Gateway or dividing line?

A study of hospital out-patients in the 1960s

GORDON FORSYTH AND **ROBERT LOGAN**

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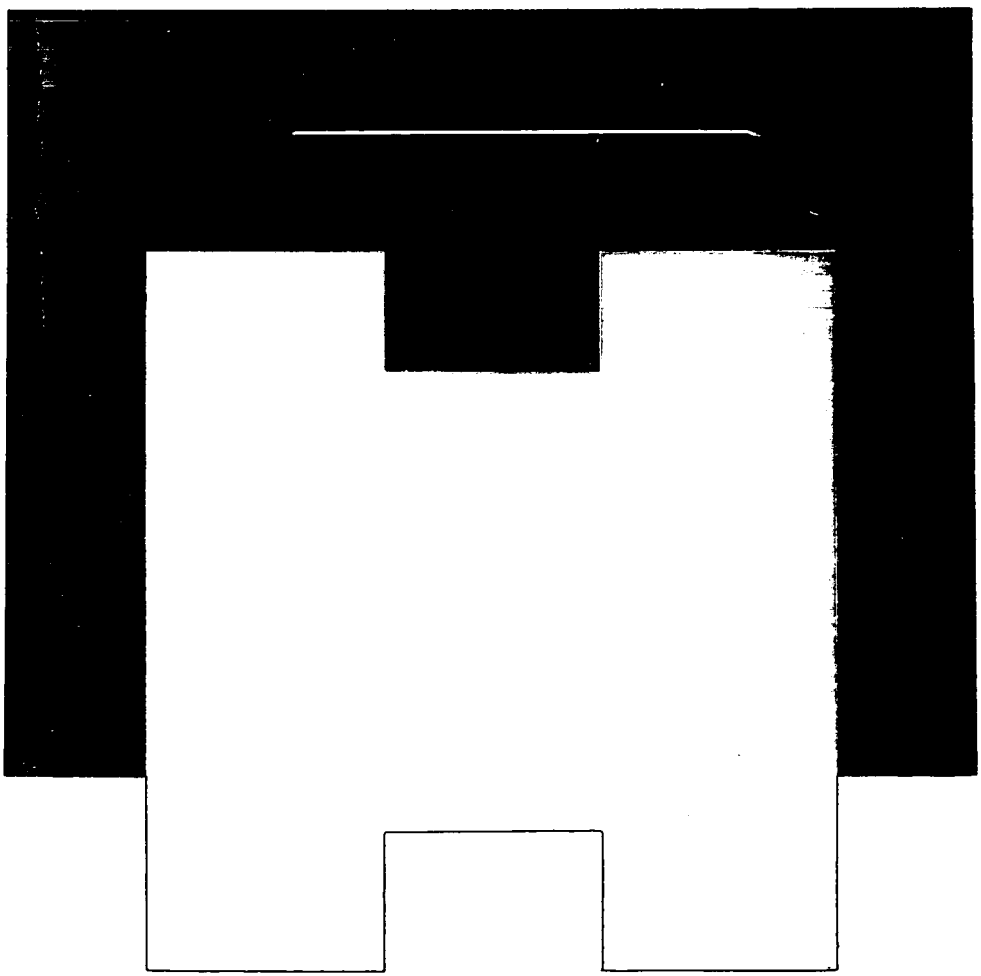
Published for the Nuffield Provincial Hospitals Trust by the Oxford University Press



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Background to the study

1. Origins of the study

In December 1957 the Nuffield Provincial Hospitals Trust convened a two-day conference at Oxford, to discuss future trends in medicine and the possible reorganization of hospital and other health services. Throughout the discussions two outstanding issues were raised again and again: hospital casualty departments in particular and hospital out-patient departments in general. Criticisms voiced about casualty services—low status of casualty departments, poor staffing, and inadequate equipment—were capable of immediate investigation and in 1958 the Trust established a small study group to carry out investigations in selected areas. The group's report (1) was published in 1960 and succeeded both in delineating the unsatisfactory state of the country's casualty services and drawing public attention to the nature of the general problem. It was appreciated at the outset that the companion study of out-patient services would take longer to organize in view of the greater scale and complexity of the services themselves and the fact that concern about the problem dwelt less on adequacy of resources than on the purpose and function of out-patient departments in the present pattern of medical care. Given the present referral system in this country, with access to specialist opinion depending on prior referral by a general practitioner, and given also the specialists' monopoly of hospital services in general, it was apparent that a survey of the operation of out-patient departments in terms of their function would necessarily have to take some account of general practitioner services on the one hand and the

impact of hospital in-patient services on the other. As an initial step towards developing appropriate research methods the Trust in 1959 established a research fellowship in the Department of Social and Preventive Medicine at the University of Manchester to facilitate pilot operational research studies in medical care. One such study concerned a sample of out-patients in the Barrow and Furness Group of hospitals and the ensuing report (2) together with an operational study by the Oxford Regional Hospital Board of out-patients in the Reading hospital encouraged a wider and more representative survey. Accordingly a series of intensive studies was commissioned by the Trust at the University of Aberdeen (3) and the University of Edinburgh (4). Later the King Edward's Hospital Fund for London formed a similar study at Guy's Hospital Medical School, London (5). Reports on these surveys were published in 1966 (6). An extensive survey of out-patient services based on eleven groups of provincial non-teaching hospitals in various parts of England and Wales was undertaken by the Medical Care Research Unit at Manchester, and the information gathered forms the main basis of this report.

2. The nature of the problem

Every year ten per cent of the British public attend hospital as out-patients. Frequently their first impressions are scarcely reassuring. In a typical out-patient clinic the new patient finds that he shares a given time of appointment with a number of other patients. A device called the 'block booking system' has been contrived to ensure that if anyone wastes time waiting it will not be the doctor. It may have been raining outside but there is nowhere to hang raincoats or deposit umbrellas. Unlike the in-patient, who is the full-time responsibility of the staff and seldom left to his own devices, the out-patient because he walks into the clinic is assumed to be capable of fitting himself unaided into the clinic's routine. He presents himself at the department, unsure of where to go or what to do, and he eventually finds his way to the reception desk or is rescued by a nurse. He may be told to follow signs and signals but these, although perfectly intelligible to those familiar with them, are strange to him and difficult to interpret. The absence of clear, individual guidance in out-patient clinics creates a host of needless anxieties, trivial perhaps to those who have never experienced them. The patient may be told to undress in a cubicle and put on a gown—but should he strip

completely or not? And what about his money and wallet? Later he will find himself wearing a ridiculous gown, parading self-consciously in front of total strangers, so that long before he reaches the consulting room his one desire is to get out as quickly as possible. This all too often is the impact on the public of their principal contact with their hospital services.

The total disregard for human dignity was well documented in a recent report by the Scottish Home and Health Department (Hospital Planning Note No. 6, 1967). Reviewing sixteen hospitals comments included: 'impersonal methods of calling patients'; 'divided and interrupted consultations were the rule'; 'lack of privacy when consultations occurred in a room in which other patients were already waiting'; 'the use of communal dressing gowns was frequently observed. Undressing cubicles were sometimes used by a succession of patients before the first patient had redressed, resulting in two patients occasionally dressing in the cubicle at the same time—even two patients of opposite sex'; 'patients were observed carrying urine specimens—uncovered—across waiting halls; some were embarrassed by having to discuss with the nurse in front of other patients the provision of specimens'.

In terms of anxiety the new out-patient has much in common with the air-traveller arriving for his first flight. Both are filled with the wonder and fear of science in the jet age as they begin their new experience in an institution full of hustle and bustle. As in the clinic the airport staff have to stream human beings to various points for connected services and there are often delays caused by emergencies. Yet the airport's reception area is comfortable and the staff feel obliged to announce and explain delays. The system is likely to make the individual passenger feel important: in an out-patient clinic it is likely to make him feel a fool. As for physical comfort out-patient clinics are closer to old Euston Station than an airport.

It is tempting to attribute the poor physical state of out-patient clinics to the financial stringency imposed upon the National Health Service during its first two decades; but this would not altogether explain the poor regard for natural human anxiety among people already anxious about their health. It is impossible to escape from our history and the voluntary hospital movement, which bequeathed to the N.H.S. its paltry stock of cramped and ill-designed out-patient facilities, had for generations identified the out-patient with poverty and degradation. As Sir James Spence (7) observed shrewdly in

1953: 'If many surburban general practitioners today have ill-equipped and unsuitable surgeries it is partly because they have copied what they saw as students in the out-patient departments of their teaching hospitals.' He thought it a pity that in the competition between dispensaries and infirmaries in the late eighteenth and early nineteenth centuries the infirmaries had won. 'Having captured the out-patient work the hospitals then made it subsidiary to in-patient care, fitting it into cramped quarters and appointing junior men to do it' (8).

The perspective of history shows that out-patients have been a source of conflict within the medical profession for over a hundred years. The voluntary hospitals' original system of accepting only patients nominated by subscribers broke down. Under the impact of the Poor Law these institutions found themselves rendering general medical care to those too poor to afford even the sick club practice of the depressed urban general practitioner and unable to endure the harsh scrutiny which the Guardians visited upon applicants for out-door medical relief. It became impossible to sort out those who had a right to attend as out-patients from those who had not. The matter grew in importance with the increasing tendency of the middle classes, for whom specialists and general practitioners were competing, to make use of out-patient departments at specialized hospitals, the situation being exacerbated by the development of specialist clinics in the general hospitals (9). Complaints about the injurious effects of so-called hospital 'abuses' were common in the medical journals throughout the second half of the nineteenth century. In 1869 the *Lancet* investigated the administration of out-patient departments in the London hospitals. One comment on the findings, typical of many, came from a Dr. W. Rendle: 'I do not want to urge the selfish reason that indiscriminate prescribing at charities is injurious to the struggling members of our profession practising in poor neighbourhoods. I should not note this if the apparent good proved to be really a benefit to the poor; but it is not. The really sick and poor have to compete with those who in reality are neither sick nor poor' (10). He urged reform to benefit 'the commencing and struggling practitioner who might and ought to be consulted and paid by many of these undeserving people'. A committee set up by the *Lancet* to consider its out-patient investigation agreed that a large part of out-patient work consisted of trivial cases which did not require any special skill and might properly be left in the hands of

'ordinary medical men' (11). The importance of the bitter economic rivalry between general practitioners and specialists lies in the profound effect it had on British medical practice. As Rosemary Stevens (12) has shown the rivalry gave rise to the present referral system. By the end of the century hospital specialist staff were acting as consultants to other doctors. The system evolved from the fear that the specialist-dominated hospitals would consume the bulk of the general practitioners' living. An alternative to the referral system might have been the fusing of the general practitioner and the hospital 'honorary' into one kind of doctor. 'One corollary . . . was open access by all practitioners to hospital beds. If this had gone through the present system of medical practice in England might have been akin to that in the United States; and the arguments on the justification for, and functions of, the hospital out-patient department *vis-á-vis* the private consulting room might have been delayed by over half a century' (13).

The referral system did not entirely resolve the conflict between the two branches of the profession, and complaints about the abuse of hospitals continued. In 1890 the House of Lords Committee on the Metropolitan Hospitals discussed the use of out-patient departments for consultative purposes. 'The desirability of so using them was generally assented to . . . but upon the question whether a letter from a doctor should be the sole passport for admission, and whether the hospital, having once seen and prescribed for the patient, might go on treating him or must send him back forthwith to his proper doctor there was less unanimity' (14). In 1910 the London out-patient situation was again studied, this time by the King Edward's Hospital Fund. Its committee wished to restrict out-patients to those directly referred by general practitioners (15). The B.M.A.'s campaign in the late nineteenth century to have out-patient departments at voluntary hospitals closed to non-subscribers had not apparently succeeded.

The Insurance Act of 1911 was rather more successful than the referral system in easing the financial dispute between doctors in hospital and doctors in the community. In urban areas 'panel' doctors with large practices, paid on the capitation system made familiar by voluntary sick club usage, were often glad to send patients off to out-patient departments. It cost the doctor nothing and the patient a few coppers. However, the scope of the 1911 Act, despite its extensions in the twenties and thirties, was limited and

professional concern over abuse of hospital services by the middle-classes continued. Even in 1938 the Hospitals Committee of the B.M.A. found itself faced with a resolution referred by the Metropolitan Counties Branch, drawing attention to abuse by Hospital Savings Association subscribers (16). The question was whether people producing a 'green voucher' from the H.S.A. should also produce a letter from their doctor. It was customary for the H.S.A. in its official publications to warn subscribers that many hospitals would not accept new patients unless at the first attendance a letter was produced from the family doctor indicating the treatment already given and the circumstances which appeared to render special diagnosis and treatment desirable. These warnings did not always deter and in any case, as the Hospitals Committee pointed out, 'there was a growing practice of persons, whether contributors or not, to seek consultation at hospitals when they could afford private fees. The view was strongly expressed that those who could afford treatment outside hospitals should not be allowed treatment inside' (17). Occasionally an isolated medical voice spoke up for the middle classes. For example, Dr. Alfred Cox (18) questioned the position of those earning over £250 per annum: 'They are assumed to be capable of meeting the doctor's bill; in fact it is often a crushing burden. The result is that many of them are driven to all kinds of dodges to avoid such a bill and few of them make that steady use of the family doctor that they ought to do.' A more popular view was that of Dr. Horace Nathan (19): 'Already the out-patient department and minor ailment clinic . . . have taken the place of the general practitioner's consulting room. . . . The time of consultants also is continually being wasted through the lack of co-ordination and efficient investigation of patients' incomes.' Official B.M.A. policy on the issue was to be found in the Council's 1938 Memorandum: 'A General Medical Service for the Nation' (20). Paragraph 34 noted: 'The specialist in medicine is the complement of the family doctor, and not a substitute for him. . . . Even if the patient happens to be right in thinking he needs the services of a specialist, and is doubly fortunate in choosing the right one, he cannot obtain full value for his expenditure of time and money if he goes to the specialist unprovided with the valuable information the family doctor could have given . . . these considerations apply whether the individual patient seeks treatment at a clinic, a hospital, or privately.' The Memorandum recalled approvingly the view set out in the Dawson Report

of 1920 (21): 'The first essential for the proper and efficient treatment of individual persons is not institutional but personal service, such as can be rendered in their own homes only by a family doctor who has the continuous care of their health.' The Dawson Report determined the nature of practice under the National Health Service, which removed what little economic threat the out-patient department still held for the general practitioner. Under the N.H.S. patients were guaranteed the services of a general practitioner as personal doctor and hospital out-patients were closed to direct access by the public. It is sobering to reflect that the present British system (although it may have its own justification in terms of the patient's welfare) developed as a rationalization of a long-standing usage which sought to reconcile a conflict within the medical profession and regulate practice in the interest of doctors.

Be that as it may the British out-patient system has the distinctive feature of limiting specialist practice to hospitals and making access dependent on prior discussion with a general practitioner. In all systems of medical care doctors will seek second opinions on cases varying in their degree of complexity and patients will sometimes need specialized care or treatment. In North America many patients refer themselves to specialists. In Sweden any patient may refer himself to a hospital out-patient department. In Denmark the out-patient system is unknown; patients are referred to consultants' private offices, the State paying the fee. In eastern Europe the process of screening and selecting cases for specialized attention is organized through a system of polyclinics serving the primary needs of nearby residents.

In Britain the N.H.S., by linking each patient with a personal doctor, making all other medical services available only through him, and sharpening the demarcation lines between doctors in hospital and doctors in the community, implied a series of functions for the modern hospital out-patient department. Primarily the out-patient department should serve as the venue for consultation between the personal doctor and the specialist. According to Sir James Spence (22): 'Above all the out-patient department should offer a true consultation on the lines of private practice. . . . The consultation must be completely private—just the consultant with the patient and his own doctor—and no nurses, almoners or clerks should be allowed in the room.' Brave words which sound hollower now even than in 1953! Since the general practitioner is not present

when the specialist sees the patient it follows that an adequate system of communications will be required if the consultation is to be effective. Associated with this consultative function, and underlined by the separation of the general practitioner from the advances of hospital medicine, is another function: the out-patient department and the communications system surrounding it should play an important role in professional education, so that doctors involved in the long-term care of patients may learn something about specific episodes of illness which may in fact have new implications for the patient in the long run. To these functions, which it is emphasized are merely implicit in the present organization of medical care under the N.H.S., may be added an older and more practical function of the out-patient department: the screening of patients to prevent unnecessary admission to a hospital bed. This has always been a function of the out-patient department but has been given greater emphasis as the costs of hospitals have increased.

The object of this survey was to ascertain how the functions of out-patient departments across the country compare with the functions described above. There is after all little point in clinging to extrapolated theories if the practice (which may have its own rationale) is radically different from what it is assumed to be. No organization should be in the dark about itself but out-patient departments are more frequently commented on than studied.

Although, in the main, financial rewards are no longer involved, the out-patient department is still a matter of dispute within the medical profession. Some general practitioners complain that patients are often retained unnecessarily as long-term attenders at out-patient departments and that in this way hospital doctors impinge on their territory. Against this some consultants suggest that many patients are sent to out-patient clinics unnecessarily and that far from taking the load off in-patient wards the out-patient department is easing the load off the general practitioner. The same point was made after a hospital case-load survey in 1955 (23). Out-patient departments are still a matter of controversy; in that at least, nothing has changed, although financial anxiety on the part of the general practitioner has been replaced by status fear. At the B.M.A.'s Annual Representative Meeting in 1967 delegates supported the Council in approving a recommendation of the Central Ethical Committee on the subject of acceptance of patients by specialists.

Existing ethical policy stated: '(a specialist) should not, except in circumstances stated below, accept a patient for examination and advice except on a reference from a general practitioner, or from another specialist, which should only be with the general practitioner's knowledge.' (Exceptions included emergencies, overseas visitors without a family doctor in this country, and cases of venereal disease.) A leading article in the *British Medical Journal* (24) noted: 'The sense of the new policy is that only so long as a specialist is himself concerned with the management of the patient may he obtain further opinions from his colleagues without first consulting the general practitioner.' Council had approved the recommendation despite objections from consultant members that the procedure would waste time for both doctor and patient. Exceptions were provided however and the code could be waived if the patient were likely to be caused great inconvenience. The *Journal* commented: 'Support for the proposals could be a welcome sign that the profession as a whole recognises the value to patients of a family doctor whose responsibility does not stop at the hospital gates' (25).

Careful scrutiny of his own out-patients led one specialist (26) to a different conclusion. 'It is unfair to judge the G.P. with his limited resources, by hospital standards of investigation; yet, subject to this reservation not all general practitioners are doing the best they can for the patient. Quite often they fail in a sphere which should be peculiarly their own, and which indeed they strongly claim as such: they often show apparent ignorance of important details in the patient's domestic background or personality, or at least fail to mention them to the consultant. . . . May not a solution be found in which the general practitioner's work is undertaken by doctors based on the hospital out-patient department? Either the general practitioner will move to the hospital or the hospital will provide the domiciliary service.'

Perhaps this analysis is correct. It may well be true that the N.H.S. is not only handicapped by nineteenth-century buildings but also by a nineteenth-century medical profession which is equally restrictive. Radical rethinking about the structure of the N.H.S. is not the business of this report; but it may help a little in stimulating such a reappraisal to indicate how out-patient clinics function within the present rules of the game.

3. Approach to the survey

1. The choice of survey areas

The study involved some eighty hospitals in eleven Hospital Management Committee Groups in nine Hospital Regions.

Areas were selected empirically. The aim was to choose the minimum number of areas to show differences across the country in the work-load and methods of operation in out-patient departments. Areas were picked in the north and south, east and west; industrial areas and farming; expanding areas and declining; seaside and inland; where in-patient beds were many and where they were few. All selected areas were at a distance from teaching hospitals so as to increase the likelihood that the out-patient load represented the total out-patient referrals in the area.

Boundaries of individual survey areas were determined by Hospital Management Committee areas (H.M.C.) and all the consultative out-patient clinics in a given specialty within the group were included and regarded as a single out-patient unit. This was necessary as, perhaps for lack of suitable central accommodation, or because of the dimensions of the H.M.C. areas, out-patient facilities are fragmented and not all specialties in the area will be in one hospital. In these circumstances it would be meaningless to measure a population-based rate of referral to a central out-patient department, without taking into account all of the subsidiary departments that help to carry the load.

Groups A and C were chosen as seaside, residential towns with elderly populations, one in the north and the other in the south; Group G also has a relative excess of elderly people but is inland. Groups B, J, and K are all industrial areas; Groups B and K both have declining populations but Group J is relatively new and expanding; Group K has a relative abundance of hospital beds but Group J an acute shortage. Groups F, E, and I are county towns, and whereas Group F is declining in population, Groups E and I are expanding and are subregional centres. Groups G and H are market towns; the former in the north and the latter in the south. The truly rural areas are Group D in the west, bleak hills, scattered population, and poor internal and external communications; and the area between Group I and Group H in the east (whose H.M.C. areas share a common frontier) where the countryside is lush and communications comparatively good.

The areas chosen were compared with the 'Classification of Towns' used by Moser and Scott in *British Towns* (27). Each of their groups was represented in the survey except for one; there were no dormitory towns in or near conurbations. This was an inevitable result of excluding areas close to teaching hospitals.

Each area chosen was thus a self-contained, provincial area corresponding to an area which would be served by the proposed District General Hospitals. (Actually, the Hospital Plan of 1962 (28) envisaged that the eleven areas would be served by twelve district hospitals; Area C1, which has an estimated population of 500 000, was to have two district general hospitals.)

The survey hospitals between them serve about 2 000 000 people. The population of the central urban areas varies between 10 000 and 160 000 and together totals 1 117 000. The population in these areas is a little older than that of the population of England and Wales as a whole.

II. The choice of out-patient specialties

This survey covered the consultative out-patient specialties of general medicine, chest diseases, paediatrics, dermatology, psychiatry, general surgery, orthopaedics, gynaecology, ear, nose, and throat, and ophthalmology. Where specialty clinics were held in neurology, diabetics, and cardiology their work was included within general medicine. Each area held consultative specialty clinics in obstetrics, radiotherapy, and dentistry, but these were excluded as their pattern of referral and the composition of their clientele are somewhat different from the rest. In obstetrics there are wide variations in the proportions of antenatal care undertaken by hospital out-patient departments and variations too in the involvement of general practitioners in obstetrics. In dentistry referrals are normally made by the general dental practitioner. Radiotherapy is a super-specialty like thoracic surgery and neurosurgery, where most referrals are from other consultative clinics within the hospital, or from other hospitals within the region.

III. Sources of data

Following letters to the Regional Boards and H.M.C.s and discussions with the Medical Advisory Committees and Group Secretaries, co-operation was promised, and permission given, for information to be collected on new out-patients, in two separate samples.

For the purpose of this survey, new out-patients were those referred from outside the hospital or from the casualty department of the hospital, and were defined as:

(*a*) Those referred for the *first* time to this particular specialty.

(*b*) Those who had been referred to this specialty *before:*

(1) but who had previously been discharged from hospital care, or who had not attended for at least twelve months,

(2) and who, while not discharged from hospital care for that episode, had been referred again with a new complaint.

This definition of 'new out-patient' is different from that used in the routine collection of hospital statistics and in concurrent studies in Edinburgh, Aberdeen, and Guy's, but identical with that used by Barr in his Oxford study (29). Thus we count as only one referral any case where a patient is referred by his general practitioner to one clinic and is then sent on with the same condition to a second; in this study the second visit is regarded as a repeat attendance.

The two samples of new out-patients were as follows:

1. Information on age, sex, area of residence, and referral agent was collected by the record room clerks on every new out-patient attending during every fourth week for a calendar year; the information was collected simultaneously in all the survey areas across the country: 50 000 patients were included and information thus gained was used to calculate rates of referral from Local Authority Areas and from individual general practices.

This presents a particular problem. Patients resident in the area served by one group of hospitals may use hospitals located outside that area. This becomes more probable the closer the patient is to the administrative boundary between two groups. In the case of hospital in-patients methods have been devised for calculating true admission rates for individual local government authority areas. The same method could be applied in theory to out-patients but in practice the task would be formidable. For out-patients there is nothing comparable to the in-patient ward admission and discharge register. It would have been necessary to collect prospectively information about age, sex, and residence of new out-patients in all management committee areas bordering on the actual survey areas. To avoid this cumbersome procedure a questionnaire was sent to 800 general practitioners in the survey areas. The answers from the 600 respondents indicate that, at least in the central urban areas,

over 90 per cent of referrals in the areas are to the local hospitals studied; however, patients living near the H.M.C. boundaries were not referred to the local hospitals to the same extent. Unfortunately, this method could not yield reliable estimates of the effective population served by the various H.M.C.s as the basis of the general practitioner's responses was invariably an impression rather than a scrutiny of detailed records. The calculation of referral rates has therefore been confined to the larger and more central local government areas and to general practices located within such areas.

2. More detailed information was collected for fifty consecutive new out-patients referred to each specialist. The information was collected by the research team in two stages: information on age, sex, and occupation was collected on first attendance; and on provisional and final diagnoses, number of attendances within six months, rank of doctor consulted, and disposal of the patient (in-patient, back to general practitioner, etc.) by an examination of the case notes and accompanying letters after six months. In addition, a sample of those still attending after six months were followed up for varying periods up to three years. Information on 13 600 patients from all specialties was collected during 1962, each area accommodating the two field-workers for one month at a time.

It is of interest to note that the respective age and sex distributions, by specialty, of the 13 600 sample and the 50 000 sample are identical, despite differences in the method of collection.

IV. **Problems encountered**

There were difficulties in a number of ways:

(*a*) The record room clerk had to make the decision whether a patient was a new out-patient or not. The only definition that gave her difficulty was when a patient already attending brought with him a letter from his practitioner, and the decision had to be made whether this was about a new condition or not. We found that it was general for all these patients to be considered new referrals. The numbers involved are, however, quite small.

(*b*) The completion of returns for the larger sample was performed by the record room clerks. This was additional work for them when they were already very busy. The sizes of the monthly samples were checked against S.H.3 returns and, although minor discrepancies were inevitable because of differences in the definition of new out-patients, there were two occasions where there were major

discrepancies. At hospital F the first three months' recording was discarded, and replaced by three months at the end of the year. In hospital D2 recording in the ophthalmology clinic was low and so recording was continued for three additional months; caution is, therefore, indicated in interpreting the results from this clinic, as an unknown degree of bias is present. Caution is also necessary with the results from the chest clinic at hospital K1, as recording was lower than expected.

(*c*) Two difficulties were experienced with the small sample. The first was to ensure that recording was made on the clinic list of the name or case number of patients attending either without appointment or following an urgent telephone call.

The second was that since a number of out-patient clinics are for one disease only (e.g. diabetes, varicose veins, haemorrhoids), the method of taking fifty new out-patients for each specialist caused the over-all sample in some areas to be over-represented with these diagnoses. In one area, for example, of the three general physicians one saw only diabetics in out-patients; since his fifty new out-patients were seen over a longer number of weeks than those of his colleagues, diabetes will appear in this area in the diagnoses more frequently than its true incidence in new out-patients there. Although this reservation diminishes the usefulness of this sample for quantitive inter-hospital comparisons, nevertheless the sample reflects well the kind of conditions that patients bring to out-patient departments. At the same time, the method did have the great merit of revealing at an early stage the incidence of local practices such as this, demonstrating that the function of out-patient departments is by no means uniform.

v. Use of direct access facilities

The method of collecting data referring to the use by general practitioners of direct access diagnostic facilities was simply to extract from the day-books of X-ray departments and pathological laboratories information showing the specific request made and the name of the general practitioner concerned. This was done in each hospital area and included the requests made during alternate months in 1962 to all types of direct access facility. The inquiry was restricted to 369 general practitioners practising within the boundaries of the major local government authorities in each hospital area. The

study is, therefore, representative only of the doctors living reasonably close to the hospital concerned. Information about size of practice list was made available by Executive Councils with the agreement of Local Medical Committees. Information about medical school, years since qualification, etc., was extracted from the *British Medical Directory*.

