

Can an optimum list size be estimated?

Sir,

The number of patients attended by a general practitioner during a working day (r) depends on two factors; the size of the doctor's list (n) and the probability (P) that a patient will receive attention. The probability can be derived by dividing the annual work rate (expressed as patient contacts per year) by the number of working days. It can also be estimated from records collected over a sample observation period.

As far as published studies indicate¹ a rough approximation for P in an 'average' practice is 0.02, based on an annual rate of four contacts per patient per year and a five day working week.

The number of patients receiving attention in one day in a practice is

$$n \times P = r$$

This observation could provide a method for estimating an optimum list size, because if r is optimal for a given P the value for n which satisfies the equation must also be optimal.

It should be possible to estimate an optimal daily work rate. On commonsense grounds, one would expect the figure to fall between 10 and 50 patients per day.

The uncertainty of this assertion would be reduced by a study in which a sample group of doctors would be invited to handle a number of simulated situations as though they were working under ideal conditions. The situations would be structured to include activities such as examination, side room and laboratory testing and counselling with the purpose of establishing the time which should be allocated to them. The measurements would be extrapolated to estimate the number of people who could be managed in this way in a day. The extrapolation would be based on a notional representative morbidity pattern for a day.

While it is accepted that the estimates might occupy a range, the concept of a range of values is of more practical use than the concept of an all-embracing result. Buchan and Richardson² have shown that such a study is feasible, although their measurements were made in the context of active practice and indicate what is possible within the constraints of the service situation rather than what is desirable.

If a suitable range for r could be identified by this method the estimated range for an optimal list size would be calculated from

$$n = \frac{r}{P}$$

The approach is illustrated by an example in which 30 patients per day is suggested as the optimum and $P=0.02$. Under these circumstances $n=1500$, the size of list envisaged in the Gillie report.

The present average list of 2,000 gives a daily working rate of 40 patients for the same probability.

The list size problem is topical because of current interest in audit and the possibility that the general practitioners contract may be revised.

If College is to advise on these matters, its advice should be based on reason and measurement and it seems that an approach to the problem along the lines indicated here could only be helpful.

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References

1. Butler J. *How many patients?* Bedford: Bedford Square Press, 1980.
2. Buchan IC, Richardson IM. *Time study of consultations in general practice.* Scottish Health Service Studies. Edinburgh: Scottish Home and Health Department, 1973.

What is the role of training for the medical receptionist?

Sir,

Earlier this year I undertook a piece of research on the role of training for the medical receptionist. Suitable questionnaires were distributed among doctors and medical receptionists within one Family Practitioner Committee area in Inner London. Opinions were sought from doctors as well as from medical receptionists, both trained and untrained, with regard to the content of courses and on the advisability of undertaking them. The results of the study are summarized below.

Most of the general practitioners were unable to judge the usefulness of the Association of Medical Secretaries, Practice Administrators and Receptionists (AMSPAR) Certificate in Medical Reception, probably due to lack of knowledge of the course content. However, the majority considered a medical receptionist course would be useful and were quite flexible with regard to possible course patterns. Of the subjects already being taught on AMSPAR courses, they considered Communication, General Practice Administration and Social and Welfare Services to be the most important areas of study on courses. They also thought dealing with ethnic groups who have language problems, book-keeping and new technology would be useful.

In the case of the receptionists, those who had attended courses found them to be of benefit while most of those who had not attended courses did not think they would benefit from attending them. The areas of study considered most useful by those who had attended courses were Communication, Medical Ethics and Medical Terminology. Those who had not attended courses considered Communication, Medical Ethics and General Practice Administration would be most useful to them. Like the general practitioners, the receptionists thought that it would be necessary to keep up-to-date with new technology in relation to their work. In general, it does

seem that both general practitioners and receptionists were in agreement with regard to topics for inclusion on courses.

