MEDICAL PRACTICE

Clinical Topics

Who undertakes the consultations in the outpatient department?

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Abstract

In a study of all 4275 outpatient consultations over one month in a district general hospital it was found that the clinics in surgical specialties had the largest numbers of patients. In general surgery less than half of new patients and only one third of all patients attending the clinic were seen by a consultant. (Nine months later about a third of all new patients had still not seen a consultant in the clinic.) In the medical clinics just over a quarter of patients were seen by doctors who had less than six months' experience in their present specialty after registration. Overall, doctors had been on continuous duty for at least 24 hours before a third of consultations. Doctors in training had actually worked during the previous night before attending a quarter of the clinics.

Much of the large volume of work is performed by tired, incompletely trained doctors. It is suggested that a greater proportion of the work should be performed by fully trained staff. The workload might be reduced by modifying the pattern of the consultation.

Introduction

British general practitioners seek the advice of specialists on the clinical management of patients by referring patients to a consultant at an outpatient clinic. In 1985 there were about 37 million such consultations. It is reasonable to expect that the patient will be seen by a specialist with suitable experience. Though many aspects of the functioning of outpatients departments have been examined, including the number of referrals,[1,2] length of time to first appointment,[3-5] and efficacy of the appointment system,[6,7] the essential question of whether a specialist opinion is given has gone unanswered.

We therefore decided to study the grade and experience of hospital staff who undertake clinics in our outpatient department.

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Method

Our hospital is a district general hospital with 477 beds and a typical range of specialist services on site, comprising general surgery, orthopaedics, ear, nose, and throat surgery, obstetrics and gynaecology, dentistry, general and geriatric medicine, and paediatrics. Other specialties covered by visiting consultants were not included in this review. Every year about 14 000 inpatients, 4000 day patients, and 57 000 outpatients are managed.

All outpatient clinics were monitored for four weeks. The numbers of new patients and of those attending for follow up appointments in each clinic and the grade and experience of the doctors who undertook consultations were recorded. The period of continuous "on call" duty worked by each doctor before the start of the clinic and whether he or she had been called to medical duties during the previous night (23 00 to 07 00) were also noted. Nine months later the notes of the new patients were reviewed.

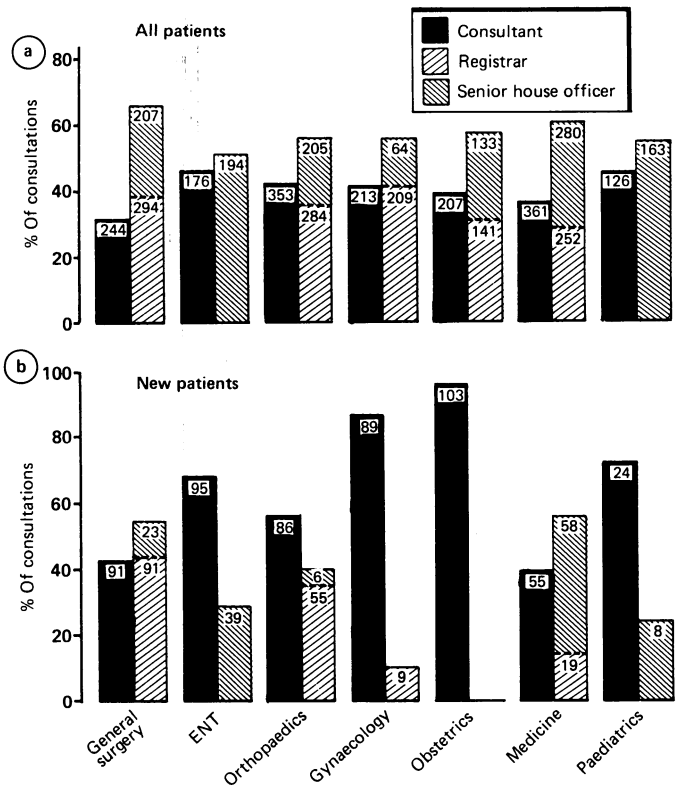
Results

Altogether 140 clinics, comprising 320 doctor sessions, were studied. A total of 124 sessions were held by consultants, 74 by registrars, 114 by senior house officers, and eight by other clinicians. They undertook 902 first consultations and 3373 follow up consultations (total 4275), a ratio of 1 to 3·7.

Overall there were 30·5 patients per clinic. This varied from an average of nine at the quietest clinic (geriatric medicine and dentistry) to 52·7 in orthopaedics (the busiest) and 44·1 in general surgery. (The national average in 1983 was 34·5 patients in orthopaedics and 28·6 in general surgery.) In surgical specialties 1957 patients were seen at 109 "doctor sessions," giving a mean of 18 patients per clinic per doctor. Consultation times were not recorded for each patient. Clinics are scheduled to last three hours, and if the time was used to the full this would allow a mean consultation time of 10 minutes.