VI. Questionnaire to consultants and S.H.M.O.s

To supplement the information collected from other sources, and to give a picture of the satisfactions and dissatisfactions they have in their out-patient work, questionnaires were sent to the consultants and S.H.M.O.s in the survey areas. Questions fell into the following five groups:

(*a*) On their allocation and use of time for out-patients.

(*b*) On the personnel, facilities, and equipment they have to help them in their work, and on the deficiencies that make their work difficult.

(*c*) On their relationships with general practitioners, *vis-à-vis* out-patients.

(*d*) On their way of handling out-patients.

(*e*) On domiciliary consultations, as an alternative method of seeing patients away from the wards.

The questionnaire contained about a hundred items for completion, many of them with space for free comment. After pilot testing locally, the completed form was used in one study area and then some more minor modifications were made. Answers, therefore, from this study area (Group G) are not comparable for some items with the answers from the remaining areas.

The method of distribution of the questionnaire was to attend a meeting of the Medical Advisory Committee in each of the study areas, and to introduce the topic as part of a presentation on the findings from other parts of the study. Copies were distributed at the meeting to the doctors attending, and for the others copies were mailed with a covering letter. Doctors slow to return the forms were written to, and sometimes telephoned.

One study area (Group E) did not receive questionnaires, as a meeting could not be arranged at a mutually suitable time.

Completed questionnaires were received from 158 out of the 190 consultants in the ten study areas. By areas, Group J had a 100 per cent return and most were over 80 per cent except for Group D, 68 per cent, and the pilot in Group G, 59 per cent. By specialty, the major specialties had response rates of 87 per cent or more, but gynaecology had 83, ophthalmology 76, ear, nose, and throat 69, and chest diseases 60 per cent. The figures for gynaecology and chest diseases may be artificially low in that the former includes Obstetricians in the denominator but not necessarily in the numerator, and the latter includes consultants and S.H.M.O.s, some of whose clinics are still sited in the Local Authority's tuberculosis premises away from the hospital.

The response rates do not include the geriatricians, many of whom do not have sessions in out-patients. However, six responses were received, and these have been included in the analyses. The results are therefore drawn from 164 completed questionnaires and cover the opinions of 90 per cent of the consultants in general medicine and paediatrics, and orthopaedics and general surgery.

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2
Survey findings

1. Facilities and organization

All told, the Manchester survey team visited eighty hospitals and had the opportunity to make comparisons between the out-patient departments in terms of patient comfort, adequacy of facilities, efficiency of organization and so on.

Apart from the proposals which appear in the appendix in the Porritt Report (1) no published standards to be achieved in the out-patient department existed at the time of the survey. This is the more surprising at a time when money is being spent on new departments many of which seem to provide for the concern of the patients no better than the departments they have replaced. We therefore had to rely on our own subjective standards as a yardstick against which to measure the facilities and organization we observed. Many of our views agree with those expressed in the appendix to the Porritt Report and quotations from this appendix are italicised in the following pages.

Briefly, our approach was to visualize the layout and amenities of the out-patient department as seen by the patient.

For the sake of convenience most of the tables and comments have been restricted to the out-patient departments of the fourteen main hospitals only. Four of these hospital departments were built pre-war, eight between the two world wars, and two post-war.

1. Arrival and reception

At the present time, the majority of out-patients arrive by public transport and bus stops were in all cases sited as near as possible to the front entrance of the hospital, although this did not necessarily mean in juxtaposition to the out-patient department. At hospital E

the bus came into the hospital grounds and stopped at the out-patient entrance, saving a 200-yard walk. In ten out of fourteen cases there was, however, no bus shelter.

More patients are using cars and require car-parking facilities convenient to the out-patient department. In two hospitals of the sample, K2 and C1, there were no parking facilities for patients. In four others, parking was provided but was already inadequate. Use of private cars will certainly increase and provision of car parks adjacent to the hospital must be made.

A small number of new out-patients (½–2 per cent) arrive by hospital transport, i.e. ambulance or sitting car; and a proportion require to be carried through to the department by stretcher. Ideally, this unloading should be under cover. In half the sample there was no cover whatsoever and on many occasions we watched patients being unloaded in snow and rain. In hospital K1 all entrances involved climbing steps.

In only two hospitals visited, D2 and H, was there covered shelter for prams and in neither case was this specifically designed. In hospital K1 the admission of prams into the hospital was strictly forbidden.

'*Good direction notices should be displayed . . .*'

Out-patient departments are not usually difficult to find but in three cases, B, D1, and K2, there were no directions whatsoever and in another three, C1, F, and G, signposting was inadequate being either too small or misleading.

'*Receptionists, who could be voluntary workers, should be posted in the main entrance hall to welcome patients and guide them to appropriate destinations. Uniformed, trained commissionaires should be stationed at the entrance.*'

Who in practice greets you on arrival? In five cases in our sample nobody: hospitals D2, E, F, K1, and K2. Patients are normally apprehensive and worried about what may be wrong with them when they visit a hospital, especially if they have not been there before. If there is no-one to tell them what to do and where to go uneasiness is increased. All too often internal signposting is absent or ambiguous. How is a patient to know whether to join the new patient queue or the old patient queue to register? It is not surprising in these circumstances that patients wait outside the wrong clinic or rely on other patients for guidance.

In the sample of hospitals visited only two, H and J, had designated receptionists. The one at hospital J worked in a draught-proof, patient-proof box and was addressed through a window. In the remainder of the hospitals a porter was on duty whose function was partly to answer queries and whose efficiency and availability varied widely. The porter at hospital A filled the job very well, while another we met would have been more at home on the parade ground.

Out-patient porters have multiple functions and should in no way be regarded as absolving the hospital from the necessity of providing a receptionist.

'. . . *a registration bureau in the main entrance hall with cubicles affording privacy and sufficient in number to avoid queueing.*'

Unless a receptionist is available to meet patients, the first point of call is usually the registration bureau. This is the first real point of contact with the hospital and is where documentation takes place. We feel this should be conducted in the most reassuring and friendly manner possible. Ideally private offices should be provided. Failing this then the patient should be seated comfortably facing the registration clerk over an open counter. To ensure privacy the counter should be divided with vertical partitions as in a bank. In fact, we frequently found patients have to stand in a queue awaiting their turn to disclose private information to a figure half hidden behind a partition. In only one hospital, E, were patients registering for the first time called into a separate room to do this. This was not ideal as the only space available was the main records office but at least the patient was treated with some consideration.

Occurrence of queues at the registration bureau is related to the efficiency of the appointments system and flow through, also to the amount of information already known about the patient, i.e. whether pre-registration is adopted or not. Pre-registration was used in four hospitals visited. Personal information about the patient is obtained prior to the visit so that folders, etc., can be prepared for each new patient. At the first visit details are quickly checked through for accuracy.

In Table 1 we have attempted to compare the hospitals in the sample regarding arrival and reception, using a weighted point system. All but the last item refer to a single feature. Ten points are awarded in this case for such aspects as avoidance of queueing, privacy, seating, and a friendly attitude by the staff.

	Maximum points available	Hospital													
		A	B	C1	C2	D1	D2	E	F	G	H	I	J	K1	K2
Car Park	2	2	2	0	2	1	2	2	2	2	2	1	1	1	0
Bus access and shelter	1	1	1	0	0	0	0	1	1	0	0	0	0	0	0
Covered unloading	1	0	1	1	0	0	1	1	0	1	1	1	0	0	0
Pram shelter	1	0	0	0	0	0	1	0	0	0	1	0	0	0	0
External signposting	2	2	0	1	2	0	2	1	1	1	2	2	2	2	0
Receptionist/ porter	10	4	3	2	2	4	0	0	0	2	6	2	5	0	0
Where and how received	10	3	5	5	6	8	3	7	5	6	3	4	3	4	3
Total	27	12	12	9	12	13	9	12	9	12	15	10	11	7	3
Score %	100	44	44	33	44	48	33	44	33	44	55	37	40	25	11

Table 1. *Out-patient departments of hospitals rated on reception criteria*

It will be noted that in our opinion very few hospitals reached even the halfway mark.

II. Appointments

An appointment system has two functions—to regulate the number seen per session and to govern the rate of flow of patients through the department, so as to minimize waiting time for doctor and patient.

It is now ten years since the Trust formulated suggestions for the regulation and improvement of appointment systems (2). A second survey (3) shows that although there has been some improvement, by and large there is still far too much unnecessary waiting. In our sample of hospitals we investigated how far, in fact, the Trust's recommendations had been put into practice and what thought is given to the regulation of the flow in individual hospitals.

We rated the hospitals in the sample as follows:

0 = No appointment system.

2 = Appointment system exists but little thought given to its management and no awareness of any problems.

4 = Those responsible for running appointment system aware of a defect in it but no action taken to find its nature or eradicate it.

6 = Investigation has been carried out to ascertain the cause of any defect but resistance to change too great to result in improvement.

8 = System has been investigated and subsequently improved.

Region	Hospital	Score %
Manchester	A*	10
Manchester	B*	20
Wessex	C1	60
Wessex	C2	70
Wales	D1*	60
Wales	D2*	50
S.E. Metropolitan	E	30
Newcastle	F*	80
Leeds	G*	10
East Anglia	H	90
East Anglia	I	50
Sheffield	J*	30
Liverpool	K1*	10
Liverpool	K2*	10

* North of the Wash

Table 2. *Out-patient departments of hospitals. Rating of appointment systems*

10 = A good appointment system with continuous attempts to regulate the flow of patients by repeated investigations.

A point was subtracted from the rating score if:

1 = Patients are seen in order of arrival instead of booking order.

2 = Block booking occurs.

An additional point is given if there is an attempt to correlate patients' bookings with the arrival of hospital or public transport (Table 2).

The lay staff are in the best position to review the working arrangements of the appointment system by periodic investigation and to make recommendations, where necessary, to the hospital consultant concerned. The latter ought equally readily to accept advice and implement it. In practice he is the arbiter and governor of the appointment system in that he alone decides the rate of booking often without regard to the pace at which he works. A common fault is overbooking at the beginning of a clinic to ensure against non-arrival or lateness of patients. Lateness of the consultant means that all the appointments are behind time. At one hospital a consultant arrived for his morning clinic at 10 a.m. regularly for years but insisted that booking began at 9 a.m. Were he wholly in private practice he might have found such egocentric behaviour expensive.

At another hospital proposals to improve the appointment system which were decided on after a careful investigation were turned down by the Medical Committee of the hospital against the wishes of its Chairman.

Common faults we found besides overbooking at the beginning of the clinic were block booking, particularly of new patients who were then seen at intervals throughout the clinic. Frequently afternoon clinics made their last appointment for 3 p.m. although the clinic never finished before 4 p.m. or later. On the other hand, bookings may finish at 5 p.m. because the clerical staff then go off duty although the consultant often works well beyond this time and would like to book appointments after 5 p.m. In some cases a new consultant continued the rate of booking patients of his predecessor although his rate of work was quite different.

The smooth working of an appointment system depends on co-operation between lay staff on the one hand and medical and nursing staff on the other. In hospital B the appointment system had fallen down completely because of poor relations between nursing and lay staff, whereas in hospital F relations were excellent and a continuous appraisal was possible.

Reference to Table 2 will show there is a distinct difference between hospitals north and south of the Wash and the Severn. North of this line only one hospital had a good appointment system but south of it four-fifths had undertaken investigations and in some areas published their findings.

III. Waiting hall facilities

The Porritt Report recommends that there should be a small central hall with waiting areas in relation to clinic suites. To be ideal this system requires receptionists in each waiting area. In the absence of these the system does not work satisfactorily. In the new out-patient department of hospital D2 the physical layout included separate waiting places but since these were not supervised, the reception staff did not like the system in that patients occasionally waited in the wrong place and were 'found' at the end of a clinic.

Very frequently the out-patient department consists of a large central hall with clinic suites opening from it. First impressions should put patients at ease. This is not usually the case. Waiting halls are often poorly furnished, ill lit, badly heated, noisy, and unimaginatively decorated. In Table 3 we have listed the various items in the waiting hall and given them a rating mark. The total of these points correlates closely with our overall impressions.

	Maximum points available	Hospital													
		A	B	C1	C2	D1	D2	E	F	G	H	I	J	K1	K2
Overall appearance	5	3	1	2	4	4	5	1	5	1	3	2	1	2	0
Heating	2	2	1	2	2	2	2	0	2	1	1	1	0	2	2
Seating accommodation	2	0	1	1	1	0	1	0	1	0	1	1	0	1	0
Flooring and noise	2	1	1	1	1	1	2	0	2	0	2	1	0	1	1
Cloakroom and toilets	5	3	4	3	4	4	4	3	2	3	3	1	3	3	1
Canteen	3	2	2	2	2	1	3	2	3	1	1	3	2	1	0
Magazines	1	1	0	0	1	1	0	0	1	1	0	1	1	0	0
Arrangements for children, etc.	1	0	0	0	0	0	0	0	0	0	0	1	0	0	0
'Exposure' to casualties, etc.	1	1	0	0	1	1	1	1	1	0	0	1	1	1	1
Total	22	13	10	11	16	14	18	7	17	7	11	12	8	11	5
Score %	100	59	45	50	72	63	81	31	77	31	50	54	36	50	22

Table 3. *Out-patient departments of hospitals. Rating of waiting hall facilities*

SEATING

In six of the hospitals the seats were uncomfortable and formally arranged in serried ranks. In the other eight hospitals the seats were also arranged in straight rows of military precision but were more comfortable.

It appears that seats are arranged formally because:

(*a*) Little consideration has been given to alternative arrangements.

(*b*) It is thought to save space.

If more thought were given to the appointment system fewer chairs and costly floor space would be needed, as there would be a small and steady flow of patients as in a private clinic.

NOISE

'*Such items as floor carpeting should be investigated. Carpets reduce noise . . .*'

No department visited had carpet and we think it will be a long time before this revolutionary B.M.A. proposal is accepted. An upgrading of this kind would be the greatest single factor in creating the right atmosphere. We are completely in agreement with the Porritt Report that carpeting should be given a trial. The reduction of noise would do much to change the atmosphere from that of a railway station to an air terminal if not to a hotel lounge. Apart from being a source of noise some floors are dangerous to infirm patients. Perhaps the best example of misplaced zeal for polishing floors that

we saw was in an orthopaedic out-patient clinic. Patients had first to climb steep wooden stairs to the first floor of a former workhouse. The department itself had a highly polished lino covered floor which shone like glass and did credit to the cleaners but hardly contributed to the self-confidence of patients in plaster.

OTHER PHYSICAL AMENITIES

'Good toilet facilities . . .'

Toilet facilities exist in, or adjacent to, all departments visited but are not always satisfactory. For an extreme example, one hospital had its toilets outside the department in a yard and these were in a continuous state of disrepair and were virtually unusable. Most were poor. One would expect hospitals to set a standard of cleanliness and hygiene. This is all too often lacking—in two of the hospitals visited, G and F, over a period of four weeks, no soap or towels were provided. Toilets are nobody's particular responsibility and the only member of the staff who normally has occasion to visit them is a hospital cleaner. Provision should be made for adequate cloakroom facilities where patients can leave coats in safety. At present patients must carry coats—wet or dry—with them wherever they go.

Few out-patient departments provide a public telephone though it would seem an essential item. Public telephones are occasionally found in odd corners of the hospital not convenient to out-patients.

'The buffet should be adjoining the hall and be imaginatively stocked.'

All the out-patient departments provided a buffet of some kind but these varied from hospital I which had an area set aside for patients using the buffet, to hospital K1 where tea was served from a trolley for very limited times each day, and hospital H where automatic machines had been installed for tea, etc. Although the arrangements were varied the refreshments were not.

Little or no thought has been given to special provision for children or old people. Only one hospital provided any means of amusement for children and that was a children's hospital. There are never any facilities for feeding a baby or changing nappies—these luxuries are only found on motorways. Provision of magazines to help pass time waiting depended on charity. Half the departments in the survey had none at all. Another out-patient sister told us that patients took so many of the magazines away that they had begun to wonder if it was worth providing them.

One general criticism of out-patient departments is that in many of them out-patients and casualty cases shared a common entrance. Seriously injured casualties had to pass patients waiting to attend clinics. All too often the hall became the store for stretchers, wheel chairs, and other bulky items. In one department we saw an iron lung which had obviously been left there for a considerable time.

IV. Clinic accommodation

We found it difficult ourselves to judge the standard of clinic accommodation in all the hospitals visited as even suites which looked adequate for one particular purpose were totally inadequate when used for another purpose. We frequently found inadequacies of space and furniture which often meant two doctors had to use the same room at the same time. There were instances of even greater deficiency. Very often in order to save time, two couches were placed in the same room. Patients could not see each other but could hear all the details of history and examination.

The clinic accommodation in no case was entirely good. Not one of the departments visited possessed its own out-patient theatre in which minor surgical operations such as cystoscopy could be done. For this purpose it was necessary to use the casualty theatre or the main theatre.

It is hardly surprising that so many doctors are uncritical of out-patient accommodation for patients when their own clinic accommodation is so deficient.

In the absence of ideal standards for clinic accommodation we have fallen back on the responses to one of the items included in the questionnaire sent to consultants. Table 4 shows for the survey areas (and not the fourteen hospitals referred to in other parts of this section) the percentage of consultants who expressed satisfaction with their out-patient accommodation.

In view of our comments elsewhere on the inadequacy of the facilities at hospital A, the high degree of satisfaction expressed by consultants there may seem surprising; however, the inquiry took place at a time when the hospital was in a stage of transition and the imminent prospect of new out-patient facilities conditioned the responses. So far as the other areas are concerned only three, (C1 and C2, E, and F) present an impression of great satisfaction on the part of consultants. At the same time in only two areas (G and K1 and K2) did the degree of satisfaction fall below 30 per cent. In other

Hospital group	% Consultants who think adequate (a) accommodation for doctors	(b) facilities for patients
A	73	47
B	42	53
C	62	47
D	75	75
F	77	65
G	20	30
H	33	56
I	32	23
J	36	18
K	15	29

Table 4. *Out-patient departments of hospitals. Consultants' opinion on adequacy of clinic facilities for themselves and for patients*

words, the opinions expressed by consultants are rather more favourable to their prevailing clinic accommodation than was expected.

v. Working conditions for reception and records staff

The efficiency of an out-patient department depends to a large extent on the calibre of its lay administrative and clerical staff. Their duties include making new or repeat appointments for patients, ensuring that all necessary notes are ready for each clinic and a wide variety of other functions which differ somewhat from hospital to hospital.

In the records departments which we visited we found a lot to criticize although the staff themselves were not always to blame. In particular many of the departments we visited were squeezed into any available space and the staff worked in extremely difficult conditions. In some cases these would certainly not have satisfied the requirements of the Shops, Offices, and Railway Premises Act, 1963. In Table 5 we have attempted to give some idea of relative working conditions in several hospitals but here we should like to give specific instances.

DISTANCE TO MAIN FILING

It is uncommon for a hospital to keep all the clinical records collected together—in our sample only two hospitals did so. The others keep the clinical records in two or more places, often at some distance from the main hospital and from each other. Ideally, the clinical records should be filed in close proximity to the out-patient department but the following are examples we observed:

Table 5. *Out-patient departments of hospitals. Rated on physical facilities for records staff*

		Maximum points available	Hospital													
			A	B	C1	C2	D1	D2	E	F	G	H	I	J	K1	K2
Distance from main filing[1]		3	0	1	2	3	3	0	0	2	2	3	2	1	1	1
Filing rooms[2]		5	1	5	4	5	5	2	0	4	3	4	4	2	3	0
Staff working conditions	Space	3	0	2	1	2	1	1	1	3	0	1	1	2	1	0
	Lighting and heating	2	1	1	1	1	1	1	1	1	0	0	0	0	1	0
	Cloakroom facilities	2	1	0	1	1	1	0	0	0	0	0	0	0	0	0
Total		15	3	9	9	12	11	4	2	10	5	8	7	5	6	1
Score %		100	20	60	60	80	73	27	13	67	33	53	47	33	40	7

1. *Distance from main filing*: 3 = to hand.
   2 = less than two minutes.
   1 = more than two minutes.
   0 = outside main hospital.
2. *Filing room*: Basic of 5 points
   minus points for:
   Multiple filing shelves.
   Inadequate lighting.
   Inadequate cleanliness.
   Poor accessibility.
   Other uncomfortable working conditions.
   Restricted circulation of notes.

   Plus points for:
   General tidiness.
   Aids to filing—colour markings, etc.
   General thought about filing.
   Working tracer card system.
   Attempt to keep notes tidy.

(*a*) HOSPITAL A: Here an increasing number were being stored in a store-room above the lift shaft accessible only by a vertical steel ladder through a trapdoor in the ceiling.

(*b*) HOSPITAL D2: This is a new out-patient department which could store only about one-twentieth of the clinical records—the remainder were stored in a converted manse outside the main building.

(*c*) HOSPITAL E: Here again many of the medical records were stored in a separate building 200 yards down the main drive.

Conditions in the main filing room itself in some instances left much to be desired and made working there very uncongenial. The worst example was at hospital K2 where the main files were housed in a converted balcony with headroom of less than four feet in places. Heating and ventilation were most inadequate. In hospital E the lack of cleanliness was all too apparent. In such conditions it is not surprising that working in the filing room is a very unpopular chore and there is no incentive to keep the medical records in order and good condition.

Records departments have seen a vast increase in the volume of their work. Most have inadequate quarters. Several have taken over part of the out-patient hall and erected temporary partitions. Only two departments were purpose built. Overcrowding certainly makes the work of the records staff far more difficult.

Table 6 presents a summary rating chart and indicates the unsatisfactory state of the clinics in terms of comfort and efficiency.

Most hospital workers feel that with new buildings many problems will automatically disappear. Better working conditions would undoubtedly help but many problems are concerned with personnel and lack of clarification of authority and these could well be carried into new departments.

An aspect that early on drew our attention was that there are no defined limits of authority in the out-patient department. Supervising responsibility lies with the hospital secretary but he is usually remote from the day-to-day running of the out-patient department. Someone whose work lies wholly in the out-patient department should be able to take minor on-the-spot decisions. At present, responsibility is shared for daily organization between the nursing staff, headed by the sister, and the lay staff headed by the medical records officer. Sister is usually regarded as the senior of the two although her

	Hospitals													
	A	B	C1	C2	D1	D2	E	F	G	H	I	J	K1	K2
Reception	44	44	33	44	48	33	44	33	44	55	37	40	25	11
Appointment systems	10	20	60	70	60	50	30	80	10	90	50	30	10	10
Waiting hall	59	45	50	72	63	81	31	77	31	50	54	36	50	22
Clinic accommodation*	73	42	62	62	75	75	—	77	20	33	32	36	15	15
Records, office facilities	20	60	60	80	73	27	13	67	33	53	47	33	40	7

* Consultants' opinion

Table 6. *Out-patient departments of hospitals. Summary of rating scores (percentage)*

interests are clinical rather than concerned with the reception and registration of patients. This encourages hesitancy if not inertia as shown in reluctance to make any changes or innovations, even measures such as rearranging the seating or providing magazines. Either the sister or the medical records officer should be clearly assigned responsibility for decisions not covered by routine procedure. If this person is the sister it is essential she should be free to exercise supervision and not be tied to the clinic of one consultant. This person should be allocated a specific amount of money for such items as flowers, magazines, and pictures; we did not find this provision in any department we visited. At one hospital the sister had tried to get permission to buy flowers and had been refused; she had also been refused permission to get flowers from the hospital gardener.

The appointment of a senior and experienced member of the out-patient staff to supervise the running of the department should result in patients discerning that their interests are the concern of the hospital. Far more use should be made of the voluntary help which is usually gladly given to hospitals. The scheme at St. Thomas's is the classic example of what can be done to oil the wheels of a large organization and provide individual help in the hundred and one trivial matters which crop up wherever a large number of people come in contact with a complex organization like a hospital. Voluntary helpers would be particularly helpful in the out-patient department as receptionists.

The most important point of all is that hospital staff should never forget that they work to provide a service for sick people. All who come into contact with patients should make it an integral part of the job to treat them as fellow humans not clinical cases. This has been said so often in so many surveys and reports that it seems

Specialty	In-patients	New out-patients	Total out-patient attendances	Consultant sessions in out-patients
General medicine	149	107	128	136
Paediatrics	140	95	130	145
Dermatology	120	105	98	117
Psychiatry	—	132	226	185
General surgery	132	110	113	115
Orthopaedics	132	125	119	126
Gynaecology	150	142	140	116
Otolaryngology	86	96	120	112
Ophthalmology	112	143	139	134

Table 7. *Changes in in-patients and out-patients* 1953–63. *Percentage change in the number of admissions to hospital and out-patient attendances in fourteen selected provincial general hospitals in England and Wales; by specialty*

tedious to make the point again. Yet it remains true. Unless it is taaen to heart by all, many of our new hospitals will be no better than our old despite improved surroundings.

2. Trends in hospital activity

Table 7 shows the broad trend, for all specialties except obstetrics, in hospital activity in the eleven survey areas between 1953 and 1963. With little change in the number of beds available the number of in-patient deaths and discharges increased by 33 per cent. Clearly this implies an accelerated tempo of activity on the wards and it is known that the average duration of stay fell throughout this period by half a day each year. Many patients are now discharged on maintenance therapy and require clinical follow-up or supervision in out-patient clinics. In addition the pattern of disease in the community is shifting towards chronicity with recurrent handicap in middle or later life and the emphasis in clinical management is on ambulant rather than institutional care. One would expect therefore to find massive increases in the provision and use of out-patient services. The expectation is only partly confirmed; over the ten-year period new out-patients increased by 22 per cent and attendances by 25 per cent. These are slower rates of increase than that shown by in-patients; but the official statistics on which these findings are based have several shortcomings. Firstly they do not differentiate between in-patients who die and those who are discharged alive. However it is known from other sources (4) that in recent years there has been a tendency for a greater proportion of deaths

to occur in hospital. In 1956, 40 per cent of all deaths occurred in hospital, by 1963 it was 50 per cent. It follows that a slightly higher proportion of in-patients did not become available for out-patient follow-up because they had died. A further special factor makes it hard to assess the relative movements of in-patients and new out-patients with certainty. This concerns the instructions given by the Ministry to those compiling hospital statistics on form S.H. 3. An inadequate definition of a 'new out-patient' (since corrected but operating throughout the period under review) left uncertain the classification of a patient who, after discharge following immediate admission to hospital, was recalled to an out-patient department for follow-up. In one region with twenty general acute hospital groups eleven records officers counted such patients as 'new out-patients' while the other nine classified them as repeat attendances (5).

If repeated in all regions this would mean that nearly half the hospitals deflated the number of new out-patients. A final weakness in the statistics concerns the number of deaths and discharges. Official returns are based on individual hospitals, not patients. It happens that a patient transferred from one hospital to another (perhaps from a general acute to a chronic sick hospital) will appear in each hospital's return and be counted twice. *In short, the official statistics inflate the number of in-patients but deflate the number of new out-patients.* It is possible therefore that the respective trends in in-patient and out-patient services are closer than the figures at first sight suggest.

