Steering patients with selected conditions to trainees

R. FOURACRE, MB, BS
Vocational Trainee, Boston Vocational Training Scheme

J. N. SAVORY, MRCGP
General Practitioner Trainer, Boston

SUMMARY. A study of trainer/trainee experience during a three-month period has shown that it is possible to steer patients to the trainee if it is done sensitively. The value of steering certain patients to the trainee has also been shown. Clinical experience was comparable and did not result in any modification to the patient steering policy. Even if patients were not being steered to the trainee, monthly monitoring would be important for detecting and correcting inadequate trainee clinical experience in selected diseases, which are easily checked.

Introduction

THE clinical content of the trainee's year in general practice has been studied in broad diagnostic groups and has been shown to be reasonably comparable with that of practising general practitioners (Bain, 1969; Gilchrist and Mackay, 1973; Richardson and Howie, 1972, 1974; O'Flanagan, 1977; Carney, 1979; Stubbings and Gowers, 1979).

However, there are some problems: O'Flanagan, Carney, and Stubbings agree that trainees see less gynaecology and more upper respiratory tract infections; O'Flanagan and Carney agree that trainees see less chronic illness; Carney and Stubbings agree that trainees see fewer musculoskeletal problems; Carney saw less of certain chronic diseases and certain life-threatening diseases (myocardial infarctions and neoplasms), and a different proportion of mental illness with less depression than his trainer.

We therefore agreed to accept that, within broad diagnostic groups, trainees gain similar clinical experience to their trainers, but that gynaecology, musculoskeletal disorders, life-threatening diseases and chronic disease may be under-represented and the pattern of mental illness may be different in the trainee's experience.

Aims

Accordingly we decided to compare, over a three-month period, our trainer/trainee experience of these particular disorders by percentage of all consultations and numbers of patients, and where marked variations were found to try to correct them. It has become customary to compare percentage of consultations for given diseases; however, we felt that, if we also considered the numbers of patients seen, a clearer picture of the trainee's work might emerge.

Our aims were as follows:

1. To compare our clinical experience of these disorders, while actively steering patients with chronic and life-threatening diseases to the trainee.

2. To determine whether, with anticipation and planning, the trainer could provide the trainee with similar experience to his own, or whether monthly monitoring would lead to attempts to change the trainee's clinical experience.

Method

The practice is centred on a market town in Lincolnshire and comprises a mainly urban population with about 12 per cent of patients living in the surrounding countryside. The practice population is 7,800. There are three partners and a trainee. The practice has its own premises and the trainee his own room. All obstetric care is shared with the local district hospital in the town. There is a full appointment system. Patients usually see the doctor of their choice, and nearly all patients with new problems are seen on the same day. The age distribution of the practice is shown in Figure 1. The social class distribution is, we think, lower than average.

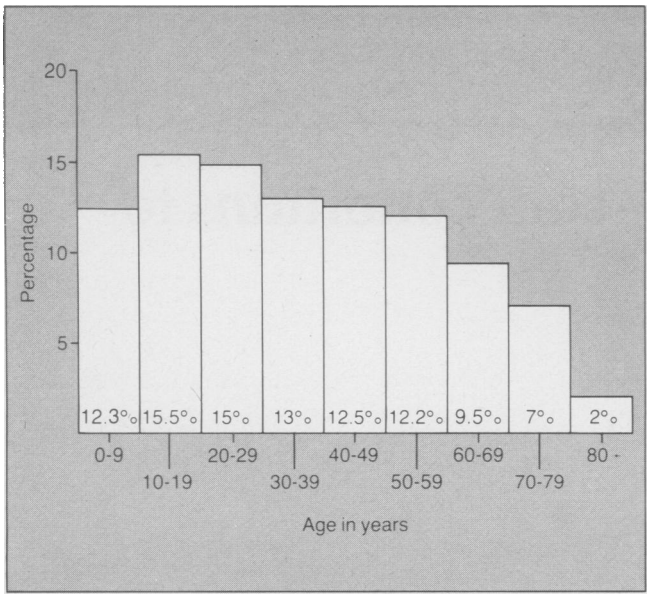

Figure 1. *Practice age distribution.*

In order to limit the workload caused by the survey and avoid hiding important detail, we decided to depart from the RCGP one to 18 broad group morbidity classification (1974) and to determine the specific diseases we wanted to include in our broad diagnostic groups. The identical RCGP classification numbers are given for comparative purposes (Table 1). The difficulty is that the surveys mentioned in the introduction divide morbidity into the 18 RCGP broad groups. Thus gynaecological disease is included in genito-urinary (10); diseases of the nervous system and sense organs (8) include major and minor nervous system diseases and sense organ diseases, e.g. otitis media; and chronic diseases occur in several of the 18 broad groups. Thus, using the RCGP one to 18 broad groups hides gynaecology, life-threatening diseases, and chronic diseases.

