Doctor-initiated consultations: a study of communication between general practitioners and patients about the need for reattendance

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SUMMARY. It has been suggested that general practitioners have the potential to regulate a large percentage of their workload through their control of 'doctor-initiated' consultations. A survey was made of 300 consecutive consultations in a group practice. After their consultation patients completed a questionnaire asking what advice the doctor had given them on the need to reattend. At the same time the general practitioner completed a similar questionnaire about the need for reattendance and the advice given. The general practitioners judged that 74% of patients definitely or possibly needed to reattend, and only 26% definitely did not need to reattend. The coefficient of agreement between patients' and doctors' views on whether reattendance had been recommended was only 0.41. Thus the room for control of doctor-initiated consultations is limited by both clinical considerations and the apparent difficulty of accurately communicating the doctor's advice on reattendance to the patient.

Introduction

ALTHOUGH much of the caseload of general practitioners is determined by demand from patients, it would appear that a large proportion of overall workload is brought about by the general practitioners' own behaviour. In a 12 month audit of consultations Morrell and colleagues[1] reported that 46% could be classified as doctor-initiated. Richardson and colleagues,[2] in a study of 142 doctors in Scotland found a range of 'return' consultations of between 37% and 84% with a mean of 56% and concluded that 'the biggest single factor affecting the proportion of return consultations, and therefore workload, is the doctor himself'. Similarly Marsh and Kaim-Caudle,[3] having found 39% of their consultations to be doctor-initiated, argued that the general practitioners could control their own workload by regulating the number of follow-up consultations which were advised.

A doctor-initiated consultation is one in which the patient attends at the invitation of the doctor. However, very little is known about this invitation process. A general practitioner might specifically invite a patient to make another appointment, or might offer an opportunity to reattend either by explicit, open invitation or a more casual end to the consultation, such as 'come back if you have any further worries'. The general practitioner could also positively discourage reattendance. Yet it is not known how frequently doctors provide firm advice about whether to reattend nor how well patients interpret the message which the general practitioner is trying to impart. If there is a discrepancy between the general practitioner's wishes and the patient's inferences, then the overall impact of the 'doctor-initiated' consultation on workload may not be as important as has been suggested.

A study was therefore set up in a group practice to examine communication between doctors and patients about the need to reattend. This involved, first, assessing prospectively the proportion of patients who were thought to need to reattend and, secondly, examining the extent of agreement between general practitioners and patients about whether reattendance was requested.

Method

A survey was carried out in a south London practice of two principals and a trainee. Three hundred consecutive patients were asked to complete a questionnaire after their consultation. This asked what advice they thought the doctor had given them on the need to reattend. At the same time, the general practitioner involved was asked to complete a similar questionnaire setting out his or her views on whether the patient needed to reattend and the advice that the patient had been given.

Results

Questionnaires were returned by general practitioners for 287 cases (96%). For 76 (26%) of patients the general practitioners judged that reattendance was unnecessary. In 82 cases (29%) reattendance was thought to be definitely needed and in 129 cases (45%) possibly needed.

Completed pairs of questionnaires were returned from both patient and general practitioner for 263 cases, an overall response rate of 88%. Table 1 shows the views of the general practitioners on the need for reattendance together with their reports of what they actually told the patient. Firm advice was mainly given to patients whom the general practitioner thought should definitely reattend; others, for whom the general practitioner was either less certain or believed that reattendance was unnecessary, tended to be given no advice. Table 1 also shows how the patients' perceptions of the advice they were given related to the beliefs of the general practitioner about the value of reattendance. Of those patients the general practitioner definitely wanted to see again three quarters absorbed the correct advice. For the bulk of patients for whom reattendance was clinically optional, the patients were less certain of the situation: half, correctly, appreciated they had a choice, and a further quarter, in believing that no advice had been given, might reasonably have inferred that reattendance was a possibility. Patients seemed least likely to appreciate that a further appointment was unnecessary with only a quarter correctly reporting that it was not necessary to be seen again.

Table 2 shows the direct comparison between the general practitioners' and patients' reports of the advice given. When given

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Table 1. Comparison of general practitioners' and patients' reports of the advice given according to general practitioners' views on need for reattendance.

