

Consultation length

Sir,

The influence of list size on the performance of general practitioners is a key issue¹ in formulating both national policy for delivering health care and College policy with regard to quality assurance. When examining performance, we must be satisfied that we have a valid measure. In their analyses of general practitioner workload, Wilkin and Metcalfe² and Knight³ used practice booking interval as a proxy for duration of consultation and analysed it as such in relation to list size.

As part of the practice activity analysis programme at the Birmingham Research Unit 17 general practitioner principals timed 3867 patient consultations and scored them in five minute bands. New and follow-up consultations were scored separately as were 204 of the consultations which were interrupted, for example by telephone calls. The distribution by duration of the 3663 uninterrupted consultations is given in Table 1. Approximately 50% of all consultations lasted less than five minutes and 90% less than 10 minutes. There was no difference between new and follow-up consultations. The method does not permit the calculation of a mean consultation period but we can estimate that it lies between six and seven minutes. There was a significant negative association between the proportion of consultations lasting less than five minutes and list size ($n=17$, $R=0.58$, $P<0.05$).

The majority of doctors (15 out of 17) were in training practices and their willingness to participate in such a pilot study suggests they were unlikely to be doctors who cut corners. This small survey therefore does support the hypothesis that duration of consultation and list size are inversely associated.

A discussion of these results with the participants, however, showed how misleading booking interval was as a reflection of their true timed performance. Much time is spent during consulting sessions in the tasks of repeat prescribing, writing reports, dictating letters and so

on.⁴ The interval between one patient leaving the consulting room and the next one entering must also be considered. If consultation length is to be used in a research exercise it must be measured.⁵ Buchan and Richardson⁶ measured consultation time precisely but used a method involving an independent observer which necessarily modifies the consultation procedure.

D.M. FLEMING

RCGP Birmingham Research Unit
Lordwood House
54 Lordwood Road
Harborne
Birmingham B17 9DB

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Consultation rates and the primary care team

Sir,

Doctors Fry and Dillane have wisely drawn our attention once again to the subject of consultation rates and list sizes (September *Journal*, p.403). As general practice changes, the statistic of consultation rate has different meanings and the concept of the primary care team should not be ignored.

The Cumberlege report¹ has drawn the profession's attention to the important contribution of practice nurses. It is inappropriate to measure the work of a practice by counting only the number of consultations with the doctor; consultations with the practice nurse

should be included. Eventually, the work of the health visitor and district nurse will be counted similarly and amalgamated in annual reports.

During the period 1982-86 the list size of our practice grew from 10 500 to 11 500 and the consultation rate with the practice nurse increased from 0.99 consultations per patient per year to 1.19 while in the same period the consultation rate with doctors fell from 3.01 to 2.69. The home visit rate remained unchanged throughout this time, at around 0.35. This is in a practice with the majority of patients in social classes 3M and upwards.

In future, the practice nurse consultation rate should be included in reports of practice workload. If this figure is omitted, then we will gain an inaccurate impression of practice, and also overlook the important work of our colleagues.

R.H. BAKER

The Leckhampton Surgery
Lloyd Davies House
17 Moorend Park Road
Cheltenham GL53 0LA

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Weight reduction in the management of hypertension

Sir,

I was disturbed by the lack of management of the patients in the non-treated obese hypertensive group described by Croft and colleagues (October *Journal*, p.445). The diagnosis of hypertension was made at entry to the trial, but this group of patients received no treatment and virtually no advice from the general practitioner for a six-month period. Informed consent for this omission of treatment was not given, patients were told that 'for six months their blood pressure would be checked periodically before any decision about specific treatment was taken'.

Several patients in this group suggested weight reduction for themselves, yet received no encouragement, advice or information from the general practitioner. For many patients, this is equivalent to disapproval. No patient in the series received advice against smoking. Possibly it was felt that smokers trying to give up the habit would eat more. However, smokers should have been told to stop.

This group of patients knew that they

Table 1. Percentage distribution of uninterrupted consultations by duration of consultation.

	Duration of consultation (minutes)				
	0-4	5-9	10-14	15-19	20+
New consultations ($n=2285$)	54	35	8	2	1
Follow-up consultations ($n=1378$)	51	38	9	2	0
All consultations ($n=3663$)	53	36	9	2	1

had hypertension, and the average person today knows that hypertension means a risk of stroke or heart attack. They also knew that they were not getting any treatment so it is not surprising that their blood pressure did not settle.

To undertake such a trial, the general practitioner must have been enthusiastic about weight reduction. Conversely, he must have been pessimistic about the approach taken with the control group and the patients would have noticed this. As an extra point, the general practitioner, not an independent observer, followed up these patients. All of these factors must bias the results.