So far as out-patient services themselves are concerned the expansion in provision is apparent: over-all, the number of consultant sessions increased by 27 per cent. On the other hand there was a lower rate of increase in the number of patients dealt with, whether new patients or repeat attenders. Table 7 presents an analysis by specialty and indicates that only in psychiatry, gynaecology, opthalmology, and ear, nose, and throat, did total attendances increase faster than the number of sessions to deal with them. It follows that the number of patients seen per session must have declined during this period in most major specialties. It may be, of course, that at the start of the period, when the regions had only just completed their establishment of consultant staff, too many patients were being seen per session and that insufficient time was available for them. If this is the case, and if the trend towards a less hectic tempo of activity in out-patients results in more time being spent with

each patient and a greater depth of investigation, then obviously an increase in the quality of services is indicated. Without knowing the initial position it is impossible to reach any definite conclusion. However, in one specialty—dermatology—it is worth noting that while consultant sessions increased by 17 per cent total attendances actually fell by 2 per cent—no doubt thanks to the massive use by general practitioners of steroid salves as a panacea. The limiting factor referred to earlier, concerning the failure to differentiate between in-patient deaths and discharges, is hardly relevant to dermatology and the decline in total attendances looks odd when set against the 20 per cent increase in hospital admissions. Similarly, though less markedly, there seems to be a discrepancy between the relative increase in the use of in-patient and out-patient services in gynaecology, and orthopaedics, and general surgery. The rates of increase should be much closer together in a system which provides more extensive domiciliary services than most western countries. Even with the various reservations taken into account doubt is cast on the supposition that in-patient and out-patient services are really geared efficiently into their respective functions.

3. The patients: age, sex, civil state, and residence

How does the out-patient population compare with the population at large?

A sample of new out-patients taken in the survey areas in the fourth week of every month gave information about some 50 000 people. Analyses of age and sex structure, marital status, and area of residence produced some unexpected results.

It is well-known that the elderly make particularly heavy demands on both general practitioner services and hospital in-patient services (see Fig. 1). In the case of hospital out-patient services however Table 8 demonstrates that in all specialties with the exception of ophthalmology the elderly are represented in the out-patient population at no higher rate than they are represented in the general population. This confirms the findings by Scott and Gilmore in Edinburgh (6) and Backett *et al.* in Aberdeen (7). It is not therefore a phenomenon peculiar to those Scottish towns but is generally true of provincial non-teaching hospital out-patient services. Bearing in mind the many infirmities of the aged and the burden chronic

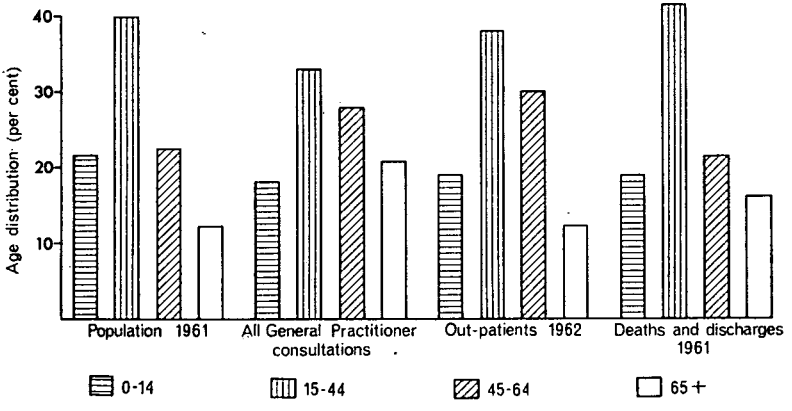

Fig. 1. Age distribution of patients using medical services compared with general population, England and Wales

disease imposes on other types of health services we naturally expected to find the out-patient case-load dominated by the elderly. The fact that their weight in the out-patient population is so close to their incidence in the population at large means in effect that they are under-represented in out-patient clinics in relation to their extra need for investigation and care. The discrepancy is particularly marked in dermatology and psychiatry.

The under-representation of the elderly is our first major finding about the characteristics of the out-patient population and deserves some comment. Speculating on the reasons for the under-representation of those who may be presumed to be most in need of the services two possible explanations may be suggested. People who are now over 65 experienced the unemployment and deprivation of the inter-war period and may have lower expectations in their approach to medical services than those whose adult years began in more prosperous times. Perhaps, therefore, old people exert less pressure on general practitioners to refer them for specialist opinion at consultative out-patient departments, so that their contact with the hospital comes at a later stage as an in-patient admitted directly. In future, when the present young and middle-aged groups pass the age of retirement, the present pattern of under-representation of the elderly in out-patient departments may not be repeated. To some extent this will depend on the validity of a second possible explanation of the present situation. Much of the morbidity among the

	Male (%)					Female (%)				
	0–14	15–44	45–64	65+	All	0–14	15–44	45–64	65+	All
Chest	5	18	25	13	61	5	18	10	5	39
Medicine } Paediatrics }	14	13	17	6	51	10	14	16	9	49
Medicine only	3	17	22	8	50	1	17	21	11	50
Paediatrics only	56	—	—	—	56	44	—	—	—	44
Dermatology	10	18	14	5	48	6	26	14	7	52
Psychiatry	3	27	13	4	46	—	30	19	5	54
Surgery	10	17	17	9	54	4	19	16	7	46
Orthopaedics	10	22	15	4	51	8	14	18	10	49
Gynaecology	—	—	—	—	—	1	63	28	9	100
E.N.T.	21	14	8	6	49	22	15	9	6	51
Ophthalmology	12	14	11	10	47	11	11	11	20	53
All acute specialties	12·5	15·5	13·5	6·5	48	8	19	16	9	52
Population at risk	11	18	13	6	48	10	18	15	10	52

Table 8. *New out-patients; distribution by age, sex, and specialty. One in four sample* 1962-3 *in eleven hospital groups*

Civil status		Age 50–9 M	Age 50–9 F	Age 60–9 M	Age 60–9 F	Age 70–9 M	Age 70–9 F
Married	O.P.	89	81	87	69	77	48
	E. & W.	88	86	84	56	63	27
Widowed	O.P.	2	8	7	18	18	33
	E. & W.	3	4	8	29	29	57
Single	O.P.	9	11	6	13	5	19
	E. &. W.	9	10	8	15	8	16

$P < 0.01$

Table. 9. *Civil status of new out-patients by sex and older age-groups. Percentage compared with population, England and Wales,* 1961

elderly is chronic and by definition can at best be controlled rather than cured. If general practitioners see specialists, and specialists see themselves, as agents of therapy, then there may be a tacit understanding among the medical profession that elderly chronics are not 'suitable' subjects for consultation. At best the general practitioner will do what he can to maintain the patient in the community until the social handicaps become so unmanageable that direct in-patient admission becomes necessary. If this analysis is correct then the future representation of the aged in out-patients will depend on a change of attitude by doctors rather than by patients. This is, of course, only speculation and to be tested would require a study among specialists and general practitioners of their attitude to medical care and their perception of their respective roles within it, particularly where chronic disease and the elderly are concerned.

In terms of marital status (Table 9) out-patients differ markedly from in-patients. Certainly beyond the age of 60 there was a higher proportion of people with a spouse attending the clinics than is to be found in the general population, while those who were unmarried or had lost a spouse were under-represented. The latter are of course admitted as in-patients at a higher rate (8). It may well be that the existence of a surviving spouse, by encouraging use of general practitioner services, stimulates an out-patient referral, while at the same time preventing admission to hospital by providing a home to which the elderly out-patient can return.

Table 10 shows the specific referral rates to out-patients from the various survey areas. As already noted in Part 1, §3 the population served by a hospital group may differ from that of administrative areas under local government. Strictly therefore Table 10 refers to

MALES

Group	0–4	5–9	10–14	15–24	25–34	35–44	45–54	55–64	65–74	75+
A	131	115	78	88	87	96	100	126	131	113
B	103	87	46	67	67	73	66	98	83	66
C	122	107	87	91	67	85	88	138	130	106
I	118	95	98	96	82	104	113	122	115	90
K	130	83	74	100	91	97	119	126	97	93

FEMALES

Group	0–4	5–9	10–14	15–24	25–34	35–44	45–54	55–64	65–74	75+
A	71	85	65	90	119	121	105	114	112	97
B	57	79	45	77	72	76	88	86	73	53
C	74	101	76	108	110	117	115	116	119	110
I	74	80	96	116	121	136	125	118	114	98
K	66	62	58	87	99	87	95	82	72	72

Table 10. *Out-patient referral for selected county boroughs by age-group. Specific referral rates, per* 1000 *population. All acute specialties*

new out-patients related to the population structure of the local government administrative areas dominating each hospital group surveyed. There are wide variations in the rate of referral. Such variations are puzzling. Why, for example, should men aged 45–54 be referred to out-patients from Group B at the rate of 66 per 1000 population, and from Group K at a rate of 119? Again, why are women aged 35–44 from Group B referred at a rate of 76 per 1000 but at a rate of 136 from Group I?

4. Influence of the general practitioner on out-patient case-load

These extreme variations are nothing new, of course, as they are to be found in most health services and have been noted in the use of in-patient facilities. It is not surprising, therefore, to find gross variations in out-patient referral rates among individual general practitioners, although the fact is none the less difficult to explain. Fig. 2 shows the distribution of 369 general practitioners in our eleven survey areas according to their out-patient referral rate per 1000 practice population. It is apparent that whilst most general practitioners refer between 40 and 80 patients per 1000 practice list (itself a very wide range) some refer over 200 while a few refer less than 20. Differences between areas may, of course, be a reflection of differences in morbidity patterns, even in a relatively small and

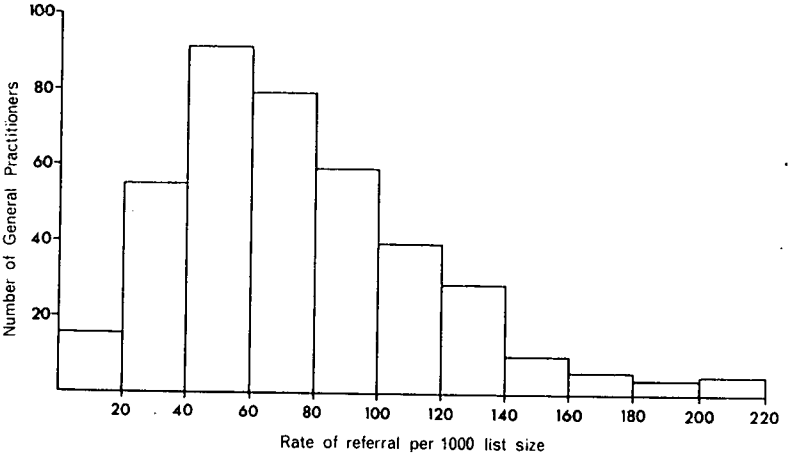

Fig. 2. Distribution of G.P.s by referral rate to out-patient clinics

homogeneous country such as Britain; but this can hardly explain the gross differences in the referral rates between general practitioners in the same town. Since access by patients to hospital out-patient departments depends on prior referral by a general practitioner it might be supposed that factors reflecting practice circumstances (so far as these are measurable) might themselves account at least in part for differential referral to out-patients. In pursuit of this line an attempt was made to study the 369 general practitioners in terms of their age, whether they practised solo or in partnership, whether they held clinical assistant posts in hospital, size of practice list, working in urban or rural areas, and so on, trying to relate these factors not only to their use of out-patient facilities but also their use of direct access diagnostic facilities.

Compared with the situation in conurbations, where teaching hospitals resist the opening of pathological laboratory and X-ray departments to direct access, general practitioners in the eleven survey areas were fortunately placed. All enjoyed direct access to the full range of clinical pathology (haematology, bacteriology, and biochemistry) although the attitude of consultant pathologists varied from warm enthusiasm to cold resentment. Radiologists were less welcoming than the pathologists and access to facilities was consequently patchy. All provided chest and routine film but the facility of contrast media was available in only three places—and then rarely used by general practitioners! Direct access to E.C.G. was

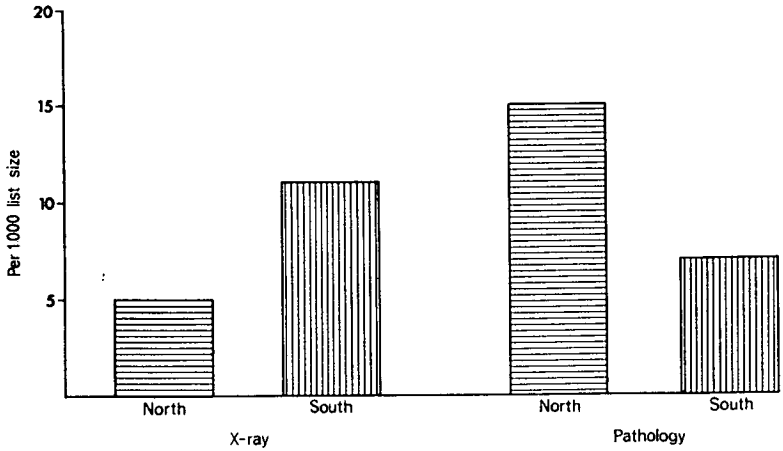

Fig. 3. Mean distribution by area of G.P.s according to referral rates to X-ray and Path Lab.

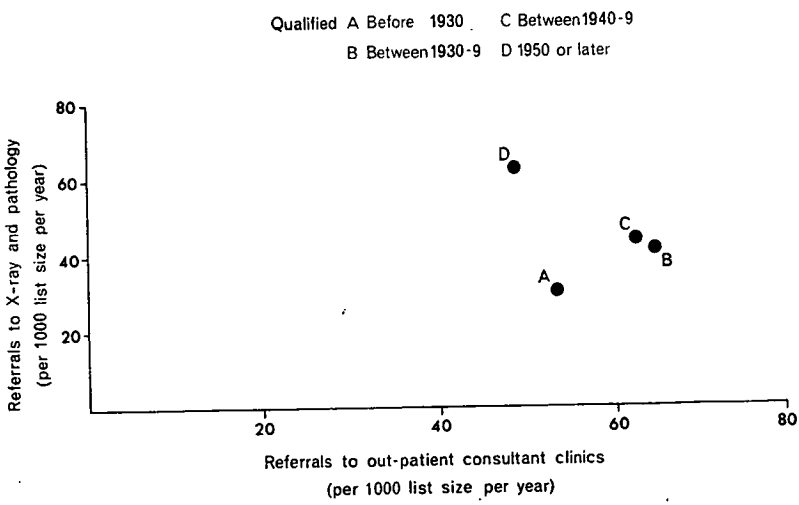

Fig. 4. Relationship between year of qualification and use of Hospital direct access facilities

available in one of the eleven areas and again there was little demand for it from the general practitioners.

This exercise produced a series of negative results. Although there is a tendency for pathology to be used more in the north and X-ray more in the south (Fig. 3) the availability and use of direct access facilities exerts no influence on the volume of referral to out-patient departments in the various localities surveyed. Similarly with the rates for individual general practitioners: if anything there is a tendency for high users of direct access facilities to be high users of out-patient departments but it is not particularly pronounced and in any case high users of direct access facilities are so rare and scattered geographically that they exert no influence on any one area. Size of practice list had no effect at all. Practitioners with comparable practice sizes had widely differing rates of referral to out-patients and direct access. Thus, some with less than 1500 patients to look after had low rates while others with lists exceeding 3000 were found among the highest users of the various facilities. Which medical school the doctor had attended or whether he possessed higher degrees or diplomas proved equally irrelevant. The age of the doctor (or more correctly the years which had elapsed since registration) did affect the use of direct access facilities in that those who qualified before 1930 used the services at half the rate of those who qualified after 1950 (Fig. 4) but then it had no effect on the rate of referral to out-patients. Fifty of the 369 doctors held clinical assistant posts in hospital and all had rates of referral to out-patients and to direct access services which were much the same as for the average general practitioner who held no clinical assistant post.

The only positive result of this enquiry into factors affecting the rate of referral to out-patients appears in Fig. 5. Clearly there is a marked tendency for general practitioners in partnership practice to use direct access and out-patient facilities more than those in solo practice. Perhaps the lone wolf in family practice also goes it alone in the other phases of medical care; or perhaps the solo practitioner is simply just unable to cope with the administrative business of referring patients to hospital out-patient facilities.

In concluding this section it is worth noting that 5 per cent of the 369 doctors made no use at all of direct access pathology or radiology, while 60 per cent applied chest X-ray to less than thirty of their patients in a full year.

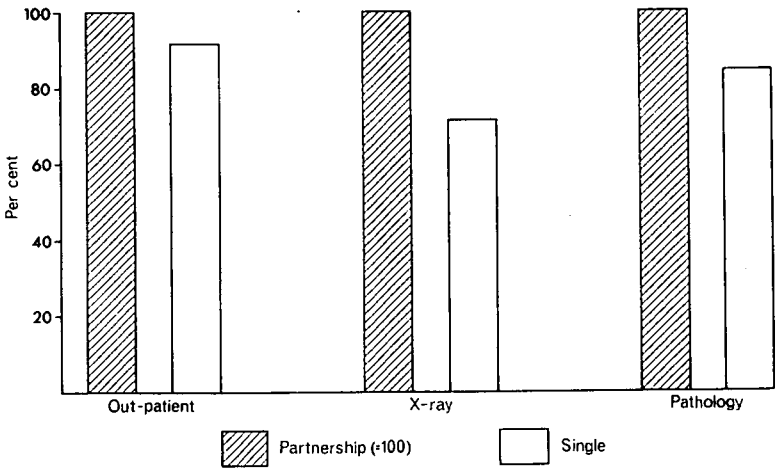

Fig. 5. Use of hospital out-patient and direct access facilities by solo G.P.s as percentage of use by G.P.s in partnership

5. Waiting for appointment

The volume of referrals to out-patient departments is ultimately determined by patients' general practitioners; the length of time which elapses between a request being made for an appointment and the consultation actually taking place is determined by the facilities available locally and the intensity at which they are used or the pace at which they operate.

There is some evidence that appointments are not always granted without undue delay. A Ministry circular (H.M. (64) 102) expressed official concern at the delay between referral and consultation and while recognizing that in some instances the fault lies in the lack of suitable accommodation, urged that attention should be given to other ways of tackling the problem. The circular (pink in colour to indicate that the Ministry wanted it to receive special attention) suggested that two weeks should be the maximum time elapsing for non-urgent cases between referral and consultation. Stewart and Sleeman (9) in a recent study of thirty Hospital Management Committees found that none could meet the two-week requirement. Inquiry among 800 general practitioners in our eleven survey areas suggested that 75 per cent of the 600 who replied were not wholly satisfied with the waiting periods in their local out-patient departments. Unfortunately there was no reliable indication given of what

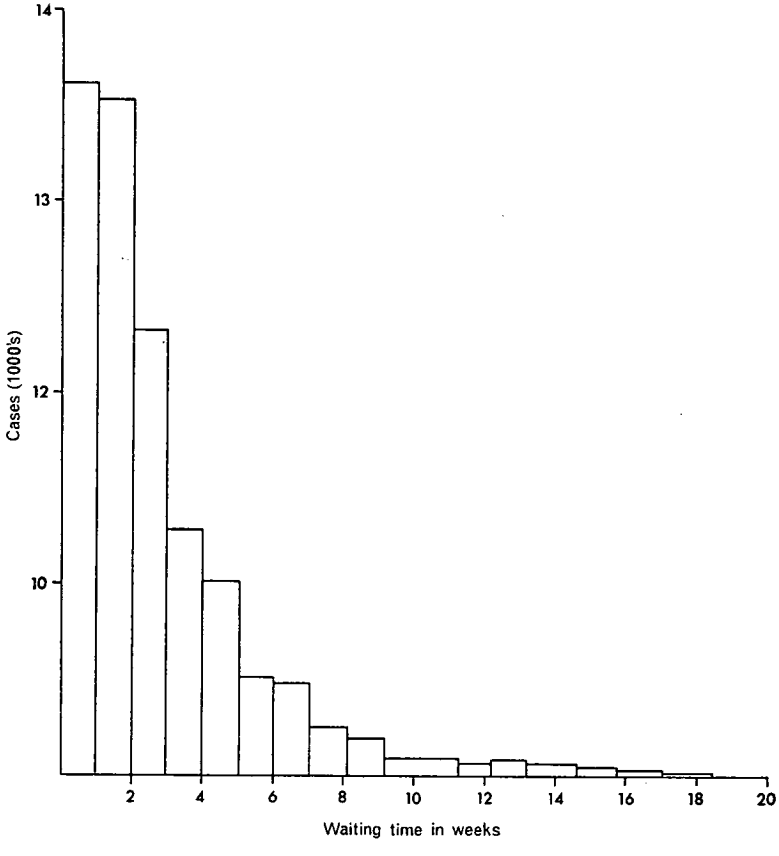

Fig. 6. Distribution of 13 600 out-patients by weeks waited for first appointment

their expectations were in this regard. Some might, for example, have been dissatisfied with a waiting period of only one or two weeks, while others might have tolerated periods of five or six weeks. However, even taking as a guide the Ministry's two weeks for non-urgent cases it is obvious that this maximum is not the general experience.

Fig. 6 shows the distribution of 13 600 new out-patients according to the weeks waited for first available appointment. The mean waiting time was between two and three weeks but the distribution is somewhat skewed and 20 per cent waited over four weeks. About 85 per cent of the referrals were considered non-urgent and 75 per cent of these cases were seen within one month. Cases marked 'urgent' by the referring general practitioner waited an average of between one

Hospital group	Waiting one month or longer	Urgent requests
A	35	18
B	26	21
C	44	15
D	23	13
E	4	7
F	15	7
G	9	6
H	10	14
I	34	34
J	2	9
K	13	14
Miscellaneous cottage hospitals	20	9

Table 11. *Waiting time for out-patient appointment. Percentage waiting over four weeks and urgent requests for appointment by hospital group*

Specialty	Waiting one month or longer	Urgent appointments
Ophthalmology	35	41
E.N.T.	26	33
Medicine	25	30
Orthopaedics	24	26
Psychiatry	19	23
Gynaecology	18	22
Surgery	17	24
Dermatology	15	18
Paediatrics	14	23
Chest	5	3

Table 12. *Waiting time for out-patient appointment. Percentage by speciality and proportion of urgent requests*

and two weeks (they represented 15 per cent of total referrals) but 17 per cent of them waited more than two weeks and 5 per cent even waited for over a month. In passing it should be noted that the criteria of 'urgency' varied widely from area to area. Where waiting periods were relatively long there was a tendency for the proportion of referrals marked 'urgent' to rise and the threshold of urgency to be reduced. In at least two hospitals 10 per cent of 'urgent' cases waited over a month but we believe this owed much to a down-grading of the case after the letter of referral had been read. It is not clear who takes the responsibility for these decisions.

Table 11 shows the wide variation between areas in the proportions waiting for over a month, and also in the proportion of cases deemed urgent. Groups A, C, and I are by far the worst off in having over a third of their cases waiting for over four weeks, while in

Groups J, G, and E less than 10 per cent wait that long. The percentage of urgent cases varies from 6 to 34. Of all the areas Groups I and B seem to be the worst off when both measures are taken into account.

Table 12 gives these percentages for the various specialties and illustrates clearly the association between waiting time and 'urgency'.

The orthopaedic patients consist of mixed non-traumatic and traumatic cases. In that the traumatic cases wait a very short time between their first attendance at casualty and their subsequent attendance at the out-patient fracture clinic or orthopaedic clinic, the waiting time for routine orthopaedic cases is thereby understated. If we restrict the analysis to those referred by their general practitioner with non-traumatic orthopaedic conditions, the proportion waiting one month or more rises to 36 per cent, making this the specialty associated with the greatest delay. 'Urgency' has been defined as a request by the referring doctor for his patient to have priority over other referrals. In the hospital associated with the highest delay (where at the time a routine appointment for a consultation with an ophthalmologist would involve a sixteen-week wait), the number of urgent requests became so large that general practitioners were asked to specify their grounds for urgency. Following the introduction of this device the proportion of urgent requests fell to an average figure of 15 per cent.

Because of selection by general practitioners for urgent appointments, patients with certain conditions wait less than others. This is shown in Table 13. (In this table the percentage is given as the nearest whole number, hence a total of 100 does not always result.) Although the diagnosis made is the final one after investigation, in general, malignant conditions are seen earlier in medical and surgical clinics. In gynaecological clinics with smaller numbers the waiting time for malignancy is the same as that for disorders of menstruation, a diagnostic group indistinguishable clinically from carcinoma of the uterus; in general, the waiting time after referral to a gynaecologist tends to be similar whatever the reason given for seeking advice. Malignant conditions were not, however, always seen early. Of the 200 patients referred to surgical, medical, and gynaecological out-patients and who subsequently were shown to have malignant conditions, six had waited more than two months.

Hernia has been chosen as an example of a surgical condition which is not by definition clinically urgent, although it may be a

Specialty	Final diagnosis	Number	Percentage waiting Under 2 weeks	2–4 weeks	More than 4 weeks
Surgical	Malignant	148	74	17	8
	Benign neoplasms	199	51	27	22
	Hernia	240	45	31	24
	Other	1749	56	25	18
Medical	Malignant	46	67	20	12
	Peptic ulcer	130	36	41	22
	Cardiovascular system	294	47	35	17
	Other	1845	43	29	27
Ophthalmology	Inflammatory diseases of conjunctive and visual tract	124	48	20	31
	Strabismus	78	24	24	51
	Cataract	151	21	18	61
	Glaucoma	28	47	19	35
	Other	627	41	24	34
Gynaecological	Malignant uterus	15	87		13
	Disorders of menstruation	177	55	32	12
	Prolapse	213	42	37	22
	Other	1108	51	28	20
Orthopaedics	Backache, sciatica, and cervical spondylosis	203	34	31	34
	Other	745	30	34	35

Table 13. *Waiting time for out-patient appointment by clinical conditions*

potent source of appreciable social disability. One-quarter of these patients waited more than four weeks before their first attendance at out-patients and subsequent recording on to a further waiting list and then many months before surgical repair.

One-third of the patients referred to the medical out-patient departments with cardiovascular disease waited between two and four weeks to be seen and a further 17 per cent waited more than four weeks; these patients included those who required investigation by electrocardiography. In the medical sample there were 130 dyspeptic patients, later found to have peptic ulcers of whom 22 per cent waited more than one month before being seen and referred to the X-ray department. There were considerable variations in the length of time patients waited for further investigation after the first attendance. In some instances a two months' wait for electrocardiography and a one year's wait for electroencephalography was noted. Other investigations may also take a long time. We recall the case of a man who was referred to a surgical out-patients with haematuria and at the first visit no definite diagnosis was made. He then subsequently waited ten months for a cystoscopy.

In ophthalmology, surprisingly, inflammatory diseases of the eye are not seen earlier than the general run of eye conditions. The more easily recognized though less damaging conditions, such as cataract and strabismus, are seen significantly earlier than the less readily

Hospital	Load, new out-patients per year (thousands)	Rate, new out-patients per session	Waiting a month or longer (%)
I	29	8	34
C*	27	6	44
A	21	9	35
B	20	9	26
K	18	6	13
F	16	5	15
E	15	6	4
G	12	6	9
H	11	5	10
D*	11	5	23
J	10	8	2

* Largest unit only

Table 14. *Relationship of waiting time to size of out-patient load and rate of attendance*

	Weeks wait for routine appointment		Weeks wait for routine appointment
January	4	July	7
February	4	August	8
March	4	September	10
April	4	October	10
May	4	November	10
June	6	December	9

Table 15. *Monthly variation of waiting time in a skin clinic where only one doctor is available*

diagnosed glaucoma where increasing delay will take its toll in permanent loss of vision.