	GPs' views of necessity to reattend (number (%) of patients)					
	Yes, definitely		Possibly		No	
GPs' reports of advice given						
Another appointment necessary	70	*(85)*	6	*(5)*	0	*(0)*
Patient given a choice	1	*(1)*	33	*(26)*	1	*(1)*
Another appointment unnecessary	0	*(0)*	1	*(1)*	18	*(24)*
No advice given	11	*(13)*	89	*(69)*	56	*(75)*
Total	82	*(100)*	129	*(100)*	75	*(100)*
Patients' reports of advice received						
Another appointment necessary	57	*(74)*	15	*(13)*	5	*(8)*
Patient given a choice	9	*(12)*	62	*(52)*	11	*(18)*
Another appointment unnecessary	3	*(4)*	11	*(9)*	16	*(26)*
No advice given	8	*(10)*	31	*(26)*	30	*(48)*
Total	77	*(100)*	119	*(100)*	62	*(100)*

advice to reattend or choice about whether to reattend, over three quarters of patients reported receiving that advice; patients given no advice or specific advice not to reattend, however, were less likely to report receiving this message.

The kappa coefficient of agreement provides a measure of the level of agreement between general practitioner and patient: it ranges between unity when there is total agreement and zero when there is none. The kappa score for the agreement between general practitioner and patient for all the cases in Table 2 was 0.41. In comparison, the coefficient of agreement in the subset of cases in which the general practitioner thought reattendance was necessary was 0.41, in cases where reattendance was thought possibly required, 0.23, and in cases in which an appointment was judged not necessary, 0.10.

Discussion

This study is based on only one practice and the results may not therefore be generalizable to others. Nevertheless, the survey does highlight various problems with communication which are likely to occur to some degree elsewhere.

The high proportion of patients who understood, correctly, that they should reattend is reassuring, although even here only three quarters of patients received this message clearly. However, in the other cases, when reattendance was either possibly needed or judged unnecessary, patients did not take away clear ideas of what the doctor thought, in part because the doctor failed to provide advice, and in part because patients seemed to misinterpret the advice given.

At a time when changes in the method of paying general practitioners is likely to place an even greater focus on overall workload, it may become increasingly important for patients to take away the correct message about the need for reattendance. In principle, clear guidance to patients on whether to reattend should help to control workload because, on the one hand, a rational plan of reattendance for those who need it may deter casual consultations or minimize the risk of future problems, and, on the other hand, clear advice to those who do not need to reattend may prevent inappropriate consultations in the future. The results here showed that reattendance was judged to be definitely or possibly necessary for 74% of patients and agreement between doctors' and patients' views on whether reattendance was necessary was only 0.41. Thus, in practice, doctors' ability to control their workload may be limited by clinical considerations and by poor communication.

In reporting a small negative relationship between consultation rates and list size, Butler[4] suggested that recall consultations are perhaps used as a means of regulating workload such that the proportion of doctor-initiated consultations is lower with larger lists. However, in a review of a number of studies, he found no clear evidence that doctors were able to reduce the numbers of doctor-initiated consultations in order to regulate excessive demand. He concluded that the behaviour of patients may be more important than that of doctors in determining workload. It may be significant that those reports which have implied that considerable scope exists for controlling workload because upwards of 50% of consultations are 'doctor-initiated', relied solely on retrospective judgements of who initiated the consultation.

Clearly the next step is to establish the effect of the message on actual reattendance patterns of patients. Yet even without this additional information it seems that the process of translating general practitioners' intentions into patients' understanding is far from straightforward.

References

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Table 2. General practitioners' reports of advice given to the patient compared with patients' reports of advice received.

Patients' reports of advice received	GPs' reports of advice given (number (%) of patients)							
	Another appointment necessary		Patient given a choice		Another appointment unnecessary		No advice given	
Another appointment necessary	58	*(82)*	4	*(13)*	1	*(6)*	14	*(10)*
Patient given a choice	7	*(10)*	24	*(77)*	3	*(19)*	48	*(34)*
Another appointment unnecessary	3	*(4)*	2	*(7)*	6	*(38)*	19	*(14)*
No advice given	3	*(4)*	1	*(3)*	6	*(38)*	59	*(42)*
Total	71	*(100)*	31	*(100)*	16	*(100)*	140	*(100)*