Consultants saw 43% (1849) of all patients. Thus 57% (2426) of all consultations were conducted by doctors in training—that is, doctors below the grade of consultant. Clinics in haematology, dermatology, dentistry, and geriatrics were staffed exclusively by consultants. The proportion of new patients seen by consultants varied from 100% in obstetric clinics to 44% (91) and 42% (55) in general surgical and medical clinics respectively. Overall, consultants saw 66% (594) of the new referrals and 37% (1255) of follow up patients. The distribution of consultations in each specialty is shown in the figure.

Nine of 19 consultants had a policy of seeing all new patients referred to the clinic. Where no such policy existed the consultant never saw half of the patients. Overall, after nine months' follow up nearly a third of the original new patients had still not seen a consultant.



(a) Percentage of all patients (n=4106; consultant only clinics=169, not shown) seen by each grade of staff by specialty. (b) Percentage of new patients seen (n=851; consultant only clinics=51, not shown).

Of the 14 different senior house officers working in outpatients clinics, eight were in their first six month appointment in their specialty. At the time of this survey their average length of experience was only three weeks. Two had six months' experience and the others one year, three years, seven years, and eight years. The average experience of the eight registrars was three and a half years. Thus nearly half (10 of 22) of the doctors in training, including all those on general practitioner training schemes, had six months' or less experience in their specialties. At the start of this study three of the four medical senior house officers had less than four weeks' postregistration experience in the specialty. They still saw 40·2% of new cases and 18·4% of all patients attending medical clinics. By contrast two senior house officers in ear, nose, and throat medicine had worked in their specialty for six and eight years.

Consultants were on call the night before for 37·5% of clinics, registrars for 46%, and senior house officers for 23% respectively. For these clinics there was a 68% chance that a doctor in training had been disturbed the previous night. If the clinic was on a Monday the doctor would have been on continuous duty for over 72 hours. The registrars in obstetrics and gynaecology fared worst. They had been disturbed during the night before the clinic on 10 out of 14 clinic occasions.

Discussion

In this hospital clinics in haematology, dermatology, geriatrics, and dentistry are staffed exclusively by consultants. All other clinics, especially in medicine and surgery, rely heavily on doctors in training to provide the service. Patients who attend these clinics are more likely to see a doctor in training, sometimes with only a few weeks' experience after registration, than to see a consultant. If the clinic follows a night on call, as it did on a third of occasions, the inexperienced doctor is also likely to be tired (and consequently under increased stress[8]). These findings are probably typical of non-teaching hospitals. This arrangement does not seem to be desirable, but given the present staffing structure and the number of new patients and follow up appointments it seems inevitable. We wonder whether patients appreciate this state of affairs.

Clearly the time allocated by the appointment system to each patient is limited, and it is debatable whether each patient receives adequate attention. In general surgery clinics an average of 10 minutes is allowed for introduction, history, examination, starting investigations, discussion with the patient, and dictating a letter to the referring general practitioner, leaving little time to discuss patient management with senior colleagues. Perhaps allocating more time to the first visit would reduce the number of follow up appointments. The average ratio of new appointments to follow up appointments was 1:3·7 for all clinics, ranging from a low of 1:2·6 in general surgery to 1:5·7 in medical clinics.

It has previously been suggested that patient care would not be affected if the number of patients attending clinics was reduced. With regard to reducing the number of follow up appointments McCormack *et al* suggested that after a straightforward operation routine follow up was probably unnecessary.[9] In support of this it has been shown that readmissions for complications after appendicectomy are usually initiated by the general practitioner[10] rather than as a result of an outpatient appointment. Kirk suggested that indirect contact by letter or telephone, particularly for results of investigations, would free staff to concentrate on patients who attend outpatient clinics for the first time.[11] Questionnaires could be used for following up patients when required.[12]

Different modifications might be needed in medical clinics. Marsh proposed that in many instances in medicine one follow up appointment was sufficient before returning the patient to the care of the general practitioner. By employing a combination of approaches a new to follow up ratio of 1:1·5 has been recommended.[14] Achieving this radical change in our hospital would eliminate 2024 of the 4275 consultations presented here.

Recently initiatives have been aimed at increasing the number of consultants and reducing the number of registrars.[15] This would increase the proportion of patients seen by fully trained staff in the outpatient department, might allow more definitive decisions to be made at the first consultation, and might reduce the number of follow up appointments. These assumptions should be critically explored before changes are implemented. It is unlikely that senior staff would contract themselves to work in a busy clinic after a night on call as juniors do at present. Thus to replace a registrar by a consultant on a one to one basis might reduce the number of doctors available for outpatient sessions. If a reduction in the number of follow up appointments was not achieved this would cause a rapid increase in outpatient consultation waiting times.

We conclude that the outpatient service in this hospital depends heavily on incompletely trained staff, who may be under stress from tiredness and volume of work. Further studies are required to see whether the same number of new referrals could be processed more expeditiously and more effectively if more time was allocated to the first appointment. A greater proportion of outpatient work should be performed by fully trained staff. The present heavy reliance in the outpatient clinic on doctors in training must be considered when planning medical staffing in hospitals.

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