In the orthopaedic sample 203 patients with the common and painful conditions of backache, sciatica, and cervical spondylosis were referred. Most of these patients were prescribed treatment and two-thirds received physiotherapy as out-patients. Before such treatment could be given one-third had waited for more than a month and 10 per cent had waited more than two months.

Table 14 shows there is some relationship between waiting time and the size of the hospital, its rate of turnover, and the degree of waiting. The larger the hospital the more likely is waiting to be prolonged.

The waiting time varies during the year, increasing during the holiday periods. This effect is less when more than one consultant in a specialty takes out-patient clinics at the same hospital when waiting time for each consultant is published by the hospital for the

benefit of the referring doctors. In contrast Table 15 shows a variation of waiting time for one dermatologist who had no relief during his holiday and no registrar. This dermatologist's pattern of work demonstrated that appointment systems are regarded as a mixed blessing by some general practitioners. He worked in a large county borough and was also on the staff of a teaching hospital twelve miles away. Inquiry among the general practitioners in the borough revealed that one-third of the patients referred for dermatologist's opinion were being sent twelve miles direct to the teaching hospital, not because of the quality of opinion sought but because at that time this teaching hospital accepted and coped with all comers. No appointment system existed so general practitioners preferred their patients to have several hours wait there rather than several weeks before attending at the local hospital. This was the only example we found where more than 10 per cent of the referrals were being sent direct to a teaching hospital.

This situation illustrates an aspect of appointment systems not always appreciated. Appointment systems have been introduced to reduce the great inconvenience caused to patients by having to wait on the hospital premises for their turn to be seen. An appointment system does, of course, mean that a fixed number of new and former patients will be seen at each session and if the demand for consultant opinion or treatment increases then the period between requesting an appointment and obtaining one will also increase, unless, of course, there is a compensatory increase in the number of clinic sessions held, or an increase in the rate at which patients are dealt with at existing clinics. While there is some relationship between waiting periods and the number of new patients seen per session there appears to be little relationship between this number and other aspects of hospital activity. For example, in general medicine, general surgery, and gynaecology (Table 16) the number of new patients per session is not markedly affected by the out-patient referral rate, the visits per patient, or the number of patients per bed per annum. In general medicine, Group C1 and G have high referral rates, see few patients per session, and have low bed turnover rates. Group J is high in all three. Group F has a high referral rate and high bed turnover but only two new patients are seen per session. Group K is low on all three. The same picture emerges from the other specialties, with each area appearing to be unique to itself and again the puzzling variations. Why are six new patients seen per

GENERAL MEDICINE

Hospital	Out-patient referral rate	New out-patients per session	Visits to out-patients per 100 new out-patients	Percentage admitted	In-patient turnover
A	8.8	6	147	12	30
B	7.3	5	241	14	23
C1	15.5	4	226	10	18
D	8.0	5.5	128	28	27
E	7.1	4	217	27	26
F	12.8	2	153	20	28
G	15.4	4	224	10	21
H	11.5	4	264	11	29
I	15.3	5	217	18	18
C2	14.4	5	238	11	22
J	11.4	7	192	20	29
K	8.9	4	193	10	19
GENERAL SURGERY					
A	19	25	157	17	47
B	16	11	174	40	24
C1	17.5	8	183	41	26
D	14.5	5	162	43	24
E	15.4	9	192	40	53
F	14.0	6	160	39	22
G	17.4	9	243	42	33
H	17.4	9	169	44	27
I	22	14	210	46	30
C2	22.7	11	240	30	42
J	23	9	221	44	54
K	20	8	215	42	29
GYNAECOLOGY					
A	15.7	16	192	50	54
B	11.3	7	210	41	32
C1	12.8	14	172	62	32
D	13.7	8	174	41	46
E	12.2	6	214	45	25
F	15.7	6	176	59	57
G	15.8	8	194	54	39
I	13.1	11	142	25	36
C2	14.7	11	183	43	45
J	15.2	7	180	40	39
K	11.9	7	214	41	45

Table 16. *Demand, tempo of out-patient use and bed turnover. Out-patient referral rate per* 10 000 *population; new out-patients per session; out-patient visits within six months per* 100 *new out-patients; percentage out-patients admitted; and in-patients per bed per year*

Source: Column 5 = S.H. 3 1962–3

general surgical clinic in Group F and 25 in Group A? Why are there only twenty-two patients per bed per annum in Group F and fifty-four in Group J? In gynaecology the average out-patient attends 2·1 times in Group K but only 1·4 times in Group I. Clearly there is nothing uniform about British hospitals.

Specialty	First visit	All visits	Never seen by consultant
Medicine	86	81	11·0
Chest	92	93	5·9
Paediatrics	88	81	8·5
Dermatology	89	78	7·5
Psychiatry	85	84	14·3
Orthopaedics	70	56	21·0
Ophthalmology	89	83	8·1
E.N.T.	81	77	15·5
Gynaecology	89	79	6·5
General surgery	89	83	7·5

Table 17. *Percentage of out-patients seen by consultant on first and all visits to out-patient department (including those out-patients admitted to in-patients)*

6. Out-patient departments in action — an operational analysis

Having reached the out-patient department what happens to the patients as a result? Are they seen by a consultant specialist or by some anonymous junior? Are they subjected to intensive clinical investigation, transferred where appropriate to some other department, referred back promptly to their family doctor, or retained for prolonged supervision? These and other questions may now be considered in the light of the treatment experienced by our sample of 13 600 new out-patients.

1. Who sees them?

It is heartening to be able to dispel at least one myth held by many general practitioners: namely that out-patients are frequently dealt with by doctors of less than consultant status. Table 17 shows that in almost every specialty at least 80 per cent of the patients are seen by a consultant at their first visit. The exception is orthopaedic surgery where only 70 per cent see a consultant. The proportion stays high for subsequent visits too, again with the exception of orthopaedics. Table 18 shows the percentage seen by a consultant according to the number of visits. The high proportion seen by a consultant illustrates the success of the National Health Service in making specialist opinion freely available to patients across the country; but it is noteworthy that after the fifth visit to out-patients a third of the patients in six of the specialties are dealt with by doctors other than the consultant. On the other hand, it is also worth

Specialty	Number of visits 1	2	3	4	5+	All
Medicine	88	86	73	69	69	79
Chest	94	92	88	94	92	92
Paediatrics	92	83	75	74	81	82
Dermatology	88	81	82	75	59	76
Psychiatry	89	82	76	75	86	82
Orthopaedics	80	56	49	46	43	52
Ophthalmology	93	83	81	71	71	82
E.N.T.	82	78	59	72	50	73
Gynaecology	92	85	78	83	66	83
General surgery	89	85	82	75	62	82

Table 18. *Percentage of out-patients seen by consultant at first and subsequent visits (excluding those out-patients admitted as in-patients)*

	Direct admission 1st visit	Later	Waiting list admission	Total admission	Still waiting	Discharge to O.P.	G.P.
Medicine	4	3	9	16	1	10	5
Chest	6	4	5	15	1	11	4
Paediatrics	5	2	5	12	2	7	4
Dermatology	1	1	1	3	1	2	1
Psychiatry	9	6	7	22	–	12	8
Orthopaedics	1	1	6	8	3	6	2
Ophthalmology	2	1	4	6	3	4	1
E.N.T.	3	1	25	28	11	20	7
Gynaecology	4	2	42	48	8	39	8
Surgery	4	3	29	35	9	26	8

Table 19. *Out-patient movement to and from hospital within six months of first visit to out-patient department (percentage)*

questioning whether 92 per cent of the repeat attenders at chest clinics really need to be seen by a consultant.

II. What happens?

Fig. 7 shows for each specialty the action taken as a result of the patients' first visit to the out-patient department. Bearing in mind that about a quarter of all new out-patients waited at least one month for specialist opinion it is surprising perhaps that such high percentages are referred back to the general practitioner after only one visit. This is the experience of over 40 per cent of the patients in diseases of the chest, ophthalmology, and dermatology. It happens to nearly a third of the patients in medicine, paediatrics, and E.N.T.; even in general surgery and gynaecology a fifth attended only once and then were sent back to their general practitioner.

Patients were rarely admitted directly as hospital in-patients as a result of their first out-patient visit (Table 19). The exception in this respect was in psychiatry where 9 per cent were thus admitted. In

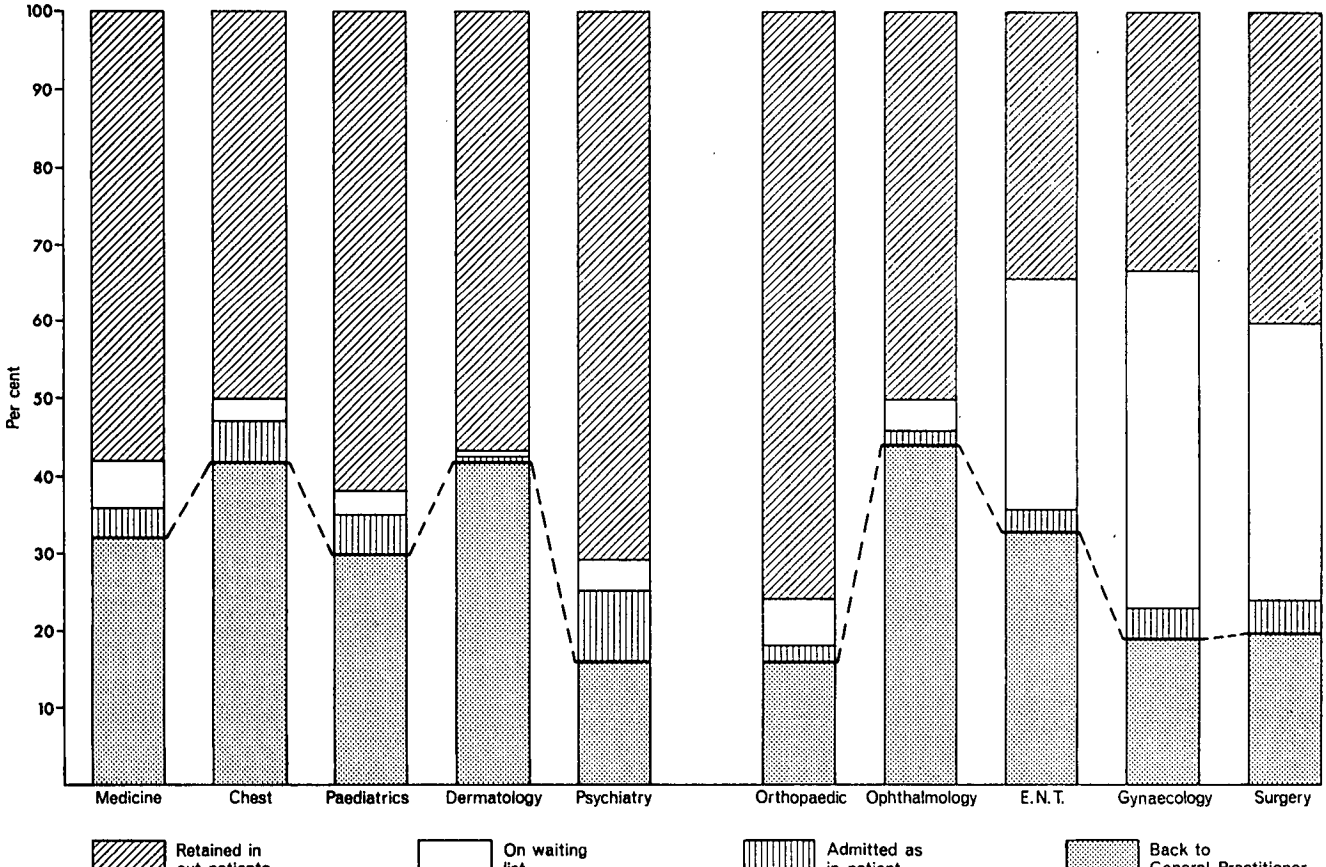

Fig. 7. Distribution of 13 600 out-patients by outcome of first visit

Specialty	Number of consultations	Nil radiological	Nil pathological	Neither X-ray nor pathology
Medicine	1	48	69	38
	2	34.5	50.5	21.5
	3+	29.5	38.5	15.5
Chest	1	17.5	85	15
	2	13	52	8
	3+	12	33	3
Paediatrics	1	68	72	53
	2	67	60	41
	3+	53	41	30
Dermatology	1	98	92	90
	2	96	86	84
	3+	99	79	77
Psychiatry	1	99	98	98
	2	96	98	94
	3+	92	90	87
Orthopaedics	1	56	97	55
	2	52	95	51
	3+	44	87	42
Ophthalmology	1	98	98	96
	2	98	98	97
	3+	91	91	87
E.N.T.	1	90	97	88
	2	76	93	72
	3+	65	88	58
Gynaecology	1	97	70	69
	2	91	49	46
	3+	90	53	46
General surgery	1	87	91	83
	2	52	73	43
	3+	50	62	39

Table 20. *Out-patients without investigations by number of consultations by specialty (excluding later admissions as in-patients) (percentage)*

surgery, gynaecology, and E.N.T., a third of the patients were put on waiting lists for hospital beds as a result of their first out-patient visit. In other specialties this happened to less than 8 per cent of the cases. Only in these three specialties therefore can it be said that the out-patient department is being used as an administrative device for rationalizing the use of hospital beds and determining priorities for waiting lists. A few patients were added to the waiting lists at their second or subsequent visits, when the results of earlier investigations became known; but these were not sufficiently numerous to affect materially the broad picture emerging from the classification based on action after first visit.

III. What diagnostic investigations?

Whatever the function of the out-patient department, whether it be to determine the need for in-patient treatment or to serve as a source of specialized opinion and advice, it is expected that the decisions taken or the opinion offered will be based on a fair degree of scientific investigation. Diagnosis may not be the whole of medicine but it is

MEDICINE

Diagnosis and I.C.D. code	Total number	Number not admitted	Out-patients without investigations		
			X-ray	Pathology	Neither
Diseases of stomach and duodenum 540–5	127	115	18	63	12
Symptoms referrable upper gastro-intestinal system 784	53	43	8	18	6
Bronchitis 50–2	31	26	4	19	6
Arteriosclerotic and degenerative heart disease 420–2	121	112	33	73	24
Hypertension 440–7	86	70	24	31	16
Symptoms referrable C.V.S. and R.S. 7820–6 7831–7	305	273	75	171	65
SURGERY					
Diseases of stomach and duodenum 540–5	72	55	10	39	9
Diseases of appendix 550–2	73	37	27	31	26
Diseases of gall bladder 584–6	72	43	8	35	7
Colitis 571–3	45	27	9	17	9
Symptoms referrable gastro-intestinal system 784	241	166	58	127	51

Table 21. *Out-patients without investigation by provisional diagnosis of referring general practitioner*

a fairly considerable component of it. Pathology and radiography are not the only diagnostic aids but they are important. A survey of the clinical investigations applied to our sample produced some results which are surprising. Table 20 for example shows that the proportion of out-patients discharged after only one consultation with *neither X-ray nor pathological investigation* in medicine was 38 per cent, and in paediatrics and orthopaedics it was over one half. In other specialties too it was often high. This absence of investigation in single attenders is not unexpected in psychiatry (98 per cent), dermatology (90 per cent), and ophthalmology (96 per cent); but, 88 per cent in E.N.T. and 83 per cent in general surgery, 53 per cent in paediatrics and 38 per cent in general medicine is unexpected.

By the very nature of their complaint and the purpose of their re-attendance, those patients recalled for a second visit have more investigations than the rest of subsequent visits, where those in

general medicine without investigation at all fell to 16 per cent. However, it is surprising to find still 30 per cent in paediatrics, 39 per cent of surgical re-attenders and 42 per cent of orthopaedics, without X-ray or pathology.

Seen from the aspect of the referring general practitioner's provisional diagnosis the level of investigation is little short of alarming. For example, of the 127 patients with diseases of the stomach and duodenum only twelve were admitted and of the other 115, although 97 had an X-ray, half had no pathological tests (Table 21). In heart disease and hypertension over one-fifth had neither X-ray nor pathology and half had no pathology. In symptoms referred to heart and lung without specific diagnosis, where one would expect most investigations to exclude possibilities, one-quarter had no X-ray, two-thirds no pathology, and almost one-quarter neither X-ray nor pathological tests.

The consultant surgeons were perhaps fuller investigators than the physicians and for diseases of stomach and duodenum they carried out more pathological tests. Again, for symptoms referred to the stomach where one would expect more tests to exclude specific diseases, one-third had neither X-ray nor pathology tests. Certainly the British consultants cannot be accused of over-investigating.

This situation is underlined in Table 22, which considers those patients who were not admitted to hospital, where necessary clinical investigations might have been carried out, and were not placed on waiting lists for such admission. The table sets the absence of investigation against the final diagnosis on discharge from out-patients. In general medicine over 40 per cent of those diagnosed as psychoneurotic had no X-ray and 55 per cent no laboratory test; for those classed N.A.D. the figures were 26 and 46 per cent respectively. Scarcely believable are the 50 per cent of discharged peptic ulcer without laboratory test and the 26 per cent with heart disease and no X-ray. Paediatricians discharge over half of those with no discerned physical abnormality without any tests; the general surgeons behaved similarly in over a third of such cases and the gynaecologists in over two-fifths. A quarter of those with menstrual disorders had no laboratory test—not even a haemoglobin estimation.

IV. Referral to other out-patient facilities

There was little referral across to other specialties in these out-patient departments. Thus, no use is made of the propinquity of

clinics and colleagues in other specialties. In medicine and paediatrics referral to another specialty was under 9 per cent, in general surgery 5 per cent, whilst all other specialties (apart from psychiatry) had under 3 per cent cross-referral, and in chest diseases and general surgery, with their burden of workers in middle and later life, often handicapped in their jobs, the referral to medical social workers was one in 1000. Taking all out-patients together less than two in 100 were referred to the medical social worker (see Table 23).

v. **Treatment in out-patients**

Treatment in out-patient departments was largely confined to orthopaedic patients, 54 per cent of whom received treatment of which 26 per cent was physiotherapy. Some 23 per cent of out-patients in dermatology had a minor operation or other treatment, but in all other specialties over 80 per cent had no treatment in the out-patient clinic (Table 24).

Few operations were carried out on out-patients, although operations under local anaesthetic were performed on 10 per cent in dermatology, 9 per cent in ophthalmology, 7 per cent in general surgery, and 5 per cent in E.N.T., but there was little under general anaesthetic, only 4 per cent in orthopaedics and less than 3 per cent in general surgery. In gynaecology less than one in 200 had operations with either local or general anaesthetic and only five received an injection. It is not known how many out-patients were admitted unnecessarily to the wards for minor surgical procedures; but Table 25 indicates that numbers of patients were admitted to hospital wards for investigation only.

vi. **Out-patients admitted for investigation only**

The proportion of patients admitted directly on their first visit to out-patients was not high, except in the surgical specialties. However, the percentage admitted for investigation only was considerable in these days of waiting for an allegedly scarce bed. From the records many apparently similar patients had similar investigations done in out-patients. Moreover, some having waited some weeks for an out-patient appointment were admitted directly on their first out-patient visit for investigation only. More were placed on the waiting list for a bed but the proportions admitted from the waiting list for investigation only were very similar in each specialty. Over-all, it

Speciality and diagnosis	Total out-patients	Neither admitted nor on waiting list: Number of out-patients	Without X-ray (%)	Without test (%)
MEDICINE				
N.A.D. or N.Y.D.	430	395	26	46
Psychoneurosis	166	157	40	55
Peptic ulcer	105	90	13	50
Hypertensive or degenerative heart disease	263	209	26	47
Diabetes	144	98	30	17
Rheumatoid arthritis	71	36	18	8
PAEDIATRICS				
N.A.D. or N.Y.D. Psychoneurotic	278	254	56	51
GENERAL SURGERY				
N.A.D. or N.Y.D.	358	291	33	55
Haemorrhoids	98	40	—	41
Peptic ulcer	67	40	9	42
GYNAECOLOGY				
N.A.D. or N.Y.D.	261	165	61	40
Disorders of menstruation	180	77	40	24
OPHTHALMOLOGY				
Cataract or glaucoma	193	160	83	83

Table 22. *Out-patients without clinical investigation. Number of out-patients neither admitted nor on waiting list and percentage who did not have an X-ray or clinical laboratory test at the final diagnosis on discharge*

	To one other specialty	To more than one other specialty	Radiotherapy department included	Almoner
Medicine	7·4	0·3	0·5	0·8
Chest	2·8	0·1	1·9	0·1
Paediatrics	8·9	0·6	—	0·5
Dermatology	1·0	0·4	5·1	0·4
Psychiatry	2·3	0·3	—	1·3
Orthopaedics	1·8	0·3	0·1	0·7
Ophthalmology	0·9	0·2	0·1	0·4
E.N.T.	0·8	0·3	1·2	0·2
Gynaecology	2·4	0·3	0·8	0·2
General surgery	4·3	0·3	1·4	0·1

Table 23. *Cross referrals of out-patients. Out-patients referred to other specialty, radiotherapy, and almoner (percentage)*

Specialty	Physiotherapy	Injections, etc.	Operation, L.A.	Operation, G.A.	Appliances and hearing aids	Plasters	E.C.T.	No therapy in out-patient	Admit in-patient
Medicine	12.3	—	—	—	2.8	—	—	83	16
Chest	6.9	—	—	—	—	—	—	92	14
Paediatrics	1.5	—	—	—	2.5	—	—	95	12
Dermatology	4.9	5.5	9.9	1	1	—	—	77	4
Psychiatry	—	—	—	—	—	—	7.6	93	23
Orthopaedics	26.0	5.7	0.7	4.0	16.0	11	—	46	9
Ophthalmology	—	3.1	9.2	0.8	—	—	—	91	6
E.N.T.	—	3.9	5.0	0.3	9	—	—	81	28
Gynaecology	2.9	2.3	0.4	0.4	5.5	—	—	88	48
General surgery	1.7	2.9	7.2	2.4	3.6	—	—	81	38

Table 24. *Treatment in out-patient department. Out-patients (percentage) by specialty receiving stated therapy*

Specialty	Direct admissions	Percentage for investigation only	Admissions from waiting list	Percentage for investigation only
Medicine	171	30	208	33
Chest	78	44	36	40
Paediatrics	63	52	40	13
Dermatology	16	—	11	0
Psychiatry	119	—	59	2
Orthopaedics	38	5	95	4
Ophthalmology	29	—	43	2
E.N.T.	41	5	299	5
Gynaecology	96	37	659	30
General surgery	156	11	795	17

Table 25. *Hospital admissions for investigation only. Out-patients admitted as in-patients, directly and from waiting list, with percentage for investigation only*

was 31 per cent of the 379 medical and 755 gynaecology patients, 40 per cent in 114 chest diseases, 37 per cent in 103 paediatrics, and 16 per cent in 951 general surgery.

Our findings and comments on the relative absence of investigation in out-patient departments should be weighed against the findings concerning the proportions admitted as in-patients for investigation only. Without a detailed examination of these in-patients it is not possible to comment on the need for their admission. However, it may at least be suggested that out-patient departments are not seen as appropriate centres for intensive investigation but that the practice is still to use hospital beds for this purpose. It may well be that, faced with a volume of new patients requiring only one visit before being returned to their general practitioner, consultants simply feel under too much pressure to use out-patient departments as intensive investigation units and prefer to admit the patient to hospital so that more detailed study can be made. The suggestion is, therefore, not that consultant opinion is reached without scientific aids, but that these aids are enlisted on in-patient wards rather than in out-patient departments. Such a decision will multiply the cost of investigation over five times for each day of stay on the wards—an in-patient day costing twice that of a good hotel.

VII. 'Detainees'

Although one-third of out-patients were returned to their general practitioner after only one visit and about another third after two or three subsequent visits, there is a long tail of 'season-ticket holders' still attending out-patient departments after six months as shown in Fig. 8 where all those above the line are still being retained by the hospital, either in the out-patient clinic or on waiting lists for

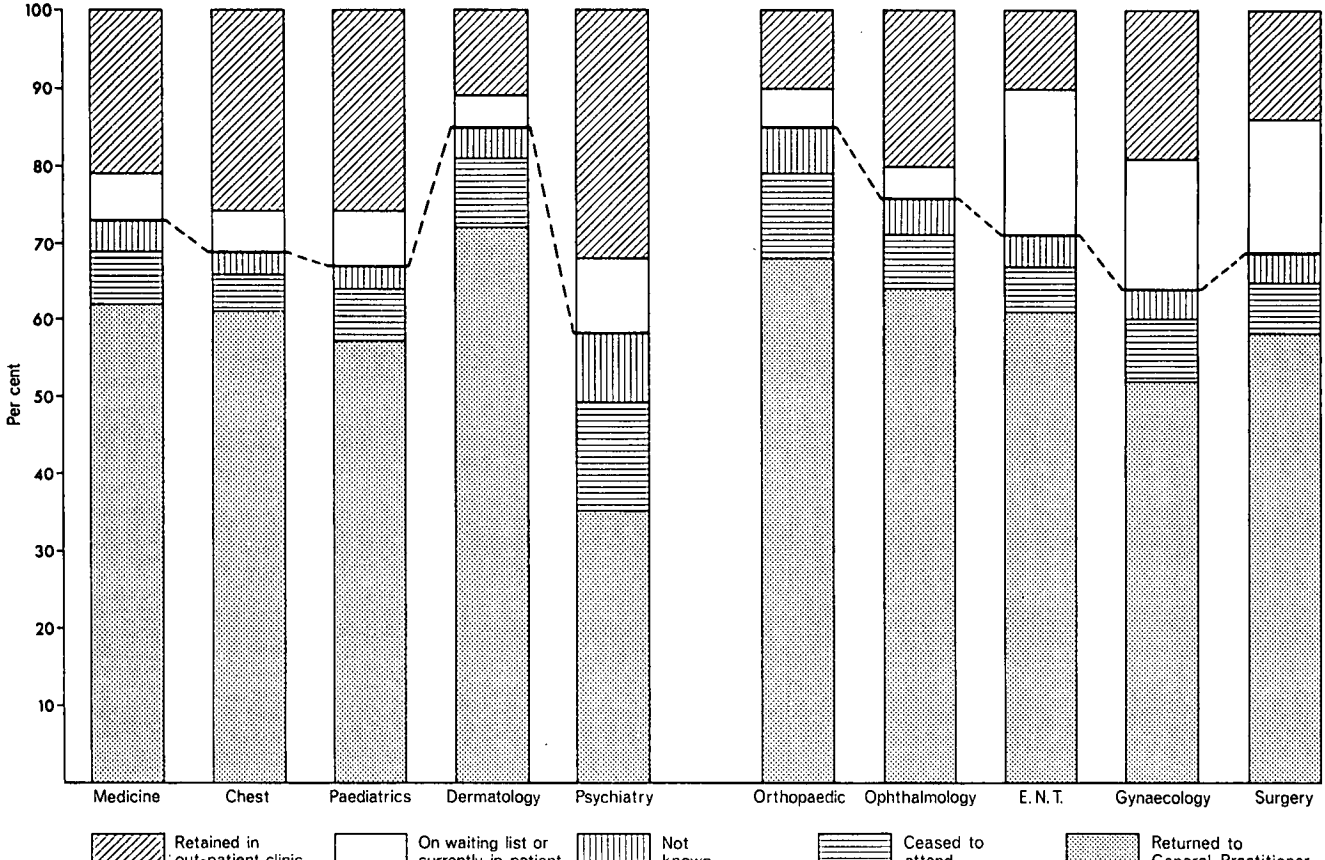

Fig. 8. Distribution of 13 600 out-patients by outcome after six months

admission. It is not unexpected to see prolonged attendances in chronic, ambulatory disease requiring specialist skills as in psychiatry. This applies also to ophthalmology, mainly cataracts or glaucoma, and E.N.T. where many patients had primary deafness. In paediatrics 26 per cent were long attenders consisting mainly of congenital malformations, epilepsy, allergy and the mentally subnormal—all chronic disease now that childhood infections are so well controlled. However, it is puzzling to find 19 per cent in gynaecology still attending when one-quarter of the cases are the common prolapse or menstrual disorders. Again, with tuberculosis cases only 13 per cent of the case-load, and cancer 6 per cent, why are 26 per cent of all chest cases still attending? Many of them were bronchitics or asthmatics. Could they not be discharged back to their general practitioner? Indeed, some 10 per cent of all out-patients decided themselves to cease to attend or their disposal was 'not known'.