We recorded during the trainee's second, third, and fourth months. We each recorded the patients' names in an exercise book, the pages of which had been labelled with the specific diseases. The first consultation about each disease episode was indicated by an 'N' after the patient's name, subsequent consultations being indicated by a 'C' after each name, e.g. on the depression page: Eileen Page NCCC; Rose Smith NCC.

If more than one diagnosis was involved, both were recorded. At the end of each month we compared our figures.

Chronic disease steering

Patients with chronic diseases who attended the surgery were asked by the trainer whether they would be willing to see the trainee for the next six months and then revert to the trainer. They were assured that they would be free to see the trainer at any time. This was arranged before the trainee's arrival in the practice. The trainer envisaged that each six months about a quarter of his suitable chronic patients would be looked after by a trainee. Thus in a two-year cycle, each patient would be looked after by the trainer for 18 months and would rotate to a trainee for the other six months. A disease register was used to achieve this.

Table 1. Specific diseases in broad diagnostic groups.

1. Gynaecological problems (323-329, 331, 334, 335, 342, 348, 350, 367): vaginal discharge 335, prolapse 324, menopause 329, all menstrual problems 326-328 + 334, infertility 331, termination 367, spontaneous abortion 350, dyspareunia 342, ectopic pregnancy 348, dysmenorrhoea 325, vulva and labia disorders 331, pelvic inflammatory disease 323
2. Contraception: Pill, coil, cap, other 585, 586
3. Breast problems (benign) 322
4. Maternity 352, 346, 364
5. Sterilization—male and female 573
6. Accidental musculoskeletal 168, 404, 406-427, 467-483
7. Selected life-threatening disease:
   (a) Neoplasia as RCGP 2. 50-68
   (b) Myocardial infarction 211
8. Chronic illnesses:
   (a) Central nervous system as RCGP 6 (155-158, 160): without special senses, migraine, vertigo and sciatica, i.e. cerebrovascular disease 155, disseminated sclerosis 156, Parkinson's disease 157, convulsions 158, and other major CNS disease 160
   (b) Cardiovascular system: hypertension 218, heart failure 215, 216, angina 230, chronic arrhythmias 214
   (c) Endocrine: thyroid disorders 88-90, diabetes 91
   (d) Anaemias: all 110-112
   (e) Rheumatoid arthritis 405
9. Mental illness as RCGP 5: major mental 124-129, depression 134

The patients who needed visiting were not usually given the choice. Their names, addresses, and details were given to the trainee who then introduced himself and explained the arrangement. The trainer likewise envisaged a two-year cycle of care for these patients. At first this reduced the trainer's chronic surgery and visiting workload, but any new chronic patients acquired by the trainees were handed over to the trainer at the end of each six months, gradually making up the workload.

Myocardial infarction and neoplasia

The trainer saw two patients with myocardial infarction (one just before the survey began) when he was on call at weekends. He made the clinical diagnosis and the initial decisions to treat the patients at home. He explained to the patients that the trainee would visit the next day and continue the care. In both cases this was done successfully in that the trainee made all the subsequent decisions about diagnosis, investigation, and management and no objections were raised by the patients. The trainee saw three other patients with

myocardial infarction while on call. He managed two of these at home himself and correctly sent the third into hospital because of the social circumstances.

The trainee saw three patients with cancer while the partner who usually looked after them was on holiday, seeing each one a few times. However, this was much less satisfactory for him than managing the two cancer patients steered to him. One was an elderly lady who lived alone, with cancer of the pelvis (initially cervix). He had seen her with a mild stroke and when, shortly afterwards, her cancer was diagnosed by the health visitor and trainer, we agreed that it would be appropriate for him to continue her care. He made the decisions about referral and what to tell her, and continued to see her at home. The other was an elderly lady with hypertension and breast cancer. The trainer steered her to the trainee for home visiting at the beginning of his six months. She presented many problems which the trainee managed competently with some discussion with the trainer, which was encouraging rather than directive. She eventually died, as was expected, while still under the trainee's care. Neither of these patients were given the choice; both were happy with their young doctor. In both cases, giving them the option would have put them in a situation in which they would have felt an obligation to choose the trainer.

Results

The trainer's and trainee's clinical experience of the broad diagnostic groups, by percentage of consultations and numbers of patients, is shown for the three months in Table 2 because monthly analysis showed problems only with maternity and contraception. A statistical analysis is not given because we do not feel that it clarifies the results; thus for diabetes, the trainee had three times as many consultations but four fifths the number of patients.