There are various training courses available throughout the country for medical receptionists working in the field. However, AMSPAR is the only body to provide nationally recognized standards to candidates who are successful in their examinations. Bain and Durno¹ indicated, using patient management questions, that standards achieved by receptionists are dependent on both attendance at formal courses and regular in-service training and review. In their report² the AMSPAR/RCGP Working Party suggested a model for part-time training, geared to local needs, which could lead to the award of the AMSPAR Certificate in Medical Reception.

In conclusion, it did seem from the questionnaires returned that general practitioners, while willing to send their staff on courses, were unaware of course content. I hope that this letter has gone some way towards clarifying the sort of subjects which are studied on courses and how they may prove useful to the receptionist in her work and hence to the general practitioner in his.

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References

1. Bain DJG, Durno D. Assessment of receptionists by questions on patient management. *Br Med J*; 284: 1165-1167, 1982.
2. AMSPAR/RCGP Working Party Report. Receptionist training for general practice. AMSPAR, 1983.

Choice or chance? An audit of patients' complaints

Sir,

May I comment on a small audit I conducted in my practice in late July 1984. It was to ascertain roughly the extent people were accountable for their ills, that is, to decide if their sickness was providential, as formerly held, or related to their lifestyle. Thus an insect bite I attributed to 'chance' and alcoholism to 'choice', likewise a man suffering from Parkinson's disease can hardly be blamed for his predicament (boxers excluded) and a sunburnt lady cannot blame others for hers.

To what extent then did 'choice' and 'chance' account for the conditions seen in my general practice audit?

From 100 consecutive consultations I attributed 50 of the complaints to chance and 34 to choice. There were 16 equivocal assignments including four contraceptive Pill repeats and two new pregnancies. The use of the Pill may be considered as choice, but there is an element of risk or chance with sex which gives the patient little choice.

But however caused, the audit only represents that proportion of people who decide to complain. Of what

significance then are the motives for consultation? It seems that frequently it was the anxiety the complaint engendered, rather than the suffering it caused. Not the condition then nor the suffering but the fear of its possible implication was the motive for consultation. Patients are often prepared to let an unpleasant condition pursue its natural course if assured of its eventual resolution, but will suffer much anguish from a milder condition if they fear its implications.

Hence some consult while others with the same condition do not, depending on their attitude, and the conditions consulted for in this survey included sore throats, a wart, a sprained ankle, a pulled neck muscle, common colds, an abrasion, a cough, a mild diarrhoea, mumps and insect bites. Yet, knowing the outcome of these conditions, do doctors ever contemplate treatment for themselves? But they often give medication to patients and medicalize an attitude, whereas explanation and description rather than prescription may suffice.

Other choice consultations included dyspepsia from dietary indiscretion, depression while living with a boyfriend because of parental disapproval, paronychia from household chores and a request to rewrite a lost hospital appointment letter, and further chance conditions included repeat consultations for epilepsy, schizophrenia, the Parkinsonism and maturity onset diabetes. But even here the diabetes was really an outcome of long term dietary excess, but let us not go to extremes.

The implications of all this are that whatever the origin, whatever his attitude, much of man's destiny lies in his own hands — he needs to stand on his own feet. The doctor's role is primarily educational (*doctum* = learned), and in fulfilling this he largely fulfills his therapeutic role.

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A nationwide prospective study of epilepsy in general practice

Sir,

A major nationwide prospective study of epilepsy in general practice was launched in May 1984. This is based at the Institute of Neurology, Queen's Square, London, and at the Chalfont Centre for Epilepsy.

Our aim is to study the clinical features and prognosis of patients with newly diagnosed epilepsy, identified at and followed from the time of diagnosis. The success of the study depends on the participation of general practitioners from various parts of the UK. An average practice, with a list size of 2,000, can expect to see about two patients per year with newly diagnosed epilepsy and the doctors taking part in the study will be asked to spend a little longer with these patients to fill in the necessary paperwork of three questionnaires per year for each patient. No other action will be required.