In general medicine the 21 per cent still attending includes over four-fifths of the diabetics and half of the rheumatoid arthritis and thyroid disease, and one-third hypertension, epilepsy, and blood disease. Most of these chronic conditions require monitoring and/or maintenance therapy. When such therapy was first introduced in the 1950s it was in hospital and it was very necessary for the specialist to test it critically under careful control from the hospital. However, a decade or more after their introduction and with the side-effects well controlled by the pharmacologists of the drug industry, is it not time for much of these skills to be fed back from the specialist to the general practitioner, and for the family doctor to take over the supervision, and maintenance of his patients whose conditions will be life-long? The difficulty is the gap between hospital and general practice in Britain.

Much the same point emerges when we consider another group of detainees, in-patients discharged from the hospital wards but retained as out-patients for follow-up. Of non-surgical cases only one in three is referred back to the general practitioner, the others continuing to attend out-patients because they suffer from chronic conditions. But this is less easy to understand in surgery, where only one in four goes back to the general practitioner, and gynaecology where it is only one in six. Table 26 shows the pattern of supervision for four common repair conditions, stripping of varicose veins, haemorrhoids, inguinal hernia, and prolapse. The first three are usually for patients in their 30s and 40s and most prolapse

	In-patients	Number of follow-up visits to out-patients 0	1	2	3+	Total out-patients
Varicose veins	62	9	16	5	7	37
Haemorrhoids	40	4	21	3	–	28
Inguinal hernia	124	1	73	3	–	77
Prolapse	121	20	39	4	–	63
Total	347	34	149	15	7	205
Percentage		17	73	7	3	100

Table 26. *In-patients discharged to general practitioner but with follow-up at out-patient department for four specific conditions of surgical repair (only those within six months after first out-patient visit)*

repairs are on women in their 40s and 50s. Only 17 per cent of these patients are discharged to the sole care of their general practitioner, the rest having to attend out-patients, 10 per cent of them two or more times. Former in-patients and 'season-ticket holders' form important streams of work in out-patient departments and play no small part in reducing the flow of new out-patients who have to join waiting lists before they can be seen by the consultant. It seems it is the immediacy of the old familiar faces that gains priority over the unknown names on the waiting list.

7. The out-patient case-load

The tables in this section show for each specialty the distribution of new out-patients by final diagnosis, and permit certain tentative conclusions to be drawn about the functions of the various departments.

Chest diseases (Table 27)

The chest clinic has certainly ceased to be the tuberculosis dispensary. Only 13 per cent of the cases now remind us of the former scourge. The chest clinic is now the chronic bronchitis clinic (the largest group at 16 per cent) with allergic asthma and hay fever (6 per cent) equal to cancer of the lung, and the rest the half dozen common enough other chest conditions.

The diagnostic range is so limited that one cannot say the clinic serves a diagnostic function, because the range of special investigations must also be limited except for respiratory function tests. Moreover, apart from antibiotics and antispasmodics, which the general practitioner can give, there is little specialist therapy.

Nothing abnormal detected No diagnosis made Mental, psychoneurotic and personality disorders		26
Diseases of the respiratory system		
Asthma and hayfever	6	
Upper respiratory	5	
Pneumonia	5	
Bronchitis	16	
Empyema and pleurisy	2	
Other lower respiratory	12	
Total		46
Tuberculosis		13
Neoplasms		6
Cardiovascular disease and congenital heart disease		4
Diseases of the digestive system		1
Other specific diagnosis		3
Not known		1

Table 27. *Final diagnosis of new out-patients. Chest diseases (percentage of 800 patients)*

Possibly in the future, when the next generation of chest physicians sort out obstructive airway disease, and they have a new specialist treatment; then they could justify a separate out-patient clinic. On the face of it today there would seem more point in amalgamating chest diseases with general medicine and include only those cases in which expertise is needed for investigation or treatment. Indeed, rehabilitative medicine based on out-patients for the chronic handicapping conditions and for the pre-geriatric may be a better investment. However, the pattern of disease and its control has changed too quickly for the entrenched specialisms and their organization. Although the old tuberculosis sanitorium was converted to geriatric wards or to cold elective surgery, the old T.B. clinic tends to linger on even when transferred to the general out-patient department because it is not easy to 'retread' specialists in late middle-age. For the most part the separate existence of chest clinics can hardly be justified.

Paediatrics (Table 28)

After the 31 per cent diagnosed clear of physical abnormality, congenital malformations, including heart prematurity and diseases of early infancy at 13 per cent form the next largest group referred from the general practitioner. (Moreover, to this must be added an even larger number of high risk babies with new-born defects, either congenital or erythroblastosis. These cases are referred from

Nothing abnormal detected No diagnosis made Mental, psychoneurotic and personality disorders		31
Congenital malformations and diseases of early infancy (excluding congenital malformations of C.V.S.)		10·6
Disorders of the genito-urinary system		
Infections	3	
Enuresis	6	
Total		8·4
Gastro-intestinal tract		
Hernia	1	
Total		5·5
Upper respiratory tract disorder		
T.s and A.s	1·7	
Total		3·5
Lower respiratory tract disorder		4·3
Allergic disorders	4	
Total		4·6
Infective and parasitic disease		1·5
Neoplasms		2·6
Endocrine disorders		1·2
Diseases of blood and blood forming organs		1·5
Mental subnormality		2·6
Diseases of the nervous system		
Epilepsy	3·5	
Total		8·3
Diseases of the cardiovascular system including functional murmurs		
Congenital	2	
Total		5·6
Skin disorders		1·8
Diseases of joints and organs of movement		2·8
Other diagnosis		2·5
Not known		1·2

Table 28. *Final diagnosis of new out-patients. Paediatrics (percentage of* 820 *patients)*

the maternity hospital for follow-up. This direct transfer of special care babies from the maternity wards forms up to two-thirds of the out-patient case-load and is unique to paediatrics. They are not included in this analysis because by definition they did not fall in the sample.)

The cases referred from the general practitioner fall into the common variety that the North American paediatrician acting as family doctor would regard as his bread and butter. However, the doctor going into general practice in Britain is not obliged to do a pre-registration job in paediatrics, so babies may frighten him when

he cannot treat them with antibiotics, which he seems to do successfully. Half of the diseases of the nervous system are epilepsy, half of those of the genito-urinary system are enuresis, and half of those of the cardiovascular system are functional murmurs, whilst most of the allergic disorders are asthma, all within the competence of the good family paediatrician anywhere.

It seems therefore that the function of the paediatric clinic is mainly to provide a follow-up service for the maternity hospital and partly to assist general practitioners in an area of medicine which their training may not have covered sufficiently and in which they feel a need for guidance and reassurance.

Ear, nose, and throat surgery (Table 29)

E.N.T. is dominated by the one-quarter tonsils and adenoids almost all of which proceed to removal, because the bridge of decision had already been crossed by the parents and the general practitioners. By contrast, N.A.D. was only 14 per cent and surely should have included the bulk of the 25 per cent tonsils and adenoids!

The next large group is 14 per cent deafness, (two-thirds of whom are over 60, and one-fifth children or adolescents). Apart from these old people with deafness the E.N.T. clinic is predominantly paediatric.

Although it is called ear, nose, and throat, throat does not appear in these categories, because its primary diagnoses must be under 2 per cent (excluding tonsils and adenoids, of course).

Apart from the tonsils and adenoids the E.N.T. out-patients earns its keep, particularly in these days of antibiotics successfully applied by the general practitioner so that only 6 per cent are otitis media and chronic sinusitis 4 per cent—a very different picture from fifteen years ago.

Dermatology (Table 30)

As might be expected the N.A.D. in dermatology is only 4 per cent. The largest group is the 14 per cent with infectious warts requiring the quick and magic treatment of soft X-ray. The same special therapy may also be needed in the 11 per cent persistent eczemas, and again for many under the benign neoplasm category. Thus, out-patient dermatology is the right and proper location for special and potentially dangerous treatment to be used in the hands of the expert.

The diagnostic function of the clinic is seen in the long list of diagnoses, to which is added 23 per cent of all the less common

Nothing abnormal detected No diagnosis made Mental, psychoneurotic, and personality disorders	14.5
Neoplasms	1·6
Otitis externa	2·0
Otitis media	6·4
Deafness	14·0
Other diseases of ear and mastoid	5·4
Allergic disorders	2·4
Acute respiratory inflammation	3·1
Hypertrophy of tonsils and adenoids	25·4
Chronic sinusitis	3·8
Deflected nasal septum	2·3
Nasal polyp	3·4
Other upper respiratory	5·5
Trauma	2·3
Other	7·0
Not known	0·8

Table 29. *Final diagnosis of new out-patients. Ear, nose, and throat diseases (percentage of* 1192 *patients)*

Nothing abnormal detected No diagnosis made Mental, psychoneurotic, and personality disorders	4.4
Infectious warts	14·1
Other infections of the skin	4·4
Infective and parasitic	4·8
Eczema	10·7
Psoriasis	7·7
Benign neoplasms—naevi, senile keratosis, haemangioma telangiectasis	7·2
Malignant neoplasms	3·3
Diseases of sebaceous glands, e.g. acne	5·5
Urticaria and allergic eczema	2·6
Diseases of arteries and veins	1·9
Other specific skin diseases	27·2
Congenital malformations and diseases of early infancy	1·5
Other—miscellaneous including symptoms	4·5

Table 30. *Final diagnosis of new out-patients. Dermatology (percentage of* 793 *patients)*

Nothing abnormal detected No diagnosis made		5.5
Psychoses		
Schizophrenic	5	
Manic depressive	26	
Other	6	
Total		36·4
Mental subnormality		1·0
Psychoneurosis and personality disorders		
Anxiety	16	
Somatic symptoms	4	
Other psychoneurosis	20	
Disorders of personality and intelligence	10	
Total		49·2
Vascular lesions affecting nervous system		0·4
Epilepsy		1·1
Other diseases of central nervous system		0·4
Other		3·2
Not known		3·2

Table 31. *Final diagnosis of new out-patients. Psychiatry (percentage of* 786 patients)

varieties of specific skin diseases, leaving only 5 per cent non-specific or with symptoms only. Of all out-patient departments dermatology has the clearest function and is the least suspect of impinging on territory which might safely be left to a retrained and revitalized corps of general practitioners.

Psychiatry (Table 31)

Psychiatry, like dermatology, has only 5 per cent N.A.D. With 36 per cent psychosis the general practitioner cannot be accused of swamping the psychiatric clinics with neurosis only. But why is mentally sub-normal only 1 per cent? Is the educational system so good with school health service that these are all covered in the school years and are isolated later from the hospital psychiatrist?

The distribution of the psychoses, with manic-depressive illness comprising one-quarter of the whole case-load, is as expected. It can now be treated, but whether the general practitioner these days could do it himself is a matter of conjecture.

Neurotic disorders, accounting for almost half the cases, have the expected distribution of overlapping diagnostic labels, the best one can do in forcing emotional and social problems into artificial categories. 'Alcoholism' is notable by its absence, although this is no doubt regarded as a symptom and is concealed under other diagnoses, or perhaps even Britain is still too moralistic to view it as mental sickness.

Nothing abnormal detected No diagnosis made Mental, psychoneurotic, and personality disorders		9.6
Infective and parasitic		1·7
Neoplasms		1·8
Diseases of central nervous system		3·2
Inflammatory diseases of the eye—		
Conjunctivitis and stye Blepharitis	5·4	
Total		13·1
Refractive errors		12·8
Diseases of the cornea		3·2
Strabismus		7·3
Cataract		13·3
Glaucoma		2·9
Congenital		1·1
Other eye conditions including Meibomian cyst		19·4
Trauma		5·4
Other conditions		5·1
Not known		0·1

Table 32. *Final diagnosis of new out-patients. Ophthalmology (percentage of* 1193 *patients)*

Opthalmology (Table 32)

In ophthalmology cataract accounted for 13 per cent of the case-load, making this the only department with a heavy representation of the elderly. Otherwise the range of conditions is diverse.

As for function, clinics in ophthalmology may be grouped with those in dermatology and psychiatry in providing a specialized diagnostic and treatment service in a full sense.

General surgery (Table 33)

The list of diagnoses in general surgery is as expected, general, and reflects the in-patient case-load as the function of out-patients is a preliminary to later admission from the waiting list, because little surgery is done except on an in-patient basis. Perhaps 5 per cent could be done under local anaesthetic in out-patients. This would include many of the 7 per cent of skin conditions of warts and sebaceous cysts and some of the 7 per cent benign neoplasms, including lipoma and ganglion of the wrist. A further 20 per cent might well be done under a general anaesthetic in out-patients. This would include the 3 per cent circumcisions, many of those superficial conditions not done under local anaesthetic, many of the 4 per cent haemorrhoids, 7 per cent varicose veins, and 8 per cent inguinal hernias, and even some hydroceles. Surgery which might be carried

Nothing abnormal detected No diagnosis made Mental, psychoneurotic, and personality disorders		16
Malignant neoplasms		
Gut	3	
Breast	1·5	
Total		6·3
Benign neoplasms		
Lipoma	1·4	
Breast	1	
Haemangioma	0·7	
Melanoma	0·8	
Other skin	1·7	
Total		7·2
Diseases of the thyroid gland		1·0
Diseases of arteries and veins		
Varicose veins	6·8	
Haemorrhoids	4	
Total		12·2
Hernia		
Inguinal	7·7	
Total		12·7
Diseases of stomach and duodenum	3·3	
Diseases of liver, gall bladder, and pancreas	2·3	
Appendicitis	2·5	13
Other gastro-intestinal	4·7	
Benign enlargement of the prostate		1·5
Redundant prepuce and phimosis		3·4
Other diseases of genito-urinary system		7·0
Diseases of the breast		2·1
Diseases of the skin		
Warts	1·1	
Sebaceous cysts	3·6	
Total		7·6
Diseases of bones and organs of movement		3·5
Congenital malformations and diseases of early infancy		1·3
Trauma		1·8
Other		2·9
Not known		0·7

Table 33. *Final diagnosis of new out-patients. General surgery (percentage of 2460 patients)*

out in the office in North America, or in the Aberdeen out-patient department, would account for perhaps as much as 25 per cent of the case-load.

It is known that the largest increase in in-patients has been those in the 60s and over, particularly in general surgery, yet in out-patients they are still under-represented. There has been a recent proportional increase in in-patients in general surgery for the common elective repair conditions in the aged; we have yet to see whether

Nothing abnormal detected No diagnosis made Mental, psychoneurotic, and personality disorders		17.9
Infective and parasitic		0·9
Malignant neoplasms		1·7
Benign neoplasms		
Fibroid	3·2	
Other uterus including polyp	5·0	
Ovary	1·3	
Total		10·4
Diseases of genito-urinary system		3·6
Ovarian dysfunction		1·7
Diseases of ovary, Fallopian tube, and parametrium		1·2
Prolapse		14·2
Disorders of menstruation		11·3
Sterility		4·0
Contraception		0·3
Cervicitis Leucorrhoea Other infections of genital organs		15·2
Other diseases of female genital organs		6·5
Pregnancy and complications		6·6
Other		3·4
Not known		1·3

Table 34. *Final diagnosis of new out-patients. Gynaecology (percentage of 1572 patients)*

or not this increase will be reflected in out-patients, as word of the successful results obtained reaches a wider audience. A common function of out-patients for those patients attending with obvious conditions, with no special investigation required, is merely to form part of the administrative procedure of getting on the waiting list for admission. This surely could be done at registrar level. Any estimate of the pressure of the case-load, should be under-weighted for such administrative needs. Why then are there such big waiting lists for out-patient appointments?

Gynaecology (Table 34)

Gynaecology is similar to surgery in out-patient function as a staging-post for hospital admission, but much of this specialty is for D. and C. to make a diagnosis in the large group of referral symptoms of bleeding or discharge. However, 15 per cent with cervicitis, leucorrhoea, and other *external* infections, could be treated by many general practitioners with either chemical cautery or electrical cautery, or other local treatment.

Nothing abnormal detected No diagnosis made Mental, psychoneurotic and personality disorders		7.1
Neoplasms		0·7
Diseases of central nervous system		1·5
Diseases of skin and cellular tissue		1·2
Rheumatoid arthritis	0·7	
Other arthritis	11·8	
Prolapsed disc and sciatica	7·4	21·6
Rheumatism	1·7	
Symptoms referrable to limbs and back		3·6
Hallux valgus and bunion		1·7
Internal derangement of knee		3·1
Sinovitis		5·9
Other diseases of bones and organs of movement		12·4
Congenital malformations and diseases of early infancy		1·6
Other non-traumatic		1·6
Total non-traumatic	62	
Head and spine injury. Fractured skull		0·6
Fractured limbs		
Upper limb	18·4	
Lower limb	7·1	
Total		25·5
Dislocations		2·2
Sprains of joints		6·3
Other traumatic		3·2
Total traumatic	38	
Not known		0·5

Table 35. *Final diagnosis of new out-patients. Orthopaedics (percentage of 1545 patients)*

N.A.D. or functional amounted to 18 per cent and were no doubt reassured; but one wonders whether, in fact, this is not suspiciously low, bearing in mind the tendency in teaching hospitals to regard an increasing proportion of the gynaecological out-patient case-load as 'functional' with a basis of emotional and sexual disturbance.

Orthopaedics (Table 35)

Orthopaedic out-patient clinics have some similarities to paediatric with the direct transfer of injuries from the casualty department. In total these traumatic cases amounted to 38 per cent, the bulk of which (25 per cent) were fractures, three-quarters of them of the upper limb and the ambulant minor fracture of the lower limb only one-quarter. Thus, it is an ambulant fracture clinic for one-quarter of its case-load.

The two-thirds non-traumatic referred from the general practitioner has 22 per cent arthritis or prolapse of vertebral disc. This may

be because the general practitioner is not competent to inject joints and is not permitted to prescribe N.H.S. surgical corsets or collars, (although he may do so privately like the physiotherapist) or to order physiotherapy directly from the hospital department. In many of the conditions in which he has no trouble with diagnosis he has to refer them to orthopaedic out-patients. This clinic at the same time, has one of the longest waiting lists, so this obstruction to the patient might well be relieved almost at once by giving the general practitioner administrative access to the surgical appliances technician and to the physiotherapist.

General medicine (Table 36)

Of all departments the function of this out-patient clinic is the most difficult to classify.

Of the 2206 patients, 27 per cent had no physical disease. The next largest category is naturally cardiovascular diseases with arteriosclerosis 7½ per cent and hypertension 4½ per cent, totalling 12 per cent, or one in eight of all new out-patients. How much of this one wonders, is handled by the general practitioner in North America with his own cardiogram. Should it not be handled at general practitioner level in this country also? The same, of course, applies to the 6 per cent diabetics.

Another large group are the rheumatics 13 per cent, with 7 per cent, about half, osteoarthritis and 3 per cent rheumatoid arthritis, still being handled by the consultant physician.

After endocrine disorders 12 per cent, come the 10 per cent gastrointestinal, but of this 6 per cent are stomach and duodenum. If the general practitioner had direct access to barium meal could not most of this 6 per cent be handled by him, particularly as patients have to wait for an out-patient appointment and then a further wait of some weeks for the barium meal, by which time the episode of duodenal ulcer pain should be subsiding alone or on treatment. The control of the condition is as imprecise as its aetiology is unknown.

Cases with conditions of the central nervous system were for neurological diagnosis, and as expected turned out to be multiple sclerosis or cerebral arterial disease, epilepsy, or migraine. It is surprising that strokes represent only 1·5 per cent when skilled rehabilitation can offer so much. One is also surprised that patients

Nothing abnormal detected No diagnosis made Mental, psychoneurotic, and personality disorders		27
Neoplasms		2·3
Endocrine disorders		
Thyroid disease	3·2	
Diabetes	6·4	
Other	2·0	
Total		11·6
Diseases of blood and blood forming organs		1·6
Diseases of central nervous system		
Strokes	1·4	
Epilepsy	1·5	
D.S. and other Migraine	3·7	
Total		6·6
Cardiovascular system and congenital heart disease		
Arteriosclerotic	7·4	
Hypertension	4·5	
Rheumatic and other heart disease	3·7	
Arteries and veins	1·4	
Total		17
Diseases of respiratory system		
Lower	2·0	
Bronchitis	1·9	
Total		4·2
Diseases of gastro-intestinal system		
Stomach and duodenum	6·0	
Rest	3·8	
Total		9·8
Diseases of genito-urinary system		1·7
Diseases of bones and organs of movement		
Rheumatoid	3·2	
Other arthritis	6·5	
Other specific	3·5	
Total		13·2
Other specific diagnosis		4
Not known		1

Table 36. *Final diagnosis of new out-patients. General medicine (percentage of 2206 patients)*

with respiratory diseases, mainly bronchitics, make up so small a proportion (1·9 per cent) in general medicine, although, of course, many of them go to the chest physician as already noted.

8. Communications

Current opinion and practice about medical care under the National Health Service is based on the view that the need for specialized attention is episodic and that normally the patient will be attended by a general practitioner during his longer-term consumption of medical services. Nevertheless the episodes requiring specialist advice are likely to be dramatic and often serious. Moreover, with many discharged on maintenance therapy and one in nine readmitted within twelve months, such episodes are increasingly relevant to the patient's long-term condition and care. It is important therefore that the consultation between specialist and general practitioner should be based soundly upon a dual exchange of relevant information both on transfer into and discharge from one sector of the service to another. This is best achieved by face-to-face discussion after joint examination of the patient. This situation is, of course, poles apart from current practice under the N.H.S. The out-patient department has as a principal function the provision of a venue for consultation between specialist and general practitioner; but the two doctors rarely meet face-to-face and other forms of communication have to be relied on to sustain this crucial interphase between the two major branches of medical care—hospital medicine and medicine in the home.

The letter is now the principal mode of communication between specialist and general practitioner, and in relation to the interchange of information about specific patients it is usually the only form of contact. This is particularly so with regard to the ambulant sick who attend out-patient departments. Sometimes the letter from the general practitioner is a mere note of introduction more than a request for an appointment, but ideally the general practitioner should indicate his problem and state the reason for seeking consultant opinion. The letter should include information which may not be readily available to the consultant, such as social and family background, past treatment and any response to this treatment where relevant. It is unusual for a general practitioner to state specifically whether he wants advice only or whether he wants the consultant to

undertake treatment himself. The consultant is more likely to introduce this and the letter will be clearer to him if the general practitioner is well known to him.

McMullan and Barr (10) in their study of the content of general practitioners' letters make the comment 'Perhaps the most striking thing about the whole range of general practitioners' letters is the type of information which tends not to be included. This was the most notable in the field of the family and social background of the patient where the general practitioner has unrivalled knowledge.'

A similar attempt to evaluate the communications systems in the eleven survey areas was made by reviewing the letters which passed between general practitioners and specialists.

In each of the hospitals a sample was taken consisting of correspondence relating to 100 consecutive medical and 100 consecutive surgical out-patients commencing in June 1962. The correspondence was examined retrospectively along with the case-notes six months later.

1. Letters from general practitioners

A combined letter/appointment request form was available in seven of the hospitals and was introduced into an eighth shortly after our study. Six of the seven northern hospitals used these letter forms and they were used in over 80 per cent of referrals in each area. In one southern area using these forms they were used in 40 per cent of referrals only. These letter forms were designed specifically for individual hospitals and were all different in format. One particular form was superior to all others in that the part for the doctor's letter was ample in size (larger than octavo), and, by having a double folding arrangement could be sealed before the patient filled in his or her part. The paper was soft enough to allow a typed copy and it was prepaid.

None of the others had a double folding arrangement or was prepaid, and only one other was soft enough to be handled easily in a typewriter, and allow a carbon copy to be made.

All the letter cards simultaneously requesting appointments have the disadvantage that with long waiting periods for consultation now unfortunately common, the letter does not include details of treatment recently tried.

a. LEGIBILITY

De Alarcon and Hodson (11) report that 26 per cent of consultants find illegibility a common fault in general practitioners' letters. In only 0·7 per cent of our sample was illegibility such that the gist of the letter was not understandable but in 7 per cent individual words were illegible or there was difficulty in reading the letter. Such difficulty, causing delay could lead to a degree of irritation with loss of attention to the remaining part of the general practitioners' information.

Eleven per cent of letters in the 2400 sample were typewritten with a difference between north and south. In the northern group 7 per cent were typewritten and only in one area was the percentage above 10 per cent, but in the southern group 17 per cent were typewritten and in only one was it less than 10 per cent. In one group in the south this percentage rose to 29.

b. LENGTH OF LETTER

Letters vary widely in length, content, and layout. The content of the letter may be underestimated if the layout is not satisfactory. Some cannot be described as letters, being a mere note of introduction. Examples of the 'please see and treat' type or the one-word letter were rare, but 3 per cent of the letters were decidedly scrappy. These included letters written on E.C. 10s (the form used for prescribing drugs) and assorted certificates.

An attempt has been made to compare the length of letters but where a proforma is used it is necessary to count the number of relevant words already printed.

Table 37 demonstrates that there is a marked difference between north and south. In letters to surgeons, 82 per cent of the letters in the north and 58 per cent in the south were less than fifty words. In letters to physicians the corresponding figures were 54 per cent north and 28 per cent south. The range of the figures, surgical 44—95 per cent and medical 22—84 per cent could, of course, be influenced by the nature of the illness or condition of the patient, since a sample of 100 is too small to result in a uniform sample of diagnoses. However, if we rank the average length of letter for each group there is a high correlation between letters to surgeons and letters to physicians. The average letter from the southern doctor is consistently longer to both physicians and surgeons. The first five places in both the

Hospital	Surgical			Medical		
	0–49 words	50–99 words	100+ words	0–49 words	50–99 words	100+ words
C1	68	27	5	34	46	20
E	44	35	21	23	44	33
H	65	32	3	22	51	27
I	55	30	15	35	41	26
C2	59	39	2	30	56	14
A	95	5	0	84	13	3
B	85	14	1	55	34	11
D	68	23	9	37	45	18
F	84	15	1	46	45	9
G	85	14	1	55	42	3
J	70	22	3	44	41	15
K	87	11	2	59	37	4
All	72	22	6	44	41	15
All north	82	15	3	54	37	9
All south	58	33	9	28	48	24

Table. 37. *Length of general practitioners' letters by area (percentage)*

column relating to medical letters and the column relating to surgical letters are held by the five southern samples. This suggests that the length of letter is being influenced by the place of practice.

The findings of Acheson *et al.* (12) that the further the general practitioner is from the teaching hospital the longer is the letter has no bearing on this sample. These differences between places may however be influenced significantly by the use of the printed form more common in the north, or by the more frequent use of the typewriter in the southern groups. A printed form with four lines of writing space under the heading 'clinical details' does not permit or encourage long letters, and does permit contractions to one word, e.g. 'Haematuria' or 'v.v.s'. This is hardly perfect but will stand alone. Conversely in a more formal letter haematuria would at the minimum be required to be incorporated into a sentence of four words, e.g. 'He complains of haematuria', and would be stark at that.

