Middle Articles

GENERAL PRACTICE OBSERVED

Visiting—Falling Work-load in General Practice

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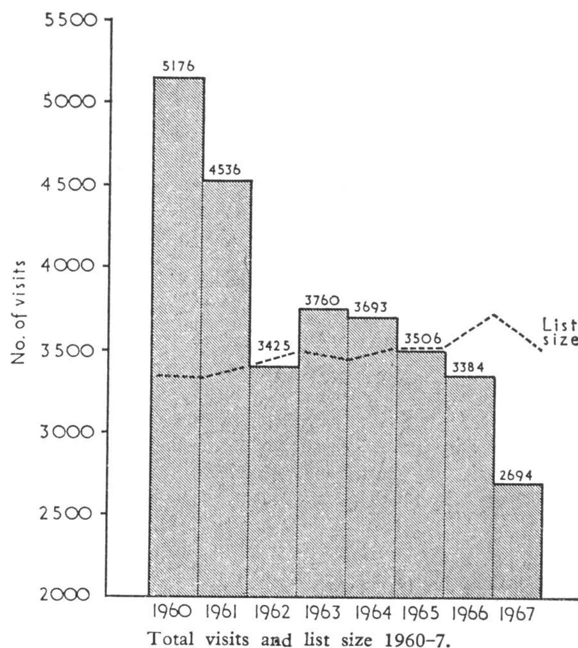
Much has been made in recent years of the increasing work-load of the family doctor and how necessary it is to attempt to lessen this in a community where the number of doctors is falling and the number of patients is rising. One cause of this excessive work-load results from the rigid adherence to the time-consuming exercise of visiting patients in their homes. That it is clinically inconvenient for a doctor to work in the patient's bedroom rather than in fully equipped premises must be self-evident. Nevertheless, a great deal of this visiting is self-inflicted.

From 1960 to 1967 (the first eight years as a principal in general practice) my personal figures of total visits and new calls have been kept. The number of new calls seen and dealt with at only one visit has also been recorded. The practice is a five-man group situated in an industrial town in North-east England. Throughout the eight-year period there has been no



Total visits and list size 1960–7.

variation in the number of doctors in the group and, by and large, I have looked after my own list of patients throughout that time. The list has shown an overall upward trend from 1960 to 1967 (see Fig.). The figures have been averaged on the basis of a 47-week year, which was the usual number of weeks worked annually in this period.

The Figure shows the astronomical fall in total visits carried out—from 5,176 in 1960 (an average of 18 per day per six-day working week) to 3,384 in 1966 (an average of 12 per day) and down to 2,694 in 1967 (an average of 9 per day). Similarly, the Table shows a decline in the number of requested new visits from 1,525 in 1960 (5.4 per day per working week) down to 1,158 in 1967 (4.1 per day).

It is the purpose of this paper to discuss how this considerable reduction in visiting work-load has been achieved and how further reductions could be effected.

Change in Attitude of Doctor

On taking over my practice from a highly esteemed senior partner I visited at approximately the same rate as my predecessor in order to establish myself as a doctor as keenly interested in the welfare of the patients as he had been. Inexperienced as I was initially, I did not know the pattern of disease locally, and, since I had only recently completed my hospital posts, the pattern of disease in general practice. Nor did I know how these diseases responded to treatment. I did not know to what extent I could rely on patients to contact me if their progress or that of their children was not favourable. I did not know which patients were stable and self-reliant, and competent to supervise their recovery unaided, and which would require return visits. There is no doubt that all these factors operated in producing the peak total of visiting in 1960. Nevertheless these factors, which can be summed up as " doctor's inexperience," only partly account for the initial fall in visiting from 1960 to 1961 and cannot have operated to any great extent in later years when the fall has continued. From the historical viewpoint, however, the 1960 figures probably reflect the visiting habits of the doctors in the practice at that time and for many years preceding 1960.

