MEDICAL PRACTICE

General Practice Observed

A general practitioner in an ophthalmology accident and emergency department

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Summary

After a short period of intensive training, a general practitioner successfully replaced a senior house officer (SHO) in the accident and emergency department of an eye hospital on one morning a week for a year. An unbiased observer compared the performance of the general practitioner after one year with that of a full-time SHO who had had 17 months' experience; their performances were about equal. Although a sessional general practitioner costs about 28% more than an SHO, the real cost is much less because undue length of service as an SHO or change to another specialty (because of the SHO surplus) delays achievement of a permanent grade. Continuity is a great advantage of the general practitioner. Replacement of some SHOs by general practitioners would reduce the surplus of SHOs with poor promotion prospects. The commonest diagnoses were Meibomian cysts (18%), corneal foreign bodies (20%), corneal abrasions (12%), and conjunctivitis (8%).

Introduction

Can a general practitioner do satisfactory sessional work in an ophthalmic accident and emergency department? General practitioners often do sessional work in hospitals, including accident and emergency departments,[1-6] but specialist accident and emergency departments are uncommon. They usually exist in eye hospitals, however.

A full-time SHO quickly acquires experience of eye diseases in general that a general practitioner does not possess, and he can also use a slit lamp microscope. A good case can be made for using very experienced and skilled medical staff in an accident department, and in some a consultant is continuously in direct charge. In other emergency departments, however, ophthalmic as well as general, quite inexperienced SHOs work without close supervision and have to be responsible for a heavy and variable work load.

There are many more trainee ophthalmologists (and other trainee specialists) in the registrar and SHO grades than there are prospects of promotion, at least "on time," to the senior registrar and consultant grade. Table I shows the latest available figures; the first column makes no allowance for early retirement, death, expansion of a grade, or transfer into any non-consultant career grade.

TABLE I—*Staffing figures in ophthalmology*

Grade (and assumed tenure)	Required staff (inverted pyramid) for equilibrium	Actual staff pyramid (or hour-glass)	
		England and Wales* at 30 Sept 1974 (WTE)	Scotland*† at 30 Sept 1973
Consultants (30 years) ..	30	308	52
Senior registrars (3 years)	3	70	10
Registrars (2 years) ..	2	106·1	28
Senior house officers (1 year)	1	197·4	22

WTE = Whole-time equivalents.
†Howitt.[14]
*Hospital medical staff—England and Wales. National Tables, 30 Septembr 1974. Statistics and Research Division. Department of Health and Social Security, June 1975.

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The surplus of registrars and SHOs and the relatively long training period in the UK probably discourage recruitment into specialties and encourage emigration of British graduates. Conversely, it is unfair to overseas graduates to appoint them to SHO and registrar posts with poor prospects of promotion if they intend to remain permanently in this country. If they do not intend to stay it is more than unfair that British patients should be used to provide experience—especially surgical—for these doctors, especially when the clinical problems in Britain are often irrelevant to those overseas and when language difficulties aggravate the risk of unsatisfactory treatment.

The predicament of the surplus registrar is an even greater cause for concern.[7–9] Problems of medical manpower, including the place of auxiliaries, have fortunately attracted more attention recently.[10–12] We studied the feasibility of employing a part-time general practitioner in an ophthalmic accident and emergency department.

Method

The general practitioner (MP) had had no postgraduate training in ophthalmology, but had done four years (one half-day a week) in the emergency department of a general hospital. She was a member of a group practice of seven doctors.

Training—An intensive training period was arranged over about two months. She attended an undergraduate class for 10 morning sessions; spent 10 morning sessions (two weeks) with an experienced SHO in accident and emergency and five sessions with a consultant in a general outpatient ophthalmic clinic; went on four ward rounds with a consultant; and shared the accident and emergency work for three to four weeks on Friday mornings with an experienced SHO working in the same consulting room.

Thereafter every Friday from 0900 to 1230 accidents and emergencies were her responsibility, but the advice of specialists working in the general clinics on the same floor was easily and quickly available.