What happened after this six-month period? Did the doctor tell the patients that they should now lose weight, stop smoking, take exercise and possibly take tablets? Did the patients who had wanted to lose weight still want to lose weight now that the doctor had decided it was time to educate them and treat their condition?

I suggest that he was six months too late.

KEVIN HAY

La Ronge Medical Clinic
Box 240
La Ronge
Saskatchewan
Canada SOJ 1L0

Sir,

The average patient may or may not know that hypertension means a risk of stroke and heart attack. Most patients with blood pressure in the range systolic 140–200 mmHg, diastolic 90–114 mmHg do not experience early morbidity or death attributable to hypertension, and hypotensive drugs have significant side-effects, an unknown future and are more easily started than stopped. The Medical Research Council's trial of the treatment of mild hypertensives¹ has not produced a clear case for immediate treatment but has underlined the importance of continued follow-up. To say that we omitted treatment assumes that I share Dr Hay's views on first-line management and I suspect that I do not. A positive approach can mean finding out what the patient knows, providing a reasoned discussion about risks, assessing blood pressure over a period in the hope that it may fall, and being reluctant to rush for the prescription pad. This was our approach to both hypertensive groups.

Since the two groups were given similar advice about salt and alcohol, Dr Hay must feel that it was unethical to withhold dietary advice from the control patients. At the time of our study there had been no randomized controlled trials of weight

reduction in untreated hypertensive patients and no general practice study to assess its usefulness. It seems reasonable to ask if ideas which are commonly promoted are effective in practice.

We accepted in our discussion that enthusiasm (of dietitians and patients as well as the doctor) may bias interpretation of the results. This limits conclusions about the precise effect of calorie restriction but does not alter the broader conclusion about the usefulness of the intervention.

Stopping smoking is not a method of lowering blood pressure. If we had opted to give advice against smoking we would have had to be serious about it and expect it to be successful — and expect weight gain. We chose to defer advice for a period during which the focus was on weight and blood pressure. Since the results of the MRC trial¹ have shown that giving up smoking is far more important than reduction of blood pressure to the smoking hypertensive in terms of the risks of hypertension, I would now agree that randomization should follow smoking advice and the benefits of dieting studied in that context.

The patients in the control group had a low dropout rate at six months. Many were judged not to need specific therapy but attended for further checks periodically and all smokers received advice. The five patients who had proposed to diet, contrary to Dr Hay's prediction, lost more weight than the treatment group and they were later joined by others now advised to lose weight. Their good attendance continued. Why?

Perhaps we were six months too early in the treatment group.

PETER CROFT

The Surgery
Palmerston Street
Wolstanton
Newcastle under Lyme
Staffordshire ST5 8BN

Reference

1. Medical Research Council Working Party. MRC trial of treatment of mild hypertension: principal results. *Br Med J* 1985; **291**: 97-104.

The age of the computer?

Sir,

I read with interest the editorial on computers by Alan McWilliams (November *Journal*, p.490). He has clearly identified some important issues facing general practitioners planning to invest in computerization.

At VAMP we are aware of the problems of obsolescence and feel that a practice

investing in computerization should be sure that: (1) they will get the full performance and natural life out of the computer hardware that they purchase; (2) their software has a long term growth path; and (3) the investment of time and effort in getting the practice data onto the computer will not be written off because future hardware or software developments are incompatible with their current system. These are the issues that McWilliams addresses and to overcome them is a tall order from a technical point of view.

Of the three strategies outlined by McWilliams we have rejected the 'throw-away' strategy and adopted a combination of the 'upgrade' and 'network' strategies. The key to this is in an operating system, Business Operating Software (BOS) and BOS/LAN which is the BOS local area network. This system can operate on over 50 makes of personal and mini computers and allows users to add additional hard discs, screens and printers. Even so, the policy of upgrading has its limitations and the capacity of the purchased computer may be used up before its natural life has expired. A network strategy avoids this problem by allowing the addition of more computers which can then run together.

The result of this 'upgrade' plus 'network' strategy is that practices can invest in suitable systems for their perceived short/medium term needs. In our case this would be a VAMP multi-user system capable of being upgraded by increasing the storage capacity or the number of screens and printers. However, practices can upgrade their systems in the knowledge that they can take advantage of new developments in hardware or software when they become available by adding the new hardware and software needed under the network without needing to throw out the existing system.

Networking alone is no substitute for a good multi-user system in price or performance, but a multi-user system needs a networking option to keep the customer options open as no one can forecast the rate of change in this area.

PETER WILLIAMS

VAMP Health Limited
39 East Hill
London SW18 2QZ

Video recording in general practice

Sir,

The article by Servant and Matheson on video recording (December *Journal*, p.555) raises several important issues.