The predominant continuing factor has been a change in my attitude to visiting as a procedure in general practice, and at the beginning of 1967 I made a definite mental effort to reduce the amount of visiting. Hence the somewhat accelerated fall in total visiting from 1966 to 1967 (see Fig.).

Older partners and those recently retired had had their initiation into general practice in the days of private practice when high visiting rates were commonplace. Visiting charges were proportionately higher than surgery charges because of the extra time required to carry them out. I had never experienced these conditions nor had this financial incentive, and, finding myself able to see more patients per hour in the surgery than when on my rounds, it appeared more economic in time and effort to decrease the latter if this was possible without detriment to the patient. I was encouraged to do this by noticing how patients coming to the surgery were more ill and more toxic than many seen at home. Particularly in the earlier years, patients revisited were up and about and patently

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well on the way to recovery. Such patients were almost devoid of clinical interest, and more interesting and more serious cases were waiting at the surgery, sometimes for long periods of time, because of the excessive visiting rounds I was undertaking. The occasional experience of the patient "not even in" or a child brought reluctantly into the house from play, confirmed me in the belief that revisits could be cut down without detriment to the patient and with considerable benefit to the doctor and to more needy new cases attending the surgery.

The Table shows how the proportion of new calls requiring a further visit (entirely the prerogative of the doctor) has fallen from 64% in 1960 to 42% in 1967—again a gradual fall, with a sudden increase in the rate of fall between 1966 and 1967. There is no doubt that the reduction in the revisiting of acute cases has played a large part in the reduction of total visiting.

Similarly, a close look has been taken at the "chronic visiting list." With improved public transport and with private transport increasingly available to old and chronic patients, such persons are now encouraged to visit the doctor rather than the doctor visit them. Many of them even seem to enjoy their trip out to the surgery and take a pride in being able to get there. There are now almost no exceptions to the rule that patients who go out for other purposes should not be visited by the doctor. Furthermore, many old and chronic housebound patients have been only too happy to exchange their routine monthly visit (a relic from earlier days) for a requested visit during an exacerbation of their illness. To the doctor the old and chronic patient is far more interesting in an exacerbation than in his quiescent phase. To the patient the need at that time is greater. Chronic visiting carried out for other than clinical reasons has little to offer compared with frequent intensive care during acute episodes.

Response by Patient

In recent years patients have become increasingly aware of the doctor's mounting work-load. Ministry of Health leaflets now ask the public to consider their requests for medical care carefully. This has affected to some extent the request for visits, and it is my impression that patients are more prepared to use their cars or their neighbours' cars to visit the surgery than was their wont only a few years ago.

Patients have rapidly accepted the change in emphasis in care which flows from receiving only one visit in an illness. At this consultation, in addition to the diagnosis being made and the treatment prescribed, the course that the illness should follow has been outlined. If a follow-up is thought necessary the stage at which the patient will be expected to be able to attend the surgery is indicated. The patient (or the patient's mother in the case of a child) is told to request further help should the expected improvement not take place according to the course outlined. With more and more patients on the telephone it has become easier for them to recall the doctor and also to obtain advice about the course of the illness if uncertainties crop up in the first few days. Similarly, if the doctor has doubts about the progress in a particular illness he can ring the patient's relatives to ascertain whether progress is proceeding satisfactorily. Hence the responsibility for continuing care, with request for follow-up of minor illness, is passed back to the patient, where it should rightly be. This emphasis has reduced the repeat visiting rate dramatically, and, whereas in 1960 64% of new calls were made again *at home*, in 1967 only 42% were so made (see Table).