Discussion

Analysis of the first month's figures, not presented here, showed the trainee's lack of experience in maternity and contraceptive work. As the trainer and his midwife see antenatal patients alternately in a separate clinic, further delegation was considered undesirable and so the trainee sat in on some antenatal clinics. Analysis of the trainee's relative lack of contraception experience showed similar numbers of patients requesting contraceptive help for the first time, and the trainer's excess of prescription repeats for the Pill was considered unimportant.

The trainer and trainee had similar experience for both percentage consultations and numbers of patients with gynaecological problems. If gynaecology, new contraception, breast diseases, and sterilization are combined, the trainer's percentage of consultations was 3·9 per cent and the trainee's 3·4 per cent, with the trainer seeing 44 patients and the trainee seeing 36. The trainee saw more patients with musculoskeletal problems and his percentage of consultations was greater than the trainer's. This was mainly due to the trainee seeing more low back pain. This result is at variance with previous reports.

Steering and sharing of patients with neoplasia resulted in similar and satisfactory experience and his excess of coronary care resulted in the trainee gaining more experience of life-threatening diseases than the trainer.

The trainer saw more patients with chronic diseases but, because the trainee saw his patients more frequently, his percentage of consultations was greater. The general practice and hospital approaches to chronic disease differ and this experience provided valuable learning opportunities. The policy of steering some of the trainer's chronic patients to the trainee contributed 28 patients (35 per cent of all the trainee's chronic disease patients), and increased his percentage of consultations from 10·6 per cent to 16·8 per cent. This clearly enriched his experience, particularly as these patients were 'his' for the six months.

Criteria for diagnosing depression vary from doctor to doctor. We formed the impression in our seminars that we had similar diagnostic criteria for diagnosing depression, and our figures are similar. This suggests that we saw similar numbers of depressed patients, but this would be difficult to prove.

Major mental disorder is another group of chronic disorders in which the trainee will be very unlikely to make an initial diagnosis. His experience therefore will probably be limited to seeing patients when their doctor is on holiday. Three such patients were steered to the trainee for the six months—a manic depressive and two schizophrenics—and they increased his percentage of consultations by 70 per cent.

Twelve of the 28 patients steered to the trainee needed visiting, the remainder attending the surgery. Trainees tend to feel strange at first when seeing patients in their homes because they have little previous experience of such encounters. During a six-month general practice attachment the trainee is unlikely to acquire many patients who need chronic visiting and the trainee found this opportunity helpful and enjoyable.

On the whole, the trainer steered to the trainee fairly phlegmatic patients who accepted their illnesses philosophically and minimized their disabilities. Some emotional patients seem to become so dependent on their doctor for support and encouragement that to ask them to see the trainee for six months would be unfair. Some slightly emotional patients were asked and were unhappy about it and their wishes were respected. A few expressed a feeling of rejection. With a little experience, predicting who would not mind seeing the trainee became quite easy, though there were some surprises. A phlegmatic 60-year-old man with disseminated sclerosis and his rather emotional wife, who tends towards

Table 2. Trainer's and trainee's clinical experience of the broad diagnostic groups, by percentage consultations and numbers of patients steered to trainee, and percentage consultations due to them.

