How many patients?

ONE of the most detailed workload studies ever reported from general practice has recently been published. The results make interesting reading for all interested in medical practice. Marsh and Kaim-Caudle (1976) have recorded details of every consultation and visit by one general practitioner in a five-partner practice, with over 3,000 patients on his list. Furthermore, the use of hospital services both by admissions, referrals, and diagnostic investigations was recorded, as well as the workload of the practice nurse and health visitor. In addition, every patient was analyzed by the Registrar General's (1966) classification of social class, and a detailed survey of the satisfaction of patients with the services they received was carried out independently of the doctor through the University of Durham.

Four years ago we posed the question, 'How many patients?', commenting on an article by Fry (1972) in which he reported caring for 4,000 patients a year. Despite the fact that the number of patients that an average general practitioner can properly look after is one of the most crucial parameters in the whole field of primary medical care, remarkably little work has been carried out on it. Why are general practitioners so reluctant to look at this variable?

This new book, however, provides some remarkable evidence. Marsh and Kaim-Caudle report that the doctor saw his patients only 1·9 times a year on average in the surgery and carried out only 0·4 visits a year. These figures were the average figures for a whole year and one, moreover, that included an influenza epidemic. As far as we know, this is the first time a British general practitioner has shown in such a detailed survey a consultation rate of below two per patient a year. The authors state that: 'The average list size of 2,400 patients may well become too small to occupy the time of the established general practitioner, but there is also the distinct possibility that in future general practitioners will consider it reasonable to have longer lists than are acceptable at present, and indeed need these in order to satisfy their clinical interests.' These suggestions directly support Fry's original hypothesis, though curiously no reference is made to it in this book.

One of the most interesting principles of this practice is the concept of returning to single-handed lists within a big group partnership. Patients normally see their own doctor and indeed the lists are filed separately.

Furthermore, patients appear to like this as 'nine out of ten respondents were aware that each doctor had his own list of patients.' Nearly five out of six preferred to see their own doctor at the surgery. Teenagers were the least concerned about this and the figures were probably slightly less among all ages regarding home visits. Virtually all respondents who preferred to see their own doctor felt he knew and understood them; about two-thirds felt they knew and understood *him*. Subsequently it appeared that 80 per cent of those patients who shared their doctor with another person in the same household felt that they 'had a "family doctor" '.

The social class analysis is important because, coupled with the age analysis of patients, it confirms the trend that primary medical care is increasingly concentrating its work on the young, the old, and the lower social classes.

Team Care in General Practice is an important contribution to the literature of general practice—indeed it may well be one of the most important books of 1976. It probably marks the end of a phase of workload analysis initiated by general practitioners in the 1940s and 1950s, for it is hard to imagine a more professional approach. Here, every single face-to-face consultation was analyzed and computerized for a whole year. It must at the very least represent a new yardstick against which all future workload analyses will have to be judged. Apart from the importance of comparing patterns in different practices in different areas, it may mark the end of the road for such single-doctor workload studies.

The future

What this work did not do, and what now urgently needs to be done, is to change the focus from quantity to quality and start to answer the question, not how often, but why are services provided and how is the quality of service to be measured?

The Newcastle Regional Hospital Board is to be congratulated on its vision in financing a study outside the direct ambit of the hospital service. The authors should be pleased to have broken new ground and established new standards for analyzing workload in general practice.

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