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The efficient use of time in general practice

HOW can surgery time be organized so that patients are satisfied and doctors retain their sanity at the end of the working day? Two papers in this issue of the *Journal* are relevant to this question.

How long should appointments be?

Ridsdale and colleagues (p.488) describe a study in which patients were allocated non-systematically to surgeries booked at five, 10 and 15 minute intervals, replicating and confirming the results of an experiment by Morrell and colleagues[1,2] in which the booking intervals were five, 7.5 and and 10 minutes. In general, there was improved communication and patient satisfaction with longer booking intervals, but little effect of time on examination (except pelvic examination and blood pressure recording), prescribing or the likelihood of the patient returning for a further consultation.

These results need to be seen alongside those of observational studies in which doctors who choose to consult at a slower rate appear to have lower prescribing rates,[3] especially of antibiotics,[4] and a lower rate of return visits.[3] However, a notable feature of the two experimental studies is that the doctors did not make full use of the time allocated to them. The mean face to face consultation time was 7.4 minutes in 10 minute booked surgeries in Morrell's study, and 8.0 and 9.2 minutes in 10 and 15 minute booked surgeries respectively in Ridsdale's. Therefore, whatever the experimental conditions, these doctors were inclined to spend an average of seven to nine minutes in consultations, which is the length of time that general practitioners actually spend with patients in normal consultations.[4-7] The average times of course conceal great variation in consultation length, for example, from one to 29 minutes in Ridsdale's study.

An average face to face time of eight minutes, however, does not take account of note writing, form filling and calling in patients, so 10 minutes is probably a realistic booking interval, and may be slightly longer than needed. This would doubtless astonish Swedish general practitioners whose average consultation time in a recent study was 21 minutes,[8] and it may be that British general practitioners could learn to make more effective use of long consultations. However, such arguments are largely academic since booking intervals of more than 10 minutes are incompatible with a list size of over 2000.[9]

What can be achieved in 10 minutes?

Inadequate time for consultation is a common complaint of patients,[10-12] and allowing a 10 minute booking interval will probably result in more satisfied clients, even though highly effective communication may on occasions be possible in very short consultations.[6,13] However, theoretical models[14,15] of the consultation emphasize the broader aspects of patient care which may be addressed during routine consultations, including opportunistic screening. Under the government's new contract adult screening will be required three yearly and opportunistic screening during consultations may well be the most cost-effective way to achieve this, especially as patients' habits are often known to the general practitioner. Ten minute appointments

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allow some time into which opportunistic screening may be fitted, a process which could be facilitated if the patients' notes contained a form which could be filled in over the course of a number of consultations. This could go a fair way towards meeting the screening requirements of the new contract, though it would not of course solve the administrative problem of contacting non-attenders. Alternative approaches to screening involve other members of the primary care team, and Marsh[16] has described how substantial parts of the doctor's traditional work can be undertaken by an extended team.

How should surgeries be booked?

Running late is bad for patients. Long waiting time is another common complaint of patients[17,18] and a paper by Hill-Smith (p.492) demonstrates the exponential rise in patients' waiting time if consultations are booked at less than the mean consultation time. However, running late is also bad for doctors. In preliminary results from a study in Lothian, Porter and colleagues[19] suggest that running late is a major source of stress for general practitioners, particularly if they have other fixed commitments to attend to. Hill-Smith's solution to this problem is to book short frequent surgeries. In practice, this is most readily achieved by breaking up long surgeries with short periods of administrative time at intervals of one to one and a half hours. These act as a buffer against cumulative lateness and allow the doctor breathing space every 10 patients or so. Hill-Smith also investigates the effect of allowing patients to choose their own appointment times. This did not appear to be an efficient use of doctors' or patients' time in his study, although in other hands, appointment times chosen by patients have been associated with short waits by both doctors and patients.[20,21]

The conclusion is that consultations in the 1990s should probably be booked at 10 minute intervals if list size allows. This interval will allow some time for opportunistic screening. If long surgeries are broken up with short periods of administrative time, this will decrease patients' waiting time and probably reduce stress for general practitioners.

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Chronic non-malignant pain: time to take on the challenge

WHILE some patients with chronic pain are referred to hospital clinics and those with malignant disease are treated in hospices, the majority of patients with chronic pain are managed by general practitioners. Chronic pain has a poor prognosis and even in one of the best specialist centres 40% of patients with non-malignant pain experienced no relief and 38% only partial relief.[1] The challenge for primary care is to provide a coherent response to the needs of patients with chronic pain.

The prevalence of chronic pain in the community has been variously estimated at 9.4%,[2] 8.7%,[3] and 11%[4] in three very different studies but it is well known that general practitioners see only a small proportion of the illness in the community[5] with many factors influencing patients' decisions to consult.[6] This 'pyramid' of patients receiving various levels of care has been quantified for back pain.[7]

Aristotle defined pain as 'an agony of the mind',[8] but in 1986 the International Association for the Study of Pain agreed on 'an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage'.[9] This definition encourages a broad approach to evaluation, and may be therapeutic in giving patients the language to communicate their distress, thereby reducing feelings of isolation.[8]

Various dimensions of the experiences of patients with pain need to be assessed, including intensity[10,11] and quality of pain,[12,13] psychological state[14,15] and their attitude to pain[16] with the use of active and passive 'coping strategies'.[17] The last of