Disease groups and sub-groups		Percentage consultations		Trainee's percentage of all his consultations due to steering	Trainee's percentage of consultations for this disease or group due to steering	Number of patients		Number of patients steered to trainee	Trainee's percentage of number of patients with this disease or group, due to steering
		Trainer	Trainee			Trainer	Trainee		
Contraception	New	*0.6*	*0.4*	*0*	*0*	6	5	0	*0*
	Old	*3.8*	*2.4*	*0*	*0*	55	27	0	*0*
	Total	*4.2*	*2.8*	*0*	*0*	61	32	0	*0*
Maternity	New	*0.4*	*0.2*	*0*	*0*	5	1	0	*0*
	Old	*2.2*	*0.4*	*0*	*0*	15	7	0	*0*
	Total	*2.6*	*0.6*	*0*	*0*	20	8	0	*0*
Gynaecology	New	*1.5*	*1.0*	*0*	*0*	20	12	0	*0*
	Old	*0.8*	*1.3*	*0*	*0*	5	9	0	*0*
	Total	*2.3*	*2.3*	*0*	*0*	25	21	0	*0*
Breast problems	Total	*0.5*	*0.2*	*0*	*0*	7	3	0	*0*
Sterilization	Total	*0.5*	*0.5*	*0*	*0*	6	7	0	*0*
Accidents and	New	*3.2*	*4.4*	*0*	*0*	39	54	0	*0*
musculoskeletal	Old	*3.6*	*5.9*	*0*	*0*	14	37	0	*0*
excluding rheumatoid arthritis	Total	*6.8*	*10.3*	*0*	*0*	53	91	0	*0*
Life-threatening									
Coronaries	Total	*0.1*	*1.4*	*0.6*	*43*	1	5	2	*40*
Neoplasia	Total	*1.0*	*1.1*	*0.8*	*73*	9	5	2	*40*
All	Total	*1.1*	*2.5*	*1.4*	*56*	10	10	4	*40*
Chronic diseases									
Central nervous system	Total	*2.8*	*3.8*	*1.4*	*37*	18	19	6	*32*
Cardiovascular system	New	*0.1*	*0.2*			2	3		
Hypertension	Old	*3.9*	*3.6*			40	14		
	Total	*4.0*	*3.8*	*1.7*	*45*	42	17	8	*47*
Heart failure	New	*0.1*	*0.3*			0	4		
	Old	*2.8*	*1.7*			25	5		
	Total	*2.9*	*2.0*	*0.6*	*30*	25	9	3	*33*
Angina	New	*0.1*	*0.3*			1	4		
	Old	*1.8*	*2.1*			17	11		
	Total	*1.9*	*2.4*	*0.3*	*12.5*	18	15	2	*13*
Arrhythmias	Total	*0.4*	*0.3*	*0*	*0*	2	2	0	*0*
Anaemia	Total	*0.4*	*0.6*	*0*	*0*	3	2	0	*0*
Thyroid	Total	*0.4*	*0*	*0*	*0*	6	0	0	*0*
Diabetes	Total	*1.1*	*3.3*	*1.7*	*52*	15	12	7	*58*
Rheumatoid arthritis	Total	0.8	0.8	0.5	62.5	5	3	2	*67*
All	Total	*14.7*	*16.8*	*6.2*	*37*	134	79	28	*35*
Depression	New	*4.6*	*3.7*			20	23		
	Old	*1.4*	*1.8*			24	15		
	Total	*6.0*	*5.5*	*0*	*0*	44	38	0	*0*
Major mental disorder	Total	*1.0*	*1.0*	*0.7*	*70*	10	6	3	*50*

Total consultations: Trainer 1,358; Trainee 1,258.

alcoholism, had seemed to be fairly dependent upon their doctor, but when they were rather cautiously offered the trainee, they were most enthusiastic. The trainee found that the more emotional patients accepted the arrangement a little less happily than the phlegmatic ones, but he found that this was quickly overcome by very frequent initial visiting. Most, on reversion to the trainer, said that they had enjoyed having a new young doctor temporarily. Only one had misgivings. He had severe rheumatoid arthritis and had developed proteinuria while continuing his gold therapy. We discussed his problems fully, but perhaps it would have been wiser for the trainer to have continued his care when this serious complication developed, since he was in a better position to support the patient through this reverse, as a result of a long established, trusting relationship. Two rather demented old ladies could not express an opinion about being looked after by the trainee. In their cases the main factor was building up a good working relationship with the families, who appreciated initial frequent visiting. None of the patients whom the trainee visited objected to not being given any choice and most, on reverting to the trainer, said that they had enjoyed the change. Nevertheless, with better planning ahead, some could and should have had the choice.

A disease index is essential when selecting each six months' quota, and must show which doctor has been responsible for the patient during the previous 18 months. As part of the value of the trainee seeing chronic patients is for him to experience giving continuing care, it is inappropriate to steer to him patients who do not need to be seen very often, such as those with controlled myxoedema.

References

Bain, D. J. G. (1969). The first freedom. *Journal of the Royal College of General Practitioners,* **17**, 29-35.

Carney, T. A. (1979). Clinical experience of a trainee in general practice. *Journal of the Royal College of General Practitioners,* **29**, 40-44.

Gilchrist, I. C. & Mackay, J. (1973). Personal points of view. *Health Bulletin,* **31**, 271-275.

O'Flanagan, P. H. (1977). One trainee's clinical experience. *Journal of the Royal College of General Practitioners,* **27**, 227-230.

Richardson, I. M. & Howie, J. G. R. (1972). A study of trainee general practitioners. *British Journal of Medical Education,* **6**, 29-31.

Richardson, I. M., Howie, J. G. R. & Berkeley, J. S. (1974). A further study of trainee general practitioners. *Journal of the Royal College of General Practitioners,* **24**, 661-665.

Royal College of General Practitioners, Office of Population Censuses and Surveys & Department of Health and Social Security (1974). *Morbidity Statistics from General Practice. Second National Study 1970-71.* London: HMSO.

Stubbings, C. A. & Gowers, J. I. (1979). A comparison of trainee and trainer clinical experience. *Journal of the Royal College of General Practitioners,* **29**, 47-52.