Typewritten letters usually imply dictated letters and economy of words is probably not so important as in handwritten letters. The number of typewritten letters in some of the twelve groups is too small to permit comparisons between the groups, but in view of the possibility that the area differences are influenced by these factors the typed letters to northern hospitals (145) were compared to 169 typed letters to southern hospitals. The results are set out in Table 38.

	0–49 words	50–99 words	100+ words
MEDICAL			
North	15	51	34
South	17	43	40
SURGICAL			
North	55	30	15
South	35	32	33

Table 38. *Length of general practitioners' typewritten letters (percentage)*

The difference between north and south still holds but is not as great as the whole sample. The proportion of short letters to physicians is little different between north and south but is significantly greater in the north in relation to letters to surgeons ($p < 0{\cdot}01$): this indicates that the effect of area still holds when the possible effect of the printed form and typewriter is removed.

c. CONTENT OF LETTER

The length of a letter is not so indicative of professional standards as is the clinical content. Do longer letters imply more clinical information? The comparison of such complex and detailed information is not easy. We devised a simple points system based on inclusion of one or more of the following items:

Presented complaint.
Amplification of history.
History.
Previous medical history.
Family history.
Social history.
Physical signs immediately relevant.
Other physical signs.
Urine testing.
Investigations already carried out.
Treatment given.
Provisional diagnosis.

These items cover a similar ground to those which De Alarcon and Hodson list in their paper as 'items which should never be omitted' with the exception of 'general practitioners' problems or specific requirement from referral'. One point was allocated for any positive or negative information in each category. This points system can be criticized on two major grounds:

1. No weight is given to any particular type of information.
2. No account is taken of the amount and depth of information in each category. For instance, one point would be allocated under social history for mention of occupation, smoking habits, or detailed exposition of the patient's family life and stresses.

Hospital	Surgical	Medical	Total	Rank	Mean
C1	280	334	614	8	
E	305	349	654	5	
H	290	379	669	3	660
I	318	368	686	2	
C2	317	391	708	1	
A	210	243	453	12	
B	260	347	607	9	
D	264	334	598	10	
F	300	362	662	4	597
G	290	354	644	6	
J	293	350	643	7	
K	248	322	570	11	

Table 39. *Content of general practitioners' letters by score per* 100 *surgical and medical letters by area*

Table 39 shows the points scored in the sample on 100 surgical and 100 medical letters in each locality. The score in the southern sample tends to be higher than in the northern sample. When placed in rank order as in the right-hand column of the table the five southern groups come in the first eight. This relative situation applies to both surgical and medical samples. The rank correlation between the medical and surgical samples is +0·85. This ranking indicates that the difference is not due to a difference in clinical material and using our methods of assessment, it can be said that doctors in the south give more clinical details than doctors in the north.

It is interesting to compare the top and bottom scorers in this table, Areas C2 and A. In both cases the general practitioners are resident in or around a coastal town with a high proportion of retired people and both areas are well-known holiday resorts. Of the two, the southern one, Area C2, is also a seaport and has more industry. On average the general practitioners in this sample from the southern town write letters which contain two-thirds more items of information than the letters from their northern colleagues. Similarly the letters to surgical clinics contain 50 per cent more items of information.

Table 40 indicates in greater detail the difference between north and south. In the surgical letters this difference is most marked in relation to physical signs, but in medical letters in relation to history and treatment. The sum of points scored per 100 letters is higher in the south than in the north in both medical and surgical letters. This difference also applies to both typewritten and handwritten letters.

	Surgery		Medical	
	North	South	North	South
Presenting complaint	71	77	91	92
History amplified	29	32	42	53
Previous medical history	16	22	25	39
Family history	1	1	4	3
Social history	12 (4*)	7	20 (13*)	18
Physical signs (immediately relevant)	60	74	49	49
Other physical signs	5	5	6	6
Urine	2	3	13	14
Investigations reported	3	7	10	16
Treatment given	6	10	28	37
Diagnosis	62	63	41	37
Total scores	267	301	329	364
Typed letters only	278	350	361	376
Handwritten letters only	264	290	324	359

* Excluding information given on printed letter form by request (usually occupation).

Table 40. *Content of general practitioners' letters. Comparisons of north and south by points per* 100 *letters*

	North	South
Less than fifty words	89	66
Presenting complaint	53	40
History amplified	17	10
Previous medical history	13	26
Family history	0	0
Social history	20 (6*)	10
Physical signs	69	92
Other physical signs	7	8
Urine	0	0
Investigations	0	5
Treatment	3	2
Diagnosis	90	84

* Excluding information given on printed letter form by request (usually occupation).

Table 41. *North–south comparison of items in general practitioners' letters. Hernia only (percentage)*

Also the typewritten letters in each group besides being longer have more information than the handwritten letters in the same group.

The range of diagnoses is too wide to allow sufficient numbers for a north–south comparison of any one diagnosis, except in the common surgical condition of hernia, of which there were seventy in the northern sample and thirty-eight in the southern sample. Table 41 shows this in detail.

There is no over-all difference in the totals of points scored between the northern and southern groups of doctors, but we are

dealing with a clinical condition with few refinements. Despite this and the general equality, in the south 26 per cent of the letters mentioned previous medical history compared to 13 per cent in the north.

d. ITEMS OMITTED

The interesting broad regional differences are in a sense secondary to the main finding of this study: namely the low over-all communicative quality of these letters from 'personal doctors'. The scoring system involved a maximum of twelve points for each letter and as 200 letters were considered in each area the total score possible was 2400. We have already noted the poor showing of Group A's general practitioners compared with Group C2; but even the latter's score (calculated from data in Table 39) is only 29 per cent!

It is perhaps relevant here to dwell less on comparisons, and more on deficiencies in mentioning details from the list of items 'which should not be omitted' according to information collected by De Alarcon and Hodson (13).

High on this list was drugs and treatment the patient is having. In the scoring system used in this study a point is allocated for any treatment mentioned however incomplete. It can be said therefore that in letters to physicians two-thirds had no mention of treatment whatsoever.

Another item which cannot be easily obtained from the patient is the social history, particularly situations of stress in the family, which may have a bearing on the clinical condition of the patient. These are rarely included even when obviously relevant and necessary. All social aspects including occupation were mentioned in less than a fifth of the letters.

General practitioners commonly use such phrases as 'for your advice' and 'for your opinion'. The use of such phrases often precludes the stating of a specific problem of the practitioner, omission of which may result in the practitioner failing to get his problem solved. Many general practitioners complain that patients are kept too long attending out-patient follow-up. Is it possible for consultants to know which general practitioners would like to do their own follow-up unless this is specifically mentioned? The phrase 'for your opinion' is too vague. If a general practitioner has a strong desire to take on the long-term care of his patient in such cases as diabetes, thyrotoxicosis, and hypertension he will have to make

a point of saying so, otherwise there is a strong probability that these patients will be added to the growing list of chronic attenders at medical out-patients.

In summary there is no evidence to suggest that a general practitioner's letter necessarily reflects his clinical or other abilities as a doctor. However, in that communication is an important and integral part of medical practice as a whole, failure in medical communication impairs the efficiency of medical practice and influences adversely clinical practice. As in the studies by McMullan and Barr (14), De Alarcon and Hodson (15), and Acheson *et al.* (16) our analysis shows that there are many deficiencies in communication from general practitioners and that there are many unexpected omissions in relation to those aspects about which the general practitioner could be most helpful. The average letter from the general practitioner is poorer in some areas than others with a distinct north/south difference. It may well be that the present widespread use of ill-designed letter cards may be having an adverse effect on communication; but whatever the cause the general quality of information about out-patients passing from general practitioners to consultants is poor in the extreme and it is our considered opinion that the communication from the general practitioner side is grossly inadequate. Part of the reason for this may be in the inadequate secretarial and ancillary services made available to general practitioners; but it should also be recognized that the tendency on the part of hospital authorities to standardize correspondence by the use of printed forms is itself an inhibiting factor.

II. Consultants' letters to general practitioners

The quality of communication from consultants to general practitioners was measured from three broad aspects: the frequency of contact about individual cases, the content of letters, and the speed of despatch. The 2400 patients who formed the basis of the foregoing study of general practitioners' letters were also used in this study (that is, 100 consecutive new out-patients in general surgery and 100 in general medicine from twelve hospitals in the survey areas) and for each patient the following information was obtained:

1. The diagnosis at the time of discharge or at the end of six months whichever was the sooner.
2. The number of out-patient attendances in the first six months.

3. The number of letters sent out as a result of these out-patient attendances.
4. The date the first letter was typed.
5. The content of the letters compared with information available in the notes.

a. NUMBER OF LETTERS AND VISITS

It is inherent in the Cohen Report on general practice (17) and the Gillie Report on the future field of work of the family doctor (18) that the responsibility for the care of a patient remains with the general practitioner while he or she is attending an out-patient department and therefore it is the responsibility of the hospital staff both medical and lay to keep the general practitioner fully informed of all developments and opinions. Ideally communication should be sent after each attendance. This view is expressed in a recent report on communications (19).

In our sample each patient attended on the average just over twice in the first six months with 43 per cent attending only once and at the other extreme only 2 per cent attending six or more times. In general surgery the sample of 1200 patients resulted in 2326 attendances and were the subject of 1685 letters, or 72 letters for every 100 visits. In general medicine 1200 patients made between them 2440 visits and were the subject of 2366 letters—a rate of 99 letters per 100 visits. This latter figure at first sight appears to approach the ideal, but it masks a range varying from 65 in hospital C2 to 146 per 100 visits in hospital A. Similarly, the range for the surgical samples was 51 in hospital G to 99; hospital A again being highest (see Table 42). If all the hospitals were placed in rank order on this figure the same hospitals would occupy the first and last three places in both surgical and medical samples. The rank correlation between both columns is high (+0·62). Since each medical and surgical sample covers several consultants in a hospital, this relationship suggests a factor operating over and above the influence of each individual consultant and peculiar to that hospital's pattern of work. A clue to this factor is seen in the varying rates of attendance for each 100 patients (Table 42). This varies from 128 (hospital E) to 264 (hospital H) in medicine and from 157 (hospital A) to 243 (hospital G) in surgery. This factor accounts largely for the ratio of letters to visits. The smaller the number of visits the higher the number of letters per

Hospital	General surgery			General medicine		
	Visits	Letters	Letters per 100 visits	Visits	Letters	Letters per 100 visits
A	157	156	99	147	214	146
B	174	155	89	241	226	94
C1	183	103	56	226	182	81
D	192	176	92	217	194	89
E	162	145	90	128	145	113
F	160	110	69	153	207	135
G	243	124	51	224	188	84
H	169	137	81	264	224	85
I	210	161	77	217	256	118
C2	240	113	47	238	154	65
J	221	156	71	192	168	88
K	215	149	73	193	208	110

Table 42. *Consultants' letter to general practitioners. Letters per* 100 *visits; general medicine and general surgery by area*

	High visits per 100 patients		Low visits per 100 patients	
	Hospital		Hospital	
	B	H	A	D
Visits per 100 patients	241	264	147	128
Age distribution				
Percentage –44	42	33	37	34
Percentage 45–64	42	38	41	52
Percentage 65+	16	28	22	14
DIAGNOSTIC GROUPS				
1. Cardiovascular	15	14	18	14
2. Lungs	13*	1	0	3
3. Gastro-enteritis	10	19	7	14
4. C.N.S.	5	11	9	6
5. Endocrine and obesity	14	11	18	12
6. Skeletal	2	2	7	11
7. N.A.D., N.Y.D. + anxiety	35	39	34	32
8. Other	6	2	6	6

* One physician was also appointed chest physician.

Table 43. *Extremes in attendance rates. Four areas compared in general medicine*

100 visits. These wide variations in the numbers of attendances per 100 patients may be due to a case-load which varies widely by age and sex and type of case, that is with a varying proportion of cases which require more frequent follow-up. In a relatively small sample of 100 patients in each specialty and each hospital the variations may be wide but as seen in Table 43 there is considerable uniformity in some respects. For example, the samples from four hospitals are

compared—the two with the highest (hospitals B and H) and the two (hospitals A and D2) with the lowest number of visits per 100 patients. The variation particularly in the broad diagnostic groupings is relatively small and is unlikely to account for the wide variation in the number of attendances.

The cross relationship between medicine and surgery requiring the number of follow-up visits suggest these are influenced by factors affecting the hospital as a whole. Such factors appear to be:

1. The density of population served: in hospitals with a higher proportion of patients from rural areas, follow-up may be avoided to save the patient a further long journey; Group C is one example.
2. Pressure of work in the clinic. This is difficult to measure. Increasing use of an out-patient department because of increasing population or any other cause, may be countered by increasing number or length of out-patient sessions or increase in senior or junior medical staff. Where this is not feasible new patients have to be accommodated at the expense of other patients and the ratio of new to old patients per session rises. To enable this to be done the patients are discharged as soon as possible and reports of investigations are sent out without requiring the patient to re-attend.

These points are illustrated in the case of hospital A. This hospital is situated in a large seaside town with an increasing population. The out-patient department is inadequate in size and the number of clinics cannot be increased during normal working hours. Although each session is unduly prolonged, expansion has been achieved by a larger number of new patients per session. This hospital has the highest number of new surgical and medical patients per session of the twelve visited, as well as the smallest number of total visits in surgery and the second smallest in medicine. In short the number of repeat visits is reduced considerably to accommodate new patients.

b. DELAY IN COMMUNICATION

Delay in receiving reports is a common complaint among general practitioners; of 600 general practitioners replying to questions on out-patient services 65 per cent complained of delay in receiving reports. De Alarcon, de Glanville, and Hodson (20) felt that 8 per cent of reports were received after the patient had returned to the

Hospital	Time interval to dictation of first letter			
	1st day	Up to 1st week	2 and 3 weeks	4+ weeks
A	91	92	8	0
B	61	87	11	2
C1	50	79	18	3
D	92	92	7	2
E	64	81	17	2
F	81	81	19	0
G	79	81	15	4
H	57	89	11	0
I	34	91	7	2
C2	69	83	17	0
J	93	94	4	2
K	84	85	15	0
Average	79	86	12	1·5

Table 44. *Delay in communication. Time interval by area, between consultation and first letter to general practitioner. Percentage of* 1157 *letters in general surgery*

Hospital	Time interval to dictation of first letter			
	1st day	Up to 1st week	2 and 3 weeks	4+ weeks
A	9	65	34	3
B	62	78	19	3
C1	59	66	24	10
D	75	87	12	1
E	9	69	33	8
F	19	92	6	2
G	24	69	24	7
H	88	94	5	1
I	75	89	8	3
C2	86	86	13	1
J	58	88	10	2
K	44	91	9	0
Average	54	82	16	2·5

Table 45. *Delay in communication. Time interval by area, between consultation and first letter to general practitioner. Percentage of* 1133 *letters in general medicine*

general practitioner. In our survey we were not able to measure the length of time between consultation and the receipt of the letter by the general practitioner but we were able to make a note of the date on which the consultants' letters were dictated and relate this to the date of consultation. Any undue delays in signing and posting the letters would not be known to us but it is possible for several days to elapse before the letter is in the hands of the general practitioner. The over-all picture is shown in Tables 44 and 45.

It is clear from these figures that the general practitioners' criticisms of undue delay have little basis in fact. Of general surgeons' letters 86 per cent are written within a week of consultation and in the case of consultants in general medicine the figure is 82 per cent. Letters delayed for over four weeks constitute a small minority in each specialty—2·5 per cent in medicine and 1·5 per cent in surgery. On the whole therefore the conclusion must be that the consultants perform quite creditably in this respect.

However, for all areas combined 12 per cent of surgeons' letters and 16 per cent of physicians' were delayed until the second or third week after consultation. As for individual areas, the surgeons in Group A were more diligent correspondents than their physician colleagues but it was vice versa in Group F. On the other hand, both specialties were guilty of delay in Groups C1, D2, and G. These criticisms are, of course, relative only, in view of the fact that in all areas the vast majority were written within a week of the first consultation. From our observations we found that most specialists work on the basis of a first letter sent immediately after a patient's first visit and one or more letters later containing the results of investigations. The adverse opinion of general practitioners may be the result of a small number of consultants, usually only one in each group with a different pattern of communication. For instance, the first letter may be delayed until investigations are completed; if X-ray contrast studies are involved this may take several weeks. In the case of one consultant this pattern included in-patient investigations for which there was a waiting list.

A failure common to all specialties, and to many specialists, was the effect on communication of direct admissions from the out-patient departments to the wards. A few consultants sent interim reports to the general practitioner but in the majority of such patients it was not the habit to send any communication, written or verbal to the general practitioner until after discharge. This means in effect that the general practitioner is unaware that the patient has been admitted unless informed by a relative of the patient.

There were no letters from out-patient departments in the case of 1 per cent of the surgical patients and 3 per cent of the medical patients in our sample of 2400. Direct admission accounted for most of these, but in a few cases administrative failure resulted in no letters at all being sent.

	Number of words			
	–49	50–99	100–149	150+
Medicine	10	26	25	39
Surgery	54	34	9	3

Table 46. *Length of consultant's first letter to general practitioner (percentage)*

	Diagnosis	Treatment	Prognosis	Investigations
MEDICINE				
First letter	81	56	4	31
All letters	88	72	5	71
SURGERY				
First letter	82	71	1·5	8
All letters	84	78	2·5	28

Table 47. *Content of consultant letters (percentage)*

c. LENGTH AND CONTENT

Table 46 shows the percentage distribution of the number of words in consultants' letters. As is well known to general practitioners the physicians' letters tend to be longer than surgeons' letters. The length of the surgeons' letters is of the same order as letters typewritten by general practitioners to surgeons.

In contrast to general practitioners' letters described earlier the marked north/south difference operates in reverse; letters from physicians in the south are significantly shorter than from their northern colleagues.

The first and subsequent letters sent for each patient were analysed for the following information:

1. An opinion of diagnosis or cause, or alternatively a statement to the effect that there was nothing wrong with the patient or that no conclusion could be reached. The fact that the diagnosis might be proved wrong eventually was deemed not relevant.
2. A statement of management offered or to be undertaken by the hospital staff.
3. The reporting of the investigations undertaken.
4. A statement of prognosis.

The results are expressed in Table 47.

In over four-fifths, an opinion regarding cause or diagnosis is offered in the first letter. At the end of six months or on discharge there is little increase on this figure, but in 16 per cent of surgical

patients and 12 per cent of medical patients there is no opinion of diagnosis or causation other than a symptomatic diagnosis. Treatment was mentioned in 72 per cent of physicians' and 78 per cent of surgeons' letters. De Alarcon, de Glanville, and Hodson (21) state that only 4 per cent of letters were vague or useless in their sample. The results of this investigation are not necessarily different. The contents of the letters are assessed in a different way, and without reference to the referring general practitioner it is not possible to say that a letter or a series of letters is 'vague and useless'. The letter from a general practitioner does not always specify his problem or the reason for the referral. Where the patient has been referred at his own suggestion or where the general practitioner is seeking certain investigations or requiring reassurance that organic conditions are not present then the letter can still be very useful without making a specific statement or diagnosis.

Specialists' letters may be grouped into three categories:

1. A bare statement of diagnosis, treatment, and/or investigation.
2. A fuller statement which includes the specialist's own physical findings on which he bases his diagnosis.
3. The discussion of some aspects of the case such as the reasons for his diagnosis, or of the results of investigations, or the pros and cons of certain lines of action.

The first category satisfies many general practitioners and fulfils the requirements of the specialist's function, but the second and more so the third fulfil another function, unofficial but no less important—the continuing education of the general practitioner in the management of individual patients. This method of education can be underestimated but has an increasing value in a situation where the general practitioner has no direct association with his local hospital and with rapid technical advances taking place in hospital practice over the last two decades.

Only 17 per cent of letters from surgeons and 25 per cent of letters from physicians fall into this important third category. The first category includes 30 per cent of letters from surgeons and 16 per cent of letters from physicians.

To make a prognosis is often difficult and specialists rarely give an opinion in this direction. In only 2·5 per cent of the surgical patients and 5 per cent of the medical patients was any attempt at prognosis made.

De Alarcon and Hodson make a point of noting whether any mention is made of what was told to the patients. Our sample found remarkably few, less than 1 per cent, of either general practitioners' or specialists' letters where this is mentioned.

d. MISCELLANEOUS COMPLAINTS

Our inquiry among general practitioners in the survey areas revealed some miscellaneous complaints, also mentioned in the *Report on Communications and Relationships between General Practitioners and Hospital Medical Staff* (22). These may now be considered.

1. *Repeated history*

That is the letter repeats the history already written by the general practitioner in his letter to the specialist. This occurred in only 1 per cent of letters from physicians and 5·4 per cent of letters from surgeons.

2. *Failure to answer specific questions*

Specific questions in general practitioners' letters are very infrequent and 2·5 per cent of the replies in all the medical sample and 2·8 per cent of the replies in the surgical sample made no mention of a specific question. It is apparent that some specialists do not refer to the general practitioner's letter at the time of dictation. For example when the opening gambit is 'Thank you for referring this patient' to a general practitioner when the referral was from a specialist colleague or other source. This occurred in relation to 10 per cent of patients who had been referred to other specialists.

3. *Failure to report investigations*

This is not a common complaint among general practitioners. This is hardly surprising. If an investigation has not been mentioned the general practitioner is not aware that it has been done. The general practitioner does not wish for a full list of investigation reports without comment, but an assessment by the specialist of these reports. However, it is common for investigations such as chest X-ray, blood count, and electrocardiogram to be performed without mention of the fact to the general practitioner. Perhaps this is because the results are negative or perhaps it is considered the general practitioner has no interest in them. These normal results, however, may be useful for the general practitioner in the ensuing months when considering some other aspect of the patient and may be useful as base lines to be kept in the general practitioner's files for

reference at a future date when a new complaint arises. In this sample 9·8 per cent of the medical patients and 12·7 per cent of the surgical patients had common investigations which were not mentioned in any correspondence. In addition there were occasional misleading reports such as after a follow-up (post-operative) attendance: 'The haemoglobin is satisfactory' (*sic*). A report stating that the haemoglobin was 61 per cent would be just as simple and far more revealing.

e. WIDER ISSUES

1. We were able to confirm some of the more important findings of this analysis by consulting letters relating to all the 13 600 new out-patients who are the concern of the main survey and included all acute specialties except obstetrics. In this larger sample, the time interval between the date of the patient's first attendance and the date of the first letter sent out was noticed and whether the communication was considered to have been inadequate, that is no reports at all or incomplete reports which failed to mention progress or change in treatment.

We found the first letter was sent out in the first week in over 90 per cent of the sample, with little difference between the specialties.

Eleven per cent of the reports were considered inadequate. These defects range from 8 per cent in chest diseases, 9–12 per cent in medicine, paediatrics, dermatology, psychiatry, surgery and oto-laryngology, 16 per cent in orthopaedics and 19 per cent in ophthalmology. Patients attending ophthalmology clinics and fracture clinics are often seen in large numbers at follow-up clinics, with letters being sent out infrequently or not at all.

2. The question of rehabilitation has not been examined quantitatively, but out of 13 600 out-patients of all ages and specialties, a fifth of whom were still attending at the end of six months, rehabilitation or the disablement resettlement officer were mentioned in only five instances in any correspondence. These were all in one hospital which had the rehabilitation clinic and close liaison with rehabilitation facilities in the area.

3. *Reliance on the patient*

It seems that two common patterns of communication are employed in relation to out-patients:

(*a*) On the first visit the patient is sent for investigation and is then discharged back to the general practitioner to whom the results and an opinion are forwarded later.

(*b*) The patient attends various departments for investigation or treatment and at a second visit to the consultant the results are collated and forwarded in a second or subsequent letter to the general practitioner.

The second system is more commonly used in this country but the first is becoming more frequent in rural areas and where pressure on the out-patient department is high (as in hospitals D2 and A).

In our survey about 8 per cent of the patients ceased to attend after six months. That is, there were no further entries or letters in the notes when it was obvious that the consultant expected the patient to attend again. Clerical staff when asked about specific instances invariably explained it as the patient failing to keep an appointment (it is not their function to cause patients to attend who have no desire to return). Many patients fail to attend of their own volition for various reasons, but failure of the system is partly responsible.

The first system depends on good secretarial staff to co-ordinate the investigations and present the results to the consultant for his opinion and its transmission to the general practitioner. The difficulty arises where the results of the investigations require the further attendance of the patient; he has to be sent for. In one hospital using this system, where it was claimed the patient had failed to attend, further investigations showed that no appointment had in fact been made. This system requires a higher degree of efficiency in the clerical staff than the second more common system.

In the second system the patient is required to attend again and is given or told to make a further appointment after investigations have been completed. The difficulty arises where the waiting time for investigation is prolonged and it is left to the patient to make a further appointment. Sometimes the patient fails to do this because he did not understand what was wanted of him. There is a tendency on the part of those who work in hospitals to think that any system is straightforward and easy to understand. Those in this strange hospital world for the first time, especially if not well, can easily make mistakes. Unfortunately too many hospitals depend on the initiative or understanding of the patient.

In either system the failure of a patient to keep an appointment is a possibility. His or her name appears on a list and the case notes are extracted in anticipation of the expected attendance. If this patient fails to attend this fact can be brought to the notice of the consultant who may then review the correspondence to the general practitioner. If, however, the patient fails to make an appointment or is not given one he is lost to the system until he or his general practitioner takes the initiative which may be many months later, if at all. His name never appears on an out-patient appointment list and his absence is not noted or acted upon. In one hospital in our survey if the patient after being X-rayed failed to attend the out-patient department again because he had not made an appointment his X-rays also remained uncollected. In several instances the correspondence ended on the note 'I have sent this man for investigation.' Further inquiry in the X-ray department showed that the X-ray had been done but the report or film lay uncollected. *Ten per cent of one surgeon's requests for X-ray examinations remained uncollected and the results remained unknown to the consultant, patient, and general practitioner.* Under this system initiative remains with the patient and if he fails to comprehend the system it fails too.

4. *Reliance on the system*

Just as the system is over-reliant on the patient's initiative, it can be argued that the family doctor is over-reliant on the system. For example, in the matter of information about proposed admission to hospital for operation and the approximate dates it will take place; there is frequent failure to notify the general practitioner that his patient has been admitted directly from an out-patient visit or from a waiting list. In all the hospitals studied there was no system for such notification. Indeed unless a general practitioner sends a patient into hospital as an emergency or from a domiciliary visit by the specialist, he does not know at any point in time which of his patients are in hospital. Such a state of communication makes nonsense of talk of continuity of care with the family doctor as the keystone of British medical practice. Treatment of a patient becomes a disconnected series of episodes of out-patient attendance, admission to hospital wards, operation, and out-patient attendance again. In this situation it is not possible for the family doctor to fulfil his role of interpreter and co-ordinator. Once the patient is in the hospital the responsibility of the general practitioner ends and his opinions

and views are not sought in relation to any form of treatment. It might be argued that general practitioners could do more to make their views known, that it is not against the ethical code for a general practitioner to *ask* what is happening to 'his' patients in hospital. Certainly the present system of communication hardly merits exclusive reliance on it. But the reality of the situation is that hospitals and consultants are often independent and again initiative from the general practitioner requires a volume of resource in record-keeping which most general practitioners simply do not have available.

9. Consultant opinions

Inevitably in conducting this investigation we faced the social scientist's familiar problem. In spite of the many discussions and consultations with hospital workers of all kinds and at all levels our field workers were always outsiders looking in and to become acquainted with every detail of a situation it is necessary to work within it. Equally, to become part of a system has its own dangers for the researcher. The critical faculties may become less than sharp and the sense of objectivity may be lost. For obvious reasons it was not possible to use the technique of participant observation in this study. As a compromise therefore a special inquiry was conducted among consultants and senior hospital medical officers working in the survey hospitals both to supplement the information collected by the field workers and to compare the impressions gleaned about the system with the views of those who work in it.