Morbidity survey—The diagnoses of all the patients seen after the initial training period—that is, for a total of 12 working months (excluding six weeks' holiday) were recorded.

Assessment was performed by comparison with a peer and by following up a sample of patients. At the end of 12 months the general practitioner's performance was compared with that of a SHO who had had 17 months' experience in that grade. Ten patients were chosen at random over four mornings and each patient was examined independently by the general practitioner and the SHO. The history and clinical findings were recorded in writing by a secretary so that when the third examination was done by the assessor (CIP) he would not know the author of any case record. Marks were allotted for diagnosis, treatment, and management, including referral to a clinic when appropriate .One in 15 records were also reviewed to find out if any unexpected subsequent visit became necessary or if the diagnosis or treatment was changed at the next attendance.

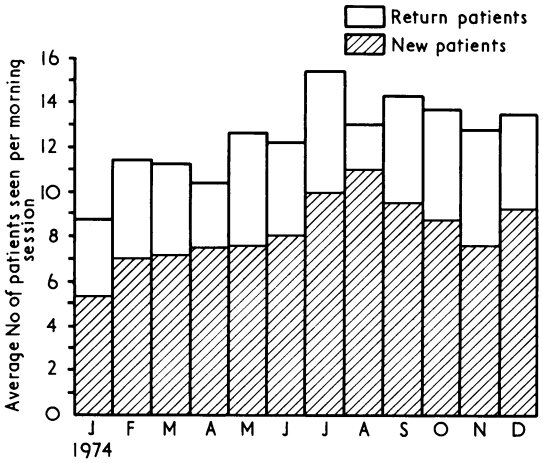
Results

The average number of new and return patients seen on Friday mornings in each month is shown in the figure. The clinical diagnoses are shown in table II.

In the peer comparison the general practitioner scored 78½% and the SHO 81%. The outcome of diagnosis, treatment, and management in all 37 cases reviewed (a 1 in 15 sample) was unexceptionable.

Discussion

We consider that this was a successful experiment. A general practitioner, with a little extra training, can cope with an ophthalmic accident and emergency department provided that a more experienced specialist is readily available. We do not suggest, however, that all such departments should be taken over completely by general practitioners. They should be employed only when their time can be fully occupied, and, of course, accident and emergency work is important for the trainee specialist at some stage.



Average numbers of patients seen during weekly Friday morning sessions each month in 1974.

TABLE II—*Diagnoses in patients seen in general practitioner's Friday morning session in 1974*

Disease		No (%)
Cysts	Meibomian	80 (18)
	Of lid margin (clear and opaque)	14 (3)
Foreign bodies	Corneal	86 (20)
	Subtarsal	12 (3)
	Conjunctival	4 (0·9)
	Intraocular	1 (0·2)
Corneal ulcer	Marginal	18 (4)
	Dendritic	11 (3)
	Others	1 (0·2)
Corneal abrasions		52 (12)
Conjunctival lacerations		12 (3)
Infections	Warts	0
	Blepharitis	8 (2)
	Stye	16 (4)
	Conjunctivitis (presumed bacterial)	8 (2)
	Conjunctivitis (? virus) including keratoconjunctivitis	35 (8)
	Herpes zoster	2 (0·5)
Iridocyclitis		13 (3)
Choroiditis		5 (1)
Allergic reaction to previous treatment		2 (0·5)
Trichiasis		11 (3)
Vascular lesions	Subconjunctival haemorrhage	6 (1)
	Traumatic hyphaema	1 (0·2)
	Vitreous haemorrhage	2 (0·5)
	Central retinal artery occlusion	1 (0·2)
	Central retinal vein occlusion	1 (0·2)
	Temporal arteritis	1 (0·2)
Detached retina		2 (0·5)
Periorbital lesions*		7 (2)
Welder's Flash		7 (2)
Lacrimal apparatus	Epiphora	3 (0·7)
	Dacrocystitis	2 (0·5)
Glaucoma (only 1 new patient)		3 (0·7)
Noxious fluid in eye		4 (0·9)
Others	Migraine	2 (3)
	Cerebral aneurysm	1
	Presbyopia	1
	Pterygium	1
	Lens opacities	1
	Sjögren's syndrome	2
	Ultraviolet burns (sun ray lamp)	2
	Macular (sun) burns	1
	Total	442 (100)

*Erysipelas in right cheek (1), sinusitis (2), basal cell carcinoma (1), cigarette burn on upper lid (1), periorbital haematoma (1), wound of bridge of nose (1).