Analysis of New Calls

	1960	1961	1962	1963	1964	1965	1966	1967
New calls made ..	1,525	1,338	1,343	1,410	1,235	1,400	1,316	1,158
New calls requiring a revisit ..	979	859	796	893	713	793	658	490
New calls requiring a revisit ..	64%	64%	59%	63%	58%	57%	50%	42%

Change in Practice Organization

During the eight years—and more especially in the last three—great changes have taken place in the organization of the practice, and these have certainly affected the visiting rate. In 1965 the uneconomical and vestigial branch surgery was closed, and, though it was thought possible that this might cause a rise in the visiting rate from patients consequently less near to a surgery, such did not prove to be the case. This was because bus routes made it possible for patients who had used the branch surgery to get to the main surgery. Concomitantly with the closure of the branch surgery came the total modernization of the main surgery into a group practice centre. The building of a thoroughly modern warm waiting-room in place of its draughty Victorian predecessor and the beginning of a comprehensive appointment system made attending the surgery no longer the potential ordeal it had previously been. The appointment system, probably more than any other change, reduced the visiting list. In the past patients feeling unwell were reluctant to attend for what might prove to be a long wait in a draughty waiting-room exposed at the same time to the risk of cross-infection. With the appointment system patients can attend the surgery, be consulted, and be back at home within a very short time. Happily, repeat visiting was cut down, since patients possibly by no means completely well could be instructed to attend the surgery by appointment, in the knowledge that they would not have long to wait.

In large group practices there is a constant danger of depersonalizing family medicine. To prevent this the practice operates as five individual practices fused for administrative and organizational purposes into one group. Each patient (and usually each family) has his own doctor, whom he normally consults and for whom he normally sends. Patients seen at the week-end or in the evenings by the "duty doctor" are referred back to their own doctors next day. As a result doctors get to know their "own" patients well. This close knowledge facilitates telephone consultations and makes it possible to convert requests for visits to attendances at the surgery. The better one knows one's patients the better one can organize them, to the benefit of both patient and doctor. Similarly, the employment of responsible level-headed nurses and receptionists to give advice on the telephone has converted requests for visits into surgery attendances.

During 1966 it became increasingly apparent that the practice area was too widespread. More especially, one small section of the practice population lived in an area remote from the rest and any visits there were extremely time-consuming. Patients living there were less likely to attend surgery because of the travelling time involved. Visiting was therefore high in an area to which it was disproportionately time-consuming to go. After some excellent work by lay volunteers a street index of the practice was made and 800 patients in the distant area were removed from the list (then about 15,000) in groups of 200 over a period of about four months. Exceptions were made in the case of the very old and of the few with serious chronic illness. There is no doubt that this geographical rationalization of the practice has decreased the visiting-list and, more important, the visiting-*time* quite out of proportion to the numbers removed. Previous to this step it was thought to be impossible to increase the practice numbers, but it is now proving possible to accept with equanimity more than the 800 patients removed—principally because they live much nearer to the group practice centre.

With the better secretarial facilities that have developed in the last three to four years it is becoming commonplace for partners to write letters and short notes to patients (if they are

not on the telephone) in preference to calling at their homes. With the use of shorthand-typists and dictaphones much information can be relayed rapidly to patients—cutting down not only visits but also surgery consultations.

Increasing awareness of three or four practices in the North-east of England where nurses are employed to do many of the repeat visits has made me more and more concerned whether the visit I was making really required a doctor. In December 1967 the decision to employ a nurse part-time visiting chronic patients and making some follow-up visits was taken by the partners. The effects of this step will become apparent during 1968. However, before transferring work to a nurse it was obviously vital to evaluate the work itself lest she perpetuate a work pattern for which there was no true clinical indication. It is more than probable that if a nurse had been employed in 1960 the reduction in total visiting in the last eight years might not have been achieved.

Result of Fewer Visits

This paper deals with visiting in itself. The total work-load in the practice has probably increased in the eight years, but the shift has been away from the home and into the surgery. In that patients can be attended more quickly (and probably more thoroughly) within the surgery premises, the work-load has been carried out more effectively and the number of hours worked has fallen. Similarly, the practice list has been able to grow without an increase in the number of doctors.

Here is evidence that the highly organized family doctor of the future, working with a full team of ancillary and para-medical helpers, could possibly look after far more patients than the 3,000 which is current practice in many urban and suburban areas. Alternatively, should list sizes stabilize at the present level then family doctors will have time available to increase the depth, quality, and range of care of their patients and possibly accompany some of them into hospital to continue to attend them. It might perhaps even be in the interest of the national economy that the Ministry of Health recommend patients to look on the visiting doctor as a person rarely needed in the normal course of events.