The method of this inquiry has been described in Part 1, §3 and here we consider first the numbers involved and the response rates.

Clearly the response rates are high; in only three areas is the rate below 80 per cent. Nevertheless the numbers involved (apart from Groups C1 and I) are small and the fact should be kept in mind throughout the presentation of the results (Table 48). Similar considerations are prompted by the analysis by specialty (Table 49).

Again the response rates are high, with only three specialties falling below 80 per cent; but the numbers are small and are heavily weighted with general surgeons and consultants in general medicine. With such small numbers cross-tabulation would be hazardous and has not been attempted. In presenting the results of this opinion poll

Area	No. of consultants	Replies	Percentage
A	19	16	84
B	20	16	80
C	34	31	91
D	20	13	65
F	19	16	84
G	17	10	59
H	11	9	82
I	25	22	88
J	11	10	91
K	19	15	79
All areas	195	158	81

Table 48. *Questionnaire response, by area, excluding geriatrics*

Specialty	Consultants	Replies	Percentage
General medicine	33	29	88
Chest diseases	20	12	60
Paediatrics	11	9	82
Dermatology	11	10	91
Geriatrics	—	(6)	—
General surgery	35	30	86
Orthopaedics	23	20	87
E.N.T.	16	11	69
Ophthalmology	21	16	76
Gynaecology	25	21	84
All specialties	195	158 (164)	81

Table 49. *Questionnaire response, by specialty*

it has been necessary to take all surgeons for example together regardless of the area in which they worked, and to deal with a given area's consultants collectively, irrespective of specialty.

1. Number and location of sessions

In the main body of this report, when considering referral rates, waiting periods for appointment, the flow patterns of work, the quality of communications, and so on, it was necessary to treat as one department all the work performed in out-patients under a given specialty regardless of how many hospital units were involved. This was a logical approach in view of the stated purposes. However, it must be emphasized that out-patient work is fragmented by the fact that in all areas out-patient sessions are held at a number of institutions. This fragmentation is bound to have consequences for the efficient organization of departments and the degree of fragmentation can be assessed from the information provided by consultants taking part in this inquiry.

Clearly in all specialties except geriatrics the degree of fragmentation is high. For most of them about a third of their out-patient work was conducted at hospitals other than the main hospital in the group but for dermatologists the proportion was two-thirds. Here it is possible only to speculate briefly on the likely consequences of consultants conducting clinics at more than one hospital. There will be more than one waiting list to supervise, and in addition to variations in waiting periods as between different consultants in the same area there may be variations in waiting periods for appointment to see the same consultant at different hospitals. Where record systems are centralized added strains may be imposed by having multiple clinics. Patients seen at one clinic may have to attend elsewhere for clinical investigations: in consequence there may be added danger of the patient failing to make new appointments and increased difficulties for the introduction of adequate safeguards to counter this. In view of the evident dispersal of consultant sessions among a number of institutions the consultants' performance in respect of their correspondence, noted in the previous chapter, is all the more commendable.

An interesting feature of Table 50 is the high degree of commitment to out-patient work. Only in geriatrics and general surgery does the average number of sessions per week at all hospitals fall below three. Dermatologists and chest physicians seem to be particularly involved in out-patient work for a majority of their time but the other specialties are also heavily committed. The importance of out-patient work emerged also when the consultants were asked to state the approximate proportion of their time devoted to it (Table 51).

Considering the high proportion of total time devoted to out-patients it is not surprising that when asked if they were spending enough time to deal with out-patients expeditiously over 70 per cent thought that they were, bearing in mind the other pressures on their time. Over a third of the respondents volunteered comments in this vein, for example: 'Too little if all patients are to be seen adequately, but if other work is to be done this is all the time available. I am already doing two sessions more than the statutory nine.'

The consultants were asked whether they preferred out-patient work, in-patient work, or had no preference. Whatever its importance in terms of volume out-patient work seems to enjoy little status in the eyes of most consultants (Table 52).

Specialty	Responses	Number of sessions		Average	
		Main unit	All units	Main unit	All units
General medicine	29	76	112	2·6	3·9
Chest diseases	12	69	77	5·8	6·5
Paediatrics	9	25	39	2·8	4·3
Dermatology	10	26	71	2·6	7·1
(Geriatrics)	6	7	8	1·2	1·3
General surgery	30	59	78	2·0	2·6
Orthopaedics	20	59	89	3·0	4·5
E.N.T.	11	29	52	2·7	4·6
Ophthalmology	16	47	89	2·9	5·6
Gynaecology	21	44		2·1	

Table 50. *Average number and location of sessions per week: analysis by specialty (ten H.M.C. groups,* 1965)

Answers included obstetric sessions.

Responses	Percentage of time
9	–20
30	20–9
31	30–9
27	40–9
67	50–
164	

Table 51. *Distribution of consultants by percentage of time in out-patient work*

Specialty	Prefer in-patient	Prefer out-patient	No preference
General medicine	7	1	20
Chest diseases	1	0	10
Paediatrics	3	2	4
Dermatology	0	3	6
Geriatrics	1	0	4
General surgery	10	0	19
Orthopaedics	5	0	15
E.N.T.	2	0	8
Ophthalmology	4	0	11
Gynaecology	8	0	11
All specialties	41	6	108

Table. 52. *Consultants' preferences on location of work*

Only a third of the 155 respondents to this question had any preference but overwhelmingly they opted for in-patient work. In view of our earlier comments (Part 2, §2) on the discrepancy in the relative trends in in-patient and out-patient numbers since 1953 it is tempting to interpret the consultants' preference for in-patient work in terms of the inability to dissociate illness from a hospital bed. Perhaps it is difficult for specialists to identify the ambulant sick with a real need for care and derive comparable satisfaction in treating them. There may be a grain of truth in this; but it must be remembered that the attitude to out-patient work is undoubtedly severely conditioned by the pressure under which such work is conducted. A number of the free comments illustrated this: 'I would prefer more time but the present system is like a conveyor belt.' 'Pressures operate hardest in out-patients in that all work must be done within a timed setting and a report sent forthwith.' 'In-patient work less allied to a time and motion attitude.' 'Volume of work prevents one enjoying out-patient clinics.' Several respondents indicated that their preference for in-patient work was based on the greater satisfaction it gives. 'More time to consider patients' problems.' 'You get to know the patients and the results of treatment.' 'We are just dealing with numbers . . . at present personal care cannot be given to N.H.S. out-patients.'

11. Pressure of work

In general, the consultants did not ascribe their pressure of work to abuse of out-patient services, although there were exceptions. Asked if their clinics were being used for appropriate cases 90 per cent of the respondents thought this was so. Dissidents were mainly concentrated in orthopaedics (7 out of 23) and geriatrics (2 out of 6) and with such small numbers involved not much significance can be attached to this. However, the majority response testified to the appropriate use of out-patient departments *in general;* and two-thirds of the comments made were critical of the general practitioner for referring trivial cases or failing to exercise proper judgement. For example: 'A few general practitioners refer far too many trivial cases but generally the referrals are quite well prepared.' 'I sometimes feel the general practitioner should trust his own judgement more. He must know his neurotics better than I do.' 'I get an annoying number of patients for investigation which the general practitioner could arrange by direct access.' 'Out-patient services should

be supplementary to the general practitioner's surgery—not a substitute for it.' Occasionally comments were more sympathetic: 'If the general practitioner is rushed and overworked in his surgery then it is natural that he will refer patients to the out-patient department. I am sure many patients ask to be referred and the general practitioner understandably takes the line of least resistance.' Included in the comments was the following rationalization: 'Trivialities and simple cases are needed to lighten the load and provide relief from the really difficult problems.'

A supplementary question was asked to estimate roughly the proportion of cases they thought should have been dealt with by the general practitioner. Three-quarters of the consultants estimated this as no greater than 20 per cent but larger estimates tended to be made by paediatricians, dermatologists, and orthopaedic surgeons. Of consultants in general medicine 21 out of 28 respondents mentioned the types of case involved, the most common being anxiety states and functional disorders, peptic ulcer, dyspepsia, and mild hypertension. Among surgeons 17 out of 29 referred to trivial cases such as sebaceous cysts and warts, and 16 out of 22 gynaecologists mentioned menstrual irregularities and vaginal discharge. Two of the gynaecologists mentioned that some referrals would not have been necessary had the general practitioners taken cytological smears and three others thought that the general practitioners should have made better examinations. Half of the orthopaedic surgeons mentioned backache as the cause of the most frequent unnecessary referral while for the paediatricians it was usually a mild behavioural problem. The over-all impression is that the general practitioner asks for specialist help in a surprising variety of minor conditions; help in investigating complaints such as backache and dyspepsia, or requests for the treatment of warts and sebaceous cysts. Nevertheless, in spite of the suggestions by some of the consultants that the volume of their work is unnecessarily increased by inadequacy on the part of some general practitioners the main reason advanced for the great pressure of work in out-patient departments was that there are too few doctors to deal comfortably with too many patients.

III. Staffing and facilities

To ease the pressure of work a third of the consultants suggested an increased number of sessions although there was some division of opinion about how this was to be achieved. Predictably, since

	At all sessions	At some sessions	Total
Senior registrar, registrar plus H.O.s C.A.*	19	18	37
Senior registrar, registrar(s) only	23	29	52
J.H.M.O., S.H.O., H.O.s only	7	5	12
Clinical assistant(s) only	15	8	23
	64	60	124
None			36
No answer			4
Total consultants			164

† Other consultants and S.H.M.O. have been excluded.
* At all sessions refers in this instance to registrar or senior registrar.

Table 53. *Distribution of consultants by availability of junior hospital doctors† at out-patient clinics*

there would be increased competition for any private work available locally, only a quarter were in favour of extra consultants being appointed in their specialty in their district. Forty per cent thought more junior medical staff a better approach. When asked about clinical assistant posts for general practitioners only 30 per cent of the consultants expressed approval, and almost all these already had a clinical assistant helping out in the clinics.

Table 53 indicates the position so far as the current use of medical staff is concerned. One in five of the consultants (and in the case of general surgeons it applied to half of them) conducted their out-patient clinics without the help of registrars, housemen, or clinical assistants. The worst survey areas in this respect were Area D, where half the consultants worked alone, Area G where it was two-fifths, and Areas K and H where it applied to one-third. Generally northern areas were worse off than southern; in northern hospitals a quarter of the consultants were without assistance in out-patient clinics as against one-seventh in southern hospitals. For one in seven of the consultants help was restricted to clinical assistants. This was particularly marked at Area G. The majority of the remainder had at least one registrar for at least some of their sessions. General physicians, orthopaedic surgeons, and gynaecologists had more help than the other specialists. Medical specialties have about half as much assistance as surgical specialties.

It is apparent that a number of junior hospital medical staff are being used for in-patient work exclusively. This situation is in marked contrast to the teaching hospitals where traditionally great emphasis has been placed on the out-patient case-load as a valuable source of

teaching material. It is sometimes forgotten that provincial non-teaching hospitals do in fact have a teaching function, in that many hospital juniors working there are seeking postgraduate specialist qualifications. Apart from courses provided centrally by the royal colleges the juniors learn their trade on the time-honoured apprenticeship basis and an important part of this is based on observing and working with an established consultant in the wards and in out-patient clinics. It is, therefore, disturbing to note that so many consultants work alone in their clinics and perhaps restrict the experience of some juniors.

It is questionable how far a more widespread provision of juniors to assist in out-patients would in fact ease the pressure on consultants. As we found in Part 2, §6 the vast majority of referrals are seen by consultants and judging by the response to another question this is considered desirable by the consultants themselves. Over 80 per cent thought it important that new out-patients should be seen personally by a consultant, dissidents being mainly in E.N.T. and geriatrics. Some respondents pointed out that although they preferred to see all new patients it was not always possible, and the registrar had to deal with some to keep down waiting lists. From those who did not think it important to see all new patients comments were made that it was good experience for the registrar to take on such cases, and that it was sufficient for the consultant to see these patients subsequently, either as out-patients or as in-patients.

Unexpectedly, the shortage of nurses does not seem to be felt in out-patients. Four-fifths of the consultants reported that they had adequate nursing help. The actual provision varied from none to seven but the scale of provision was not apparently related to the satisfaction expressed.

Asked what other help they had in the clinics a third of the consultants replied that they had none and this applied to half the consultants at Area I and a quarter of those at Areas B, C, and J. Few consultants reported more than two helpers and most only one, usually a secretary, medical social worker, or clerk. Voluntary workers were scarcely mentioned at all. Asked what additional help they would like the consultants without staff usually specified extra clerical help. Less than half the consultants thought that nurses were performing tasks which might be done by less well-qualified staff. Despite the earlier emphasis on great pressure within the clinics the consultants' views on additional staff needed seem very modest

indeed. One's impression is that in terms of staff the out-patient clinic is a small unit with the consultant working in some isolation. Isolation is often said to be an unwholesome characteristic of British general practice; it is presumed not to be a feature of specialist practice. The impression gained from this questionnaire is that consultants may not always work in large integrated units; however it must be appreciated that many consultants are in fact able to consult other specialist colleagues about cases during the clinic. In our sample two-thirds of the consultants said this was so; they were mainly in the major specialties and at Areas B, A, H, and I. The minor specialties, particularly paediatrics, appear to be less fortunately placed. Of those able to confer with colleagues half claimed to do so frequently and half seldom. Of those unable to confer three-quarters thought that even were they able to they would do so rarely. Only the ophthalmologists seemed to regret their relative isolation.

Consultants were more inclined to complain about the shortage of ancillary and technical staff. They were asked to specify any such staff needed in the investigation of new patients, and to say whether they worked in the clinic or were otherwise available the same day. There were eighty-four replies indicating shortages. In the medical specialties those mentioned most frequently were E.C.G. technicians, medical social workers, and dieticians. Audiometricians, appliance and plaster technicians, and optometrists were also listed frequently. These responses do not by any means reflect ambitious expectations. Indeed it seems almost incredible to think that a consultant cannot have an E.C.G. tracing during his clinic sessions. Apparently patients have to be brought back to the clinic as repeat attenders to have necessary investigations or to receive particular advice about diet. It would be an interesting exercise to see realistic costings made of such repeat attendances matched against the cost of providing an adequate level of technical and ancillary staff. Our earlier observations about the absence of investigation among out-patients should also be weighed against the delay involved in securing some basic services because of staff shortages. Even in the elementary services of X-ray and pathological laboratory matters are far from satisfactory. One consultant in seven claimed to experience *frequent* delay in obtaining reports from these departments. The situation seemed to be especially bad at Area I.

Records facilities were included in the inquiry, and the consultants' opinions confirm the impressions of our field workers. Out

of 160 replies 115 expressed dissatisfaction with the records system they used. Not all were as condemning as the consultant who claimed that his hospital had the worst records in Great Britain and that he had opted out by keeping his own. Specific complaints were usually aimed at the quality of facilities rather than the quality of records staff. But only one in seven claimed to have experienced delay in securing records of old patients.

The majority of consultants write their findings into the out-patient notes by hand themselves although for two-fifths of them this is not by choice. A fifth dictate notes to a secretary and have the notes typed into the record. Oddly, 70 per cent of the consultants said their secretarial help was adequate for their out-patient commitments. We may be on the threshold of computerised record linkage; but if the consultants' horizon is limited to handwritten notes, and their expectations confined to a little more secretarial help, we are likely to stay on the threshold for a very long time. Suggestions for improving local records did not go beyond having a different coloured folder for each consultant, using punched cards, or duplicating all records so that all departments might have a copy. A surgeon urged a completely fresh start but did not say in which direction.

As for equipment in their clinics, 87 per cent were satisfied with what they had, the dissidents being concentrated in Areas C, I, and G. Where inadequacy was specified it related usually to diagnostic equipment.

An insight into the level of clinic accommodation may be gleaned from the 20 per cent of consultants who reported that frequently they have two or more patients in the same room while taking histories or conducting examinations. It was almost the rule among ophthalmologists and very common for orthopaedic surgeons.

IV. Controlling the flood

An important function of the records system is the control of waiting lists and the rate at which new patients are booked for appointment. The consultants were questioned about their local situation and the arrangements made. As we found in Part 2, §5 there were five areas where over a quarter of the patients had to wait for over four weeks to secure an appointment. Yet only in Area I (where 34 per cent of patients waited over four weeks) did

Area	Number of consultants*	
	Control	No control
A	15	–
B	16	2
C	23	7
D	9	3
F	16	1
G	8	2
H	8	1
I	20	2
J	8	3
K	10	4
All areas	133	25

* No answer = 6.

Table 54. *Consultants, by area, controlling patient appointment rate*

Area	Number of consultants reporting			
	Satisfaction for patients*		Satisfaction for staff†	
	Yes	No	Yes	No
A	11	5	11	3
B	14	4	16	2
C	25	5	25	5
D	6	6	9	3
F	14	3	15	1
G	8	2	8	1
H	9	–	8	–
I	17	5	14	8
J	9	2	9	2
K	10	3	11	3
All areas	123	35	126	28

* No reply = 6. † No reply = 10.

Table 55. *Consultants' opinions on appointment systems, by area*

a majority of consultants think their patients had difficulty in securing an appointment.

The evident complacency about waiting periods is more easily understood when we consider the degree of control exercised by consultants over the rate at which patients are booked. Asked if they specified the number and rate at which patients were to be seen of 158 replies 133 said that they controlled their work-load in this way (Table 54). They represented a majority in all areas. The consultants were questioned further about how the appointments system worked: in particular, were they satisfied with the way it functioned (*a*) for the patients and (*b*) for themselves. Again there were heavy majorities indicating satisfaction (Table 55). Satisfaction from the

Area	Number of consultants			
	New patients*		Old patients†	
	With	Without	With	Without
A	11	5	9	7
B	11	7	10	8
C	19	11	21	9
D	9	3	10	2
F	12	5	10	7
G	7	3	8	2
H	6	3	6	3
I	13	9	9	13
J	7	4	9	2
K	7	7	11	3
All areas	102	57	103	56

* No reply = 5. † No reply = 5.

Table 56. *Tracing non-attenders: consultants, by area, with and without routine procedure*

patients' point of view was expressed by 123 consultants with only 35 dissatisfied, and the responses were very similar in the case of satisfaction for the medical staff. Again all areas showed a majority of satisfied consultants. Only in Area D was opinion equally divided on the subject of patient satisfaction.

A few of the comments made are worth noting. One consultant who was satisfied with the existing system pointed out that a little wait in the clinic was better than a longer spell on the waiting list. Most comments, however, came from the dissatisfied. 'Spacing of appointments is really determined by local transport facilities.' 'People are registered as they arrive and not in order of appointment.' 'Too many junior clerks without proper experience or supervision.' 'Tendency to overload with too many so-called new patients who are really old patients with new letters.' 'Too many patients because registrars are not experienced to know when to discharge.' Several commented adversely on the block-booking system. Only one consultant mentioned unpunctuality by patients.

Earlier in this report we found that in no hospital surveyed was there any mechanism to ensure that patients needing further appointments actually made them. In relation to this it is interesting to note the arrangements made to keep track of patients *with* appointments but who do not in fact put in an appearance. The consultants were asked if they had a set procedure to follow if either a new patient or a repeat attender failed to turn up. Table 56 shows the response, and suggests an absence of efficient control and administration. Whether

new or old patients are involved in no single area does *every* consultant follow a set procedure. The procedures followed were often as haphazard as their incidence. Sometimes the patient was notified, sometimes the general practitioner, sometimes both. Sometimes action was taken only if the case were deemed 'important'. Chest physicians, perhaps because of the legal requirements covering tubercular patients, were punctilious in their regimes and never seemed to give up trying to trace non-attenders. But where responsibility was backed only by moral sanctions anything might happen—at one extreme an honest soul admitted that, faced with non-attendance, his usual procedure was 'to thank God and turn to the next patient'.

v. Attitude to general practitioners

We have already noted that only a minority of consultants welcome the idea of extending clinical assistantships for general practitioners. The inquiry revealed low expectations in two other fields, the availability of direct access facilities and the kind of information contained in letters of referral to consultative out-patient departments.

DIRECT ACCESS FACILITIES

Consultants were asked whether they thought general practitioners in their areas should have direct access to a number of diagnostic and therapeutic facilities. Pathological laboratory services were divided into haematology, bacteriology, and biochemistry. Virtually all the consultants agreed that direct access was appropriate to haematology and bacteriology but only two-thirds thought this was applicable to biochemistry. In general, paediatricians were against general practitioners having such direct access. In terms of area, only Areas I and F, taking all specialists together, showed a majority against direct access for general practitioners. Similarly with direct access to X-ray facilities. Almost all consultants favoured direct access for chest X-rays, and 90 per cent favoured direct access for other straight X-rays (apart from Area G, where only 25 per cent were in favour); but when it came to contrast series there was a marked shift of support. Less than two-fifths of the consultants thought direct access appropriate for contrast X-rays. There were some interesting area variations. In Areas H and D, where the facility was not available to general practitioners a majority of the consultants thought that it should be. The service is made available

at Areas B and F; but at Area B two-thirds of the consultants were in favour of the scheme, while at Area F two-thirds were opposed.

Direct access to physiotherapy was supported by only a third of the consultants, and in the specialties most involved, orthopaedic and general surgery, there were overwhelming majorities against. Only a third of consultants in general medicine approved of general practitioners having direct access to E.C.G. Paediatricians and chest physicians tended to favour the idea but dermatologists, for reasons best known to themselves, were thoroughly opposed. The majority did not foresee a change in the provision of direct access facilities leading to any change in the volume of referrals to out-patient clinics. Only 5 per cent thought increased availability would lead to increased referrals. Of the comments volunteered about direct access facilities twenty-three mentioned that existing services were not adequate to cope with increased demands and thirty-seven mentioned incompetence on the part of general practitioners in using them. 'Ancillary aids can be abused if indiscriminate use permitted.' 'The general practitioner has insufficient knowledge or expertise.' 'Interpretation of investigations should be in specialist hands.'

LETTERS FROM GENERAL PRACTITIONERS

More than half the consultants felt that general practitioners' letters gave all necessary information for three-quarters of the patients. By specialty general surgeons and gynaecologists were the most satisfied and general physicians the least satisfied. On the whole southern consultants seemed more satisfied than northern.

Expressions of satisfaction should, of course, be set against expectations and an attempt was made in the inquiry. Consultants were required to state which of six items they required in a letter of referral and to say for each whether they expected it 'almost always', 'sometimes', or 'rarely'. About 85 per cent of the consultants wanted a relevant history almost always, but less than half wanted details about the general practitioners' findings on examination. Most specialists (75 per cent) insisted on having relevant past medical history but dissidents were found in all specialties. Less than half the consultants wanted social history usually. Most physicians and paediatricians attached importance to it but surgeons rarely wanted it. Nearly all wanted details of recent treatment but only three-quarters wanted details of relevant investigations. Asked to specify

the commonest deficiencies in general practitioners' letters the respondents listed 197 items, two-fifths relating to lack of information on recent treatment. In summary, although the consultants' expectations were far from exacting they were by no means always satisfied.

VI. Domiciliary consultations

Under the National Health Service, specialists may be paid a specific fee for conducting an examination in the patient's home at the request of the general practitioner. The fee has remained constant over the years and is now rather less than a private consultant will be paid for a routine medical examination for insurance purposes, considering the time involved for the visit. However, to counter the obvious possibilities of abuse the number of domiciliary consultations is limited for individual consultants and those in full-time service are not paid for the first eight visits they make. Compared with out-patient attendances, the number of domiciliary consultations is small: for example, in 1964 there were 323 577 domiciliaries compared with 7 505 000 new patient attendances (23). The ratio of domiciliary to new out-patients has remained steady around one to twenty-three since 1957.

Consultants taking part in this enquiry were asked a number of questions about their own involvement in domiciliary work. Virtually all the consultants (97 per cent) undertook such visits. One-tenth of them did not say how many they did in 1964 and three others were not consultants at that time. Of those replying, half did two or more a week and most of these, three or more. Two-fifths of the consultants consulted in the homes with a frequency of once a week or once every two weeks, and the remainder less often.

Three-quarters of the consultants felt that less than one-fifth of their domiciliary consultations could have been conducted instead in the out-patient department. Geriatricians were unanimous in agreeing that the domiciliaries were not a substitute for out-patient visits, and the only specialty where there was a majority taking an opposite view was orthopaedic surgery. Three-quarters of the consultants were also agreed that less than one-fifth of the consultations were arranged for the purpose of arranging admission to hospital. However, over two-fifths of the general surgeons thought that more than 20 per cent of their domiciliaries were arranged for this purpose. Geriatricians were evenly divided between those who said that

all the consultations were for purposes of hospital admission, and those who said that practically none fell in this category.

One-quarter of the consultants said that the general practitioner attended the domiciliary consultation almost always; but half of them said that this occurred rather infrequently. It seems that general practitioners are more likely to be present if the consultant is a paediatrician or a consultant in general medicine, than if the consultation is with one of the surgical specialists.

Altogether 114 consultants volunteered 136 specific comments about domiciliary consultations. There was some polarization. Sixty-eight of the comments were in favour of the system, the majority suggesting that the service should be extended. For example: 'They are an excellent and necessary part of the N.H.S.' 'They are a valuable part of the work of the N.H.S.: even more should be encouraged.' 'A valuable service: a pity some doctors do not use it more.' Thirteen of these comments specified ways in which the service was of benefit to individual patients. For example: 'They also save a great deal of physical and mental stress for the elderly and infirm.' 'In a scattered rural area it is easier to get the specialist out to see an elderly patient.' 'Theoretically infants could attend clinic, but it is probably in their interest to be seen at home.' Twenty-one of the comments indicated that the consultations were normally justified or that the service is rarely abused. For example: 'If the case is obviously an emergency, I arrange admission.' 'I do not think these consultations are abused and are in Paediatrics extremely helpful.' Some of the comments specifically mentioned the saving in hospital admissions allowed by such consultations. 'An excellent thing for keeping patients out of hospital who would waste beds.'

However, twenty-eight comments concentrated on the lack of necessity of the consultations and on abuse of the system. There was one area in which about half of the consultants' comments were critical of the general practitioner and the patient as well. 'Admission racket worked by only a few general practitioners.' 'Unless one is willing to play the admission game, one loses out.' 'General practitioners used them as bribes; am unbribable.' In other areas there were only a few comments on abuse of the system. For example: 'The system is abused by patients, especially relatives.' Other comments on the misuse of such consultations were couched in gentle but no less definite terms. 'Few are really necessary.' 'Consultations

stopped since becoming full-time; no change in out-patients; no complaint of the hardship to patients, wonder if they are necessary?'

The remainder of the comments fell into two groups, the first twenty-seven in number referred to general practitioners and either related to difficulty in arranging to see the general practitioner, or to the consultant's desire to see him. Only one consultant found the general practitioner's presence an embarrassment. The remaining thirteen comments were on pay, the majority of which were that the fee for the domiciliary consultation was much too low, or that full-time consultants should be treated on a basis of equality with the part-time consultant. Examples were: 'Pay should not be limited to a specific number per annum', 'underpaid when visiting is at a considerable distance'. 'Improper that the first eight should not be paid for.' 'Good for patient, general practitioner and consultant, therefore typical of administrators and physicians to have treated it always with parsimony and suspicion. Fee now half its original value.'