The average list size (at 1 October 1975) of general practitioners in the Lothian Region was 1955 compared with 1962 in Scotland and 2372 in England and Wales, which may explain why many practitioners in this city can do part-time sessional work. The practice from which MP came had an average list of 1890 for each partner in the group.

ECONOMICS

Is it economic to employ general practitioners instead of SHOs when it costs about £390 a year to employ an SHO for half a day a week (10% of full-time salary in middle of range) and £510 a year to employ a general practitioner (in the hospital practitioner grade), which is about 28% more? Other factors considerably reduce that difference.

Promotion prospects—About 75% of the SHOs in England and Wales and about 36% in Scotland (see table I) have no prospect of promotion to registrar, at least at the end of a year (and even after promotion there is also a serious surplus of registrars). Even if a full year as SHO is regarded as essential for the training of an ophthalmologist, any time over that period should probably be regarded as being an exaction from the trainee himself. In terms of money, he loses the difference between an SHO's salary and his expected top rate of pay as consultant (or other permanent grade).

Transfer to other careers must often occur when promotion prospects are poor. Would a year as an SHO in ophthalmology provide useful experience for a career in other subjects? Very rarely, if at all, unless, for example, a neurologist, neurosurgeon, or plastic surgeon intended to take up a special interest in the eye and adnexa, when a much shorter period of selected experience might be valuable. Economically, therefore, a year as an SHO in ophthalmology for someone going into another career is to a large extent wasted (as also is the time of the teachers).

Continuity—A great advantage of a sessional general practitioner is that the eye department and its patients would be spared the recurrent need for training a new SHO with the resulting inefficiency, especially in the first few weeks of his clinical practice. This point has been emphasised in relation to the general practitioner as registrar in paediatrics, obstetrics, and dermatology by Sweetnam *et al.*[13]

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Contemporary Themes

Emergency medical care

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Summary

A survey carried out over five periods between 1973 and 1975 to study the mode of referral of emergency medical patients to a district general hospital showed that, out of a total of 2511 patients, 51% referred themselves, 40·8% were referred by general practitioners, and only 4·7% by doctors employed by the emergency treatment service. Of the 1720 patients admitted to the medical wards, 50·9% were referred by general practitioners and 37·3% were self-referred while the corresponding figures for the 791 not admitted were 19% and 80·7% respectively. Two-thirds of the self-referred patients came from their own homes, usually by ambulance ordered by a "999" emergency call. The figures were similar in each of the five periods.

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Introduction

The pattern of emergency medical care has changed considerably over the past 15 years, during which hospitals have played an increasing part in primary emergency care.[1] Until the early 1960s it was rare for a patient suffering an acute medical illness at home not to be seen by his general practitioner first. Medical emergencies were, therefore, admitted to hospital after consultation with the general practitioner. This was beneficial in that emergency treatment was available before transport to hospital, personal details of the patient were communicated and discussed, and hence continuity of care was guaranteed. A possible disadvantage was inevitable delay in admitting particular patients. Overall this was a good system for the patients but bad for the doctors, who were grossly overworked. Such personal attention in an emergency could not continue indefinitely. The demand on individual general practitioners became intolerable.

About 15 years ago the "999" emergency call for ambulance or police began to be used in this district by patient, relative, or neighbour for a medical emergency occurring in the home, thus bypassing the general practitioner. After the introduction of multiple practices in 1966-7 this tendency increased. There was a change in the old-established relationship between the general practitioner and the hospital in an emergency. Patients reported