Further Steps to Reduce Visiting

What more can be done by the profession to reduce visiting further ? Firstly, hospital doctors must realize that the well-organized family doctor does not expect to visit his patients routinely at home. Particularly on discharge from hospital patients should be instructed to attend the surgery at the appropriate time after a few days' convalescence in their homes. Secondly, works medical officers and ambulance men must look on the family doctor's surgery as the site of their workers' medical care—and not, except in cases of serious illness, their bedrooms. After prearrangement on the telephone, transfer by the works ambulance or car to the doctor's surgery, en route for the patient's home, would be a commendable innovation. Thirdly, urban and suburban practitioners might well get together and rationalize the geography of their practices in order to minimize the travelling distances of each doctor. Fourthly, visiting nurses (be they mentally reorientated attached local authority nurses or nurses employed direct by the practice) should be working for every family doctor. Fifthly, and the only factor not utilized in producing my falling rate, the possibility of transporting housebound and chronic patients to the surgery by suitable transport could well be more actively explored.

Conclusion

There is no doubt that seeing a patient in his own home often provides vital and valuable diagnostic information about him and his illnesses. For this reason alone visiting must always play some part in comprehensive family care. Nevertheless such visiting can be overdone ; for great reductions in visiting were achieved between 1960 and 1967.

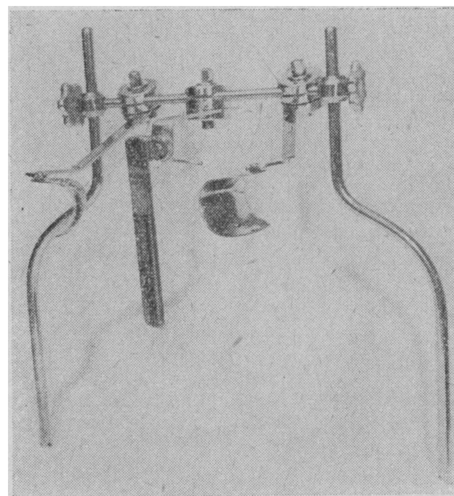
I acknowledge the help of Miss Susan Hayton, A.A.M.S., in compiling the figure used in this paper.

NEW APPLIANCES

Abdominal Robot Retractor

Mr. D. LANG STEVENSON, surgeon, Whipps Cross Hospital, London E.11, writes: A robot retractor has been designed which offers considerable advantages to the surgeon in a wide range of abdominal operations. What is achieved is sustained retraction in any desired position, thus dispensing with the constant need for rest and readjustment inherent in hand retraction, not to mention the arduous task often imposed on an assistant. Moreover, the apparatus provides the valuable additional services of upward traction.

The basic assembly consists of a horizontal bar attached to two uprights which fit into the rail fixtures on any standard operation table. On the bar are three friction disc devices for grasping the retractor arms. Movement in two planes is thereby permitted as well as lengthening and shortening of the arm. All parts can be autoclaved. The photograph shows the apparatus assembled.



Retractor assembled.

Two large curved retractor blades are used for the abdominal wall. This pattern is particularly effective for retracting in the midline towards the xiphoid or pubis. Upward as well as lateral retraction greatly improves exposure. For deep retraction a special ball-and-socket jointed holder provides attachment for blades of different size and pattern, which can be held in any desired position. A special inverted-U-shaped blade accommodates the gall bladder, the porta hepatis, and the oesophageal hiatus.

A portacaval anastomosis can be done virtually single-handed through an eleventh-rib incision without opening the chest. An assistant is thereby relieved of an unenviable role reputed to require almost as much post-operative resuscitation as the patient.

The makers of the retractor are Abbey Surgical Instruments Ltd., 69 Wimpole Street, London W.1, who will be pleased to make any retractor blade to specification.