Earlier, in considering consultants' opinions on their out-patient clinics, we found many comments concerning great pressure of work and the lack of time for increasing out-patient sessions because they were fully occupied with other work. In only one answer to the question about domiciliary consultations was a comment made that this work was restricted by lack of time.

10. Summary

1. *Facilities and organization*

The survey found that the general level of accommodation in out-patient departments was extremely poor for both patients and staff. Little provision appears to be made for the reception of patients. They are left to find their own way round unfamiliar buildings and scant regard is paid either to the natural anxieties experienced by patients or to basic human dignity. The responsibility for the day-to-day management of the departments is not in practice at all clear. Formally the hospital secretary is responsible but is usually remote from the clinic. Daily supervision tends to rest with senior nursing staff whose skills are clinical rather than managerial. The result is usually inertia so far as minor improvements in the reception and guidance of patients are concerned. Thought should be given to the

appointment of staff to be responsible for the management of clinics and able to take decisions and implement them.

2. *Trends in hospital activity*

As they stand official figures suggest that the number of new out-patients is increasing less rapidly than total attendances or in-patient deaths and discharges. However the definitions used deflate the number of new out-patients and inflate the number of in-patients. At a time when the Ministry of Health is making considerable efforts to encourage the collection and use of more meaningful in-patient data attention should be given to the need for and possibilities of automated record linkage systems to encompass out-patient service data as well.

3. *Under-representation of the aged*

The survey established that in the out-patient population the aged are under-represented. This is surprising in view of the extra demands made by the elderly on general practitioner and hospital in-patient services. This discrepancy requires further investigation. It may be that general practitioners and old people themselves regard the handicaps of ageing as unavoidable and therefore not appropriate for special investigation.

Single and widowed persons were also under-represented in the out-patient populations.

4. *Influence of the general practitioner on out-patient case-load*

Wide variations were found between the survey areas in the rate at which people were referred to clinics. An attempt to explain this variation by studying the characteristics of the general practitioners making the referrals proved very disappointing. Doctors in partnership tend to refer at a higher rate than those in solo practice but size of practice population appears to exert no influence. Doctors who use direct access diagnostic facilities tend to refer to hospital out-patient clinics at a high rate as well; but frequent users of direct access facilities are too rare for the association to be accepted as significant.

5. *Waiting for appointment*

The survey established that in many areas the period between referral and appointment was too long. In four areas over a quarter

of the patients waited for at least a month. There is some evidence to suggest that the waiting-period is related to the size of hospital: the larger the hospital the more prolonged the waiting-period for appointment. A conflict of choice emerged too. In some hospitals the waiting-period for appointment was kept short by not regulating the number of patients per session. In other words a wait of hours in the clinic may be the price of not waiting weeks to be allowed to attend.

Another disturbing waiting period was found. After waiting weeks for an initial appointment some patients then had to wait months for necessary investigations such as E.C.G., E.E.G., X-ray, and so on.

6. *Out-patient departments in action—an operational analysis*

Contrary to a belief held by some general practitioners, consultants do in fact examine the overwhelming majority of patients referred to them at the first and subsequent visits. All hospitals surveyed receive high marks on this score. While this fact illustrates the achievement of the N.H.S. in making specialist advice available throughout the country it may also have its drawbacks. The virtue of the consultant seeing nearly all the patients hinges on the degree of pre-selection by general practitioners. Evidence was found to suggest that general practitioners do not always exercise with care their responsibility for this pre-selection. In diseases of the chest, ophthalmology, and dermatology over 40 per cent of the patients were referred back to their general practitioner after only one visit, and this happened to about one-third of the referrals in general medicine. Many of these cases had no organic disease and perhaps were referred for reassurance. However, in a system which emphasizes the importance of the personal doctor it is legitimate to wonder if such referrals indicate a breakdown in communication and rapport between the patient and the general practitioner.

Other unnecessary referrals occurred which were not the fault of the general practitioner. In general surgery, gynaecology, and E.N.T. large numbers of patients had to attend clinics as part of the administrative process of getting on a waiting list for a hospital bed. For many common conditions there was absolute agreement between the general practitioner's diagnosis on referral and that of the consultant after examination. It seems ludicrous not to accept the general practitioner's diagnosis in such cases and allow him to send the patient's name forward to be placed on a waiting list, instead of sending the patient unnecessarily to a clinic. Similarly in orthopaedic

surgery general practitioners have to send patients for surgical appliances which they are presumably not trusted to prescribe with discrimination and discretion.

For these and other reasons out-patient departments are more crowded than they need be and consultants generally feel that out-patient work is rushed and unsatisfying. At the other extreme a number of patients were found who had become permanent attenders at out-patient departments for no apparent reason.

A number of patients who attended, particularly in general medicine and gynaecology, received no recorded pathological or radiological examination. For those diagnosed as psychoneurotic the fact is surprising. For those with no defined diagnosis and those diagnosed as suffering from peptic ulcers or menstrual disorders the fact is little short of alarming.

7. *The out-patient case-load*

In practice it is not possible to talk about the function of the out-patient department in general: the function varies by specialty. Thus, while dermatology, psychiatry, and ophthalmology provide specialized diagnosis and treatment in a full sense, chest clinics can barely be justified. In paediatrics the case-load is dominated by referrals from maternity hospitals and otherwise provides a service to general practitioners in an area of medicine where they might perhaps, with better training, feel more secure. Orthopaedics draws 38 per cent of its cases from casualty, and much of the rest of the case-load could be avoided by allowing general practitioners to order physiotherapy or prescribe certain surgical appliances. General surgery and gynaecology serve mainly as administrative agencies to regulate the use of in-patient facilities. General medicine is least easy to classify; but with almost 30 per cent of the cases having no physical disease it may be said that an important part of the clinics' function is to reassure general practitioners. Some referrals might be avoided if general practitioners had direct access to barium meal series.

8. *Communications*

An analysis of letters from general practitioners revealed that the quality of communications is grossly deficient in that details of past medical history, social history, and treatment are frequently omitted. On the other hand, consultants' expectations in these respects are remarkably low.

Consultants' letters to general practitioners are usually better but again details of investigations which yielded negative results are usually omitted. In only a minority of consultants' letters can it be said that the case is discussed at such a level as to constitute an educational aid to the general practitioner.

In terms of speed in writing letters the consultants perform commendably in that the majority of letters are written within a week of the consultation.

An absence of machinery was found to trace patients who, when expected to make a further appointment, for unknown reasons failed to do so. *In one hospital* 10 *per cent of a surgeon's X-ray films remained uncollected.*

The present system is over-reliant on the patient's understanding of what is expected of him in the matter of booking a further appointment.

Where an appointment is made and the patient does not attend, tracing him depends on the individual consultant. Most consultants adopt a set procedure for tracing non-attenders but by no means all, even within the same hospital. The procedures adopted are as variable as their incidence.

9. *Consultant opinions*

Despite the inadequacy of accommodation and facilities a fair proportion of consultants seem satisfied with things as they are and expect nothing better. Many use no junior medical staff in their clinics and some have no secretary.

Most prefer in-patient work to out-patient work as they find it less rushed and more satisfying. Recognizing the need for more sessions a few are prepared to see extra consultants appointed in their own specialty in their own area but more would prefer the appointment of extra junior staff. A consensus was that domiciliary consultations are rarely abused and the service should be extended.

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3
Conclusions

It is apparent from the findings of this survey that there are many inadequacies and deficiencies in the present arrangements made for out-patients. Equally, however, it is clear that the problems are complex and cannot be treated in isolation from the question of hospital management in general. Indeed, it is possible to go further and argue that what is involved is the major issue of the appropriate structure for organizing specialized advice and treatment of the ambulant sick. In these conclusions, therefore, it is proposed first to consider the revealed inadequacies in the light of the considerable difficulties facing hospital authorities in managing out-patient departments; second, to consider the functions of out-patient departments in terms of the managerial difficulties imposed by the present structure of the National Health Service; and finally, to speculate, albeit tentatively, on ways in which the present structure might be modified to produce a more satisfactory state of affairs.

1. Management of clinics

The exercise of managerial responsibility in out-patient clinics is made extremely difficult by a number of specific problems.

1. Lack of information

Meaningful statistical information is the essential basis of planned control; and yet at no level of the hospital service can it be said that information is collected about out-patients which allows rational appraisal of the use of the services, let alone the control of their provision. Official statistics are few and in some respects misleading. Because of the method of collection and the definitions used the number of in-patient deaths and discharges is inflated and the

number of new out-patients deflated. It is not therefore possible to be certain about the respective trends in the use of the various services. Because the figures relate to institutions and not patients it is not possible to ascertain the number of people involved, or the treatment they received or how long they waited for it. In 1964, sixteen years after the hospital service was organized on a national basis, an elementary item such as the average waiting period between referral and appointment in out-patients could not be ascertained from routine data but had to be the subject of special inquiry. There are exceptions but many hospital authorities are not in a position to know the basic facts themselves. The secondary waiting period—for necessary clinical investigations decided on at the initial consultation—is even less ascertained. Unless they know the facts how can hospital authorities tackle the shortcomings of the services? To be fair it has to be recognized that for too long the Ministry, Regional Boards, and Hospital Management Committees were understaffed, both qualitatively and quantitatively, in relation to the problems involved in collecting and analysing the kind of information required. Perhaps they are still and will continue to be unless it is grasped that even in health services savings from improved efficiency in the use of capital resources are often realized only after extra investment in the human skills responsible for managing those resources. Given the necessary staff and equipment the Ministry of Health and the Regional Hospital Boards could arrange for the supply of the necessary data. Recently the Ministry has made considerable efforts to encourage Regional Boards to improve in-patient data, mainly through the development of hospital activity analysis (1). This recording system is still only partial and exploratory, and so far the problems are mainly concerned with the collection of data within selected areas. At some stage, however, the question will arise of analysing and interpreting the results locally, and it may be then that the shortage of trained statisticians in the hospital service will make itself felt. The development of hospital activity analysis is partly associated with a desire to understand more clearly the wide variations existing in costs between one hospital and another. This is laudable; but it is important that in developing a more useful system of reporting and recording, room be made for the possibilities of record linkage and the inclusion of items which can be used to assess the service's efficiency in terms of public satisfaction. Meanwhile, until meaningful information is collected about what

goes on in out-patient clinics, those responsible for administering them must continue in the uncomfortable situation in which their attention is drawn to specific problems only by public or professional grumbling.

11. Lack of control within clinics

Some of the survey findings indicate the financial stringency from which the N.H.S. has suffered; others suggest inadequate thought and preparation. Inadequate provision of pram shelters and car parks; entrances shared with casualty departments; uncovered unloading bays for ambulances, so that patients in wheel chairs are exposed to the weather; no provision for reception; patients left to find their own way round unfamiliar corridors; no clear guidance on undressing requirements; no advice about valuables; all these omissions cause the minor embarrassments and petty humiliations which make too many out-patients feel distressed rather than reassured. Some of these deficiencies will disappear with new and better-designed buildings, some of which have been provided since this survey was carried out. Even with new buildings, however, there remains the difficulty of managing the clinics. The administration of non-medical matters is the responsibility of the Hospital Management Committee, and in a single hospital the responsibility for out-patient departments is exercised by the hospital secretary. Unfortunately, the line between medical and non-medical aspects is not easily drawn; and the hospital secretary enjoys nothing like the status or influence of the consultant. In any case the hospital secretary does not work in the out-patient department. The consultant does work there, but can hardly be responsible for aspects which officially are not his concern. In practice the day-to-day running of departments falls between the records officer and the out-patient nursing sister. The same dichotomy exists between the respective duties and responsibilities of these officers as exists between the consultant and the hospital secretary; and they have even less power to initiate reform.

The difficulty is seen most clearly in the matter of appointment systems. This may seem a surprising statement after finding that many consultants do in fact specify the number of patients to be seen in any one session and the rate at which they are to be seen. The main point is, however, that the hospitals do not have a uniform policy in this regard. Most consultants restrict the number of patients

to be seen but by no means all, even within the same hospital. It is remarkable that such a matter is left to the individual and is not the subject of a deliberately decided and applied general policy within each hospital.

It is not our concern here to argue which policy should be adopted: we suggest only that the advantages and disadvantages should be assessed in each area and a policy adopted according to local needs. There is clearly much to be said for not restricting the numbers to be seen. The minority of consultants who do not set a number may be condemned for overcrowding clinics and making patients wait for hours in the uncomfortable waiting hall; but at least they can claim that their open-door policy benefits the public in that it shortens the waiting-period between referral and appointment. Equally the majority of consultants, who limit the number of patients they will see, can plead that this allows them to give adequate time to each patient. This is true; but this policy can produce a certain inflexibility in that at times of increased demand the period of waiting between referral and appointment becomes extended. The backlog of work will remain untackled unless the duration of sessions is extended temporarily or unless the rate at which patients are booked is increased. However, bearing in mind the failure continuously to measure the waiting-period it is not likely that changes will be initiated regularly. In passing it is curious to compare the attitude to out-patients with that adopted in other branches of the N.H.S. Most general practitioners, when requested, feel obliged to see a patient if not the same day at least the next. When it comes to in-patients most hospitals, faced with an emergency, will stretch their facilities even to the point of putting up extra beds to accommodate the extra demand. And yet the same hospital doctors can be quite inflexible in their approach to out-patient departments.

Although it is not our purpose to recommend policies, there is little to be said for combining a procedure which limits the number of patients to be seen with one which brings them to the hospital gates at a common time. The patient gets the worst of both worlds. Having waited weeks for an appointment he may then wait for some time to be seen once he is there. The Ministry's concern about waiting time in clinics has often been expressed and in 1958 it was suggested (2) that any hospital not seeing half the patients within 15 minutes of their appointed time and 75 per cent within 30 minutes,

with not more than 3 per cent waiting an hour, needs close investigation. In the Nuffield Provincial Hospitals Trust's survey (3) of waiting times in 1964 only 11 of 60 hospitals studied met these standards. Compared with 1952 the average waiting time had fallen from 56 to 25 minutes; even so at 24 of the hospitals studied over 10 per cent of the patients waited an hour. At 35 of the hospitals excessively large block-bookings were made. Who decides that clinics will operate on a block-booking basis?

Again the difficulty of exercising managerial responsibility is seen in the handling of re-appointments. No general arrangements are made to ensure that patients who are supposed to make a further appointment do in fact make one. Probably few patients make this mistake but someone in authority should make certain, otherwise there can be some waste of time and resources. Perhaps the most disquieting finding of this survey was the discovery that 10 per cent of one surgeon's requested X-ray films were simply lying idle and useless because patients had not made re-appointments and there was nothing in the system to bring the fact to anybody's attention.

Similarly with the minority (about 10 per cent of the survey sample) who had 'ceased to attend': some had made further appointments but had failed to keep them. No general and uniform procedure is laid down to trace such patients. The matter is left once again to the individual consultant. Inevitably the effect is patchy. Some consultants take the time and trouble to ensure that their previous efforts have not been wasted while others do not bother.

In summary, there is a clear need to bridge more effectively the gap between medical and non-medical preserves in hospital management. This might be helped by the creation of machinery, in each hospital complex, to make a continuous review of the referral of patients. The reviewing process should not be frustrated by having to exclude aspects which involve, even indirectly, the performance of consultants. To achieve this it will be expedient to provide medical representation on the reviewing body. To proceed from review to policy formulation and implementation it may be necessary to reintroduce medical administration below the Regional Board level. The issues involved are too complex and have too many implications to be discussed here; but it should be noted that the continued existence of the consultant unit may not be compatible with the introduction of efficient hospital management. The future may well lie in the direction of area specialist departments under chiefs of

service responsible for many of the aspects which the present cadre of lay hospital administrators find beyond their ability to investigate and outside their ability to control. These are controversial issues and all we can do here is suggest that the present system of management is failing in a number of respects.

It is however noteworthy that since the study was conducted the Ministry has published the *Report of the Joint Working Party on the Organisation of Medical Work in Hospitals* (4). The report recognizes that general management in hospitals is a distinctive function 'but should not be divorced from clinical policy as these are clearly interrelated'. It is not proposed to recreate the old-style medical superintendent since the need is for collective thinking and action. In each hospital group it is recommended that a representative body of clinicians, backed by operations research, undertake a continuous review of hospital activity. In association with this it is proposed to reform the organization of medical staff and form broad medical or surgical divisions, each with an appointed chairman. Representatives from these divisions would form an executive committee, with a chairman who would be an experienced clinician but would have 'time in his contract for administrative duties'. The Working Party drew attention to the need for training in administration not only for professional medical administrators but also for the chairmen of the new executive committees and for the profession as a whole.

2. Functions of out-patient departments

1. Screening for admission

The main purpose of this survey was to review the operation of out-patient departments in the light of the functions they are expected to serve. A function considered natural to these departments is to provide a screening process for hospital admission. In fact, the survey suggests that it is not really possible to speak from this standpoint about out-patient departments in general. The function of screening for admission applies only to three specialties: ear, nose, and throat surgery, general surgery, and gynaecology. In other specialties the bulk of patients are referred back to the general practitioner without being admitted to hospital. It seems, however, that considerable proportions of patients are admitted to hospital through the out-patient screen for investigations only, many of a type which might have been undertaken in the out-patient department. Although these patients

at most accounted for 16 per cent of the general surgery case-load, they accounted for over a third of the referrals to general medicine and paediatrics. Without a detailed knowledge of all the circumstances prevailing in individual cases it would be dangerous to be dogmatic and say that these patients should not have been admitted. Given a long waiting period for technical investigations following the initial appointment, and faced with a situation which gives in-patients priority in the availability of these investigations, the consultants probably were right and acted in the best interest of their patients. But is it sound policy to allow the need for intensive diagnostic facilities to be obscured by permitting the unnecessary use of even more expensive in-patient facilities?

II. Easing the general practitioner's burden

The extent to which out-patient departments serve to ease the burden of the general practitioner is extremely difficult to assess. A study of particular groups of patients, however, suggests that in varying degrees the out-patient department may serve this purpose. A high proportion of cases seen in the departments are referred for the treatment of minor conditions, especially for minor surgical conditions. In theory many general practitioners, particularly those who had undergone extensive hospital training in surgery before entering general practice, could deal with these cases themselves, as their North American colleagues do. In practice many (one suspects most) general practitioners in this country simply do not have the necessary facilities. The provision of such facilities might well be more economic than the continued use of transport services, the hospital's infrastructure, and consultants' time for cases which, given the proper facilities, could be dealt with at the primary doctor level.

Another interesting group of patients relevant to the question of unnecessary referrals are those who attend only once and then are referred back to their general practitioner. Two-thirds of these cases received no pathological investigation and nearly half no X-ray. What is the rationale of their referral in the first place? Again caution is necessary. Without being privy to the dialogue between doctor and patient it is difficult to know what the exact motive for referral was. Inevitably a proportion are referred for the exclusion of a particular disease and this is only to be expected. Relevant to this may be the fact that a fifth of the medical cases were found to have no defined organic disease. Other cases were referred for

reassurance and it was understandable that they should attend only once. Even so it may be asked how far referral for reassurance indicates an inability on the part of the general practitioner to reassure the patient himself. The fault may lie with the patient but it is certainly odd that a branch of the medical profession which places such ideological emphasis on personal care and approachability should resort so often, in order to allay patients' anxieties, to a branch of the profession which is supposed to emphasize objective clinical science. And even odder is the infrequent use of science in such cases by the consultants. How could they be sure that there was no organic disease without clinical investigations? In some cases it may have been the general practitioner who needed to be reassured that nothing organic was amiss, and referral to out-patients in these circumstances is understandable; but it seems rather a cumbersome way of instituting a dialogue between general practitioner and consultant over patients whose anxiety is shared by their personal doctor. In the absence of better and quicker systems of communication there is little else the general practitioner can do.

Another group of patients whose needs should possibly be met by general practitioners rather than out-patient staff are many of those retained for out-patient supervision. In the survey about a quarter of the referrals to medical departments (including paediatrics, chest diseases, etc.), were still attending after six months, and although the proportion was much lower in most surgical specialties it was still substantial. This situation is the fault of the hospital, not the general practitioner. It underlines once again the need for a better system of reviewing the use of out-patient services.

III. The consultative function

The unnecessary retention of patients is relevant to the question of the out-patient department's consultative function, just as is the fact of long waiting periods for appointment.

In their respective ways they represent critical phases from the aspect of continuity. When a patient is retained for a long period as an out-patient he is the responsibility of the consultant for the particular condition which caused his referral. But for any other complaints he is the responsibility of the general practitioner. In sickness as in other affairs troubles rarely come singly and this divided responsibility can create great anxieties for the patient. Similarly with a long waiting period for an appointment to see a consultant.

For that particular condition the general practitioner has sought advice but is still waiting for it. Meanwhile the patient's other problems are still his responsibility and again the patient may be caused anxiety because while he is on a waiting list for a particular condition he is nobody's responsibility. This is important really only in cases when the condition is serious but it is useful to record that an interregnum does exist at this stage. At least it is clear that the break between primary and secondary doctor at the vital stages of referral to and discharge from out-patient departments should be as short as possible and should be controlled. Cammock and Lee (5) have drawn attention to the problem of dual care in the present system.

IV. Communications

A substantial proportion of out-patient activity can be said to be consultative. However, if by 'consultation' is meant a dual exchange of findings and opinions between general practitioner and consultant then it is apparent from the analysis of letters passing between the two that the present performance falls very short of the expectation. The fault is mainly with the inadequate information coming from the referring doctor's side although it is true also that the requirements and expectations of the referees are not very great. Many consultants prefer not to be influenced towards a particular line of investigation or diagnosis by a detailed letter from a general practitioner but theirs need not be the last word in the argument. Experiments in providing general practitioners with mechanical aids have been found to improve the quality of referral letters (6). Such experiments deserve further study and perhaps wider application; would it be possible, for example through closed-circuit television, for consultants to be available for short regular periods of discussion with general practitioners—particularly over cases about which general practitioners themselves needed reassurance? At least this would be a step towards the kind of exchange which is alleged to have prevailed in the bad old days when a consultant's income varied directly with his ability to persuade general practitioners that his advice was not only sound but amply and speedily available. Demands for consultation were, of course, fewer in those days and pressures not so great.

v. **Referring the obvious**

A particularly interesting group of patients are those referred for obvious surgical conditions such as haemorrhoids, varicose veins, or hernias, who have to attend out-patient departments in order to be placed on a waiting list for a hospital bed. It seems strange indeed that a general practitioner cannot be permitted to send the name of the patient for inclusion on the list rather than send the patient along first. Is it the case that consultants do not trust general practitioners in their diagnosis of these conditions? It is a curious feature of our out-patient services though that while many consultants insist on the one hand that they are sent too many patients, a large number also persist on the other in requiring the obvious to be referred to them. If the operating theatre and bed facilities were made available to them perhaps some general practitioners, particularly the former registrar surgeons, would be happy to avoid these unnecessary 'consultations' and undertake the necessary repair surgery themselves. Adequate safeguards would, of course, be needed; hernia repair by a general practitioner is one thing, removal of the gall bladder quite another. Of course, this opens the prospect of review and control of professional practice which at the moment is quite foreign to the thinking and experience of British doctors—unless they have worked in North America, where the profession is said to have a more obvious regard for corporate responsibility although the voluntary insurance companies may also have less regard than the Ministry of Health for professional susceptibilities.

3. Epilogue

The possibility of opening hospital facilities to general practitioners is not yet a real prospect. But mention of the fact serves to remind us that we have been considering the function and operation of out-patient departments as if the present arrangements were immutable. Are they? The perspective of history shows that the present gulf between specialists and general practitioners in the location of their work is not the result of an arrangement consciously thought out and applied within the N.H.S. Rather it has been produced over many years, starting with the intra-professional economic rivalry of the nineteenth century, complicated by the development of specialized hospitals and special units within general hospitals so that by the 1930s only a minority of general practitioners even in voluntary

non-teaching hospitals, had control of beds (7). The system was carried over into the National Health Service because the National Health Service is a political artifact and possibly had built into it the structural nooks and crannies in which the professional pressure groups shelter their economic interests (8). In a democratic system we like to think that the framework of our institutions is determined by the community in the community's interest rather than by factions. This is probably naïve in an age of pressure group politics; but it may well be that the balance of power within the medical profession has shifted since the era when the National Health Service was given some of its present characteristics and the separation of the general practitioner from hospital medicine may not always persist. There are already straws in the wind. Junior hospital doctors are said to emigrate rather than enter general practice because they regard it as a low status occupation and a waste of their clinical skills (9). Some general practitioners are pressing for the privilege of admitting certain types of patient to hospital and being responsible for their care themselves. In Scotland an experiment has been launched which allows general practitioners to work as part-time surgeons. Part of the current thinking about in-patient work could have profound consequences for the organization of out-patients. This concerns the possibility of extending day-bed and out-patient facilities so that some of the procedures currently carried out on an in-patient basis may be transferred to out-patient clinics. A number of individual consultants, including Farquharson (10), Stephens and Dudley (11), Caridis and Matheson (12), and Lawrie (13) have reported the successful undertaking of numerous special procedures on an out-patient basis. Such procedures and routine operations account for about one-third of all in-patients. Invariably those who advocate or demonstrate the transfer of such work to out-patient clinics emphasize the need for careful selection of the patient and close collaboration with the general practitioner. Could the present system of communications sustain this type of development on the scale envisaged? Pulling in another direction altogether are developments such as the renewed interest in health centres, which although they hold great promise for the better integration of general practitioner and community health services, also carry the danger of isolating the general practitioner even further from hospital medicine. Again the issues involved are far too complex and far-reaching to be discussed here and much more is involved than

the quality of out-patient services; but obviously the time is ripe for experiments in the organization of our health services and these experiments could well include attempts to reconstruct the whole nature of the arrangements for providing consultation between general practitioner and specialist. The new towns offer great opportunities for testing some of the questions which spring immediately to mind. To begin with, why have out-patient departments at all? They developed at the hospitals as we know because the poor flocked there and the voluntary hospitals had to prevent the swamping of their in-patient facilities. Retaining the out-patient departments next to the in-patient wards may perhaps be justified today by arguing that the expensive paraphernalia of scientific medicine are located in the hospital and it would be too expensive to duplicate this equipment elsewhere. But what would be the costs? Has anyone tried to measure them? Relevant to this is the assumption that all out-patients require costly clinical investigations; but as we have seen from the survey not all out-patients receive these investigations, particularly in the medical specialties. Could not the surgical specialties continue to work from hospital out-patient departments and the medical specialties move closer to the general practitioner, with consultants working in one or more health centres? Would 'unnecessary' referrals decline if the general practitioner had to face the consultant? Would the level of investigation and communication improve if the consultant had to face the general practitioner? The same questions would arise if the move were in the other direction and experiments were tried which involved the general practitioner working from the hospital, although there are dangers here in that the undesirable features of out-patient departments might attach themselves to general practice. Still, a careful study should be made of the logistics involved in the various options which might be tried. Of course, the system we do not know is always more appealing than the system we know; but our present arrangements for out-patients leave much to be desired.

Some of the observations we have made and some of the changes we have hinted at will not be welcomed. There does seem, however, to be a desire for change, even though it tends to be focused on financial matters and the 'Tripartite Structure'. In its desire for radical rethinking about the provision of medical services the medical profession surely should not object if in the process some of its own shibboleths are brought into question. Throughout this

inquiry we have assumed that medical care has in every instance to be based on personal care by a general practitioner. Like so many others this assumption has never been tested in this country in the light of its value to the patient. As with the specialists' monopoly of the hospitals the general practitioners' monopoly of the patients is something bequeathed to us by the Victorians. Perhaps more than anything else we need to define the role of the general practitioner objectively in terms of twentieth-century circumstances, and having done that, make it possible for the role to be fulfilled.

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