referral rates to outpatients."

REFERENCE

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