

Workload of general practitioners

Wide variations, but bound to increase with the new contract

For the second time the Department of Health and the BMA are surveying general practitioners' workload for the review body. Information from this survey will not be available until late 1990. The previous report (carried out during 1985-6) was based on a one week diary kept by about 1000 general practitioners.¹ It showed that each week the average general practitioner spent 38 hours on general medical services, 31 hours on call, and 6 hours on other medically related work. The department and the BMA interpreted these findings very differently: the department states in *Promoting Better Health* that a general practitioner works only 38 hours a week,² whereas the BMA includes all hours and claims that general practitioners work 73 hours a week.

Data on the work of general practitioners have come both from single practices³ and from large surveys.^{4,6} The surveys emphasise the wide variation in the workload of individual general practitioners. The workload comprises not only face to face consultations (which constitute at most two thirds of the total workload⁷) but also practice administration, patient services, health service commitments, education, and other medical commitments—for example, hospital appointments and police and insurance work.⁶ In teaching trainees on the use of time I have yet to find a group who cannot list 20 different tasks carried out each day by the general practitioner.

For clinical work the annual consultation rate for each registered patient is the usual way to assess workload, but results may often not be comparable as all practices, even those in national surveys, are self selected, and slight changes in definition create large differences in consultation rate.⁸ The second national morbidity survey gave an average consultation rate of 3.2,⁹ whereas the general household survey gave 3.8¹⁰ and Cartwright's survey of 1400 patients suggested that 4.5 was more accurate.¹¹ There is also a gradation of consulting rates across Britain, with the highest rates in northern Scotland and the lowest in south east England¹²; and the rate for individual general practitioners varies from less than two to eight consultations for each patient annually.^{4,12} All consultation rates fell during the 1960s and 70s,¹³ but they are now stabilising and may even be rising because of increased preventive consultations and the move to care for chronic illness in the community. The percentage of consultations that were home visits fell from 35% in 1950 to 18% in 1978,¹³ but the actual time taken to carry out these visits remained at 28% of the working day.¹⁴ Though variations between rural and industrial practices may not be as great as expected,¹⁵⁻¹⁷ there are differences within similar areas^{4,5} and even within the same practice. Social deprivation causes a rise in consultation rate.¹⁹

Variations in workload also occur with the doctor's age,^{16,20} sex,^{20,21} and type of practice.²⁰ Recent surveys have proved suggestions first made over 35 years ago,²³ that a doctor's personality is a prime determinant of workload differences.^{17,24} General practitioners who are stable extraverts tend to practise within the region of their university, hold more postgraduate diplomas, recall more patients, see more chronic illness, and have higher consultation rates.²⁵ The morbidity that practitioners have to manage is a major influence on their workload and varies not only with area of practice^{5,9,26} but also with both the patient's and the doctor's age and sex^{9,21,26,27} and with time: current records show less respiratory and more cardiovascular and preventive medicine.²⁸

General practitioners spend on average eight minutes on each consultation.¹ Many practices have answered the call for 10 minute appointments made by Tudor-Hart and others.^{4,29,30} But these averages have to be seen in the light of Marsh's description of the eighth of his patients who create half of his clinical workload³¹ and of O'Dowd's account of the "heartsink" patient, which may better describe the work of the general practitioner. They do, however, lay to rest the myth of the golf playing general practitioner.

What effect will the new contract and the implementation of the white paper on the NHS have on the general practitioners' workload? At a conservative estimate the time taken both administratively and clinically to carry out just the preventive medical check on the elderly will be five hours a week. Larger lists, which may be encouraged by a contract based on capitation, have already been shown to increase the hours spent consulting and decrease the number and time of the individual patient's consultations; larger lists also cause a disproportionate reduction in visiting.^{4,5,20} Linking these changes to laudable ideas of special disease clinics, more practice audit and postgraduate education, and annual practice reports must raise the question of how many hours any doctor may be expected to work. It must encourage doctors to delegate duties, although they must be warned that as the numbers of employed and attached staff increase so do the hours worked by the doctor.¹ The Department of Health will have to consider with great care the increased needs for both general practitioners and ancillary staff if it is to see a satisfactory implementation of both a new contract and the white paper.

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Resource management: process and progress

All hospitals should study the report

The concept of resource management was welcomed by many doctors in Britain, especially those in NHS hospitals who hoped that its successful introduction might make their future contribution to management more positive. The government's initiative in 1986 selected six hospital sites where the method was to be worked out and evaluated with the cooperation of doctors.¹

Resource management has since become one of the few aspects of the government's proposals for reform of the NHS² to which doctors have responded encouragingly even if conditionally.³ They insist that before the system is extended it must be shown that accurate and relevant information can be produced that can be linked to decision making about the use of resources in clinical departments. Though high hopes persist for a successful and practical outcome to the initiative, these have been modified by reports that progress has been difficult and slow. Anxiety is growing that introducing resource management might show a new layer of snags rather than the benefits expected. Signs from the development sites have therefore been eagerly awaited, and when the first report of the evaluation team appeared in midsummer it was seized upon for indications of impending achievement or disillusion.⁴

The Brunel team carefully explains in this first report that its main concern has been in monitoring progress and that it is the final report due at the end of 1990 that will "attempt to evaluate the developments in terms of the costs and benefits associated with the introduction of resource management." The account given is entirely factual, describing the different approaches and progress made at the six sites without any hint of assessment or judgment as to the likely usefulness of the various methods. It is not possible to glean from the report any support for the view that resource management should be widely introduced and given priority funding. Such caution is what might be expected from a research team only halfway through its programme, but the final results of evaluation seem likely to be available only very close to the date the government has set for implementing the NHS reforms. The team has, however, described and emphasised the time taken to develop the organisation and information systems and to handle the changes required for resource management. The report states: "Enormous progress has been made but the two and a half years that have passed since the health notice have not been sufficient for any of these sites, despite the advantages of their initial starting points, to implement a full RM [resource management] system."

No one doubts that the existing financial management systems are unsatisfactory. Resource management seems to

many doctors to be the most promising direction to follow for improvement, but it will take some years after the 1990 evaluation for any benefits to services to be clear cut. How should doctors advise management meanwhile—in view of the government's intention of proceeding with resource management regardless of the evaluation being carried out by Brunel's team? Clearly, the six sites should continue to participate in the research programme. The whole NHS will eventually be grateful to them. The report also seems to contain sufficient material to use as a basis for an interim extension of resource management. The team found variations among the six sites, but there was a common initial phase of analysis of the clinical services of each hospital and a thorough rethinking of the medical management organisation appropriate for future resource management. This process requires that doctors should give a good deal of their time to discussion with financial and other managers. At the six pilot sites the process was started four to 10 years ago.

In most NHS hospitals the report could usefully be read and the points raised in it considered by doctors with the help of local managers. Time given to this exercise would not be wasted. The issues reflect the differing management experience of real hospitals. The report provides facts without accompanying advice and therefore challenges local interpretation and ingenuity. The cost of future improved management systems is expected to be separately funded so developments in medical management should have every chance of implementation. By the time most hospitals are ready some research based options for financial investment should be available.

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4 Buxton M, Packwood T, Keen J. *Resource management: process and progress. Monitoring the six acute hospital pilot sites. Interim report of the Brunel University Evaluation Team*. London: Department of Health, 1989.

Correction

Hypertension in children

An editorial error occurred in this editorial by Dr M de Swiet and Mr M J Dillon (19 August, p 469). The end of the fifth paragraph should read "... peripheral and renal vein plasma renin and renal angiography usually suffices to unravel the cause."