PRACTICE OBSERVED

Organising a Practice

Three is the magic number

J F M NEWMAN

I have long suspected that partnerships in medical practice, as in many other disciplines, are designed for the benefit of the participants or partners rather than for the benefit of the recipients or patients. The ideal way to practise is single-handed, when the advantages of knowing one's own patients, being totally responsible for their care and management, and the relative simplicity of the mechanics of working outweigh the problems that undeniably exist. Most partnerships have arisen from single-handed practices by growth, absorption of vacant practices, or by amalgamation until the weight of the number of patients necessitates an increase in the number of doctors. Once a certain list size is achieved the practice can follow only one of two courses—either to move into the mini-clinic, multiple doctor organisation, which seems to many to have an air of super efficiency but a distinct lack of personal medicine, or to attempt to deliver personalised family medicine in a larger setting. We have chosen the latter. Forced then, paradoxically to some extent, by success engendered by growth, the vital thing is to continue the features that were successful and to avoid the practices that large groups have been forced to adopt to deal with the larger numbers and the increased work load.

How then to set about running a large practice with three principals and yet try to achieve the homespun Dr Cameron image? Not easy. Firstly, the doctors. The choice of partners is notoriously difficult, yet errors made at this stage may be totally disastrous. I have been fortunate in having two reasonably young men with whom I share the same ideals of general practice despite a considerable age difference. What is more, if you are in your 50s you may have to look at a lot of applicants before you achieve this happy state. Secondly, the office staff—the first point of contact with patients. They are encouraged, above all, to be friendly (we have had our dragons in the past and thankfully have got rid of them), to inquire as to which doctor the patient wishes to see or to visit, and generally to adopt a friendly attitude without being too intrusive into the patient's private affairs. None the less, it is important that they attempt to learn the degree of urgency and some indication of the nature of the complaint that initiated the call. Reprimanding, we think, is for the doctors to do and not the lay staff. Thirdly, and most importantly, the patients: while encouraging the idea of the personal doctor we try to avoid the image of three doctors running three separate single-handed practices under one roof. Unless new patients make specific requests they are allocated to one of the partners on a numerical basis just to keep the list in balance. Most patients see all of us at some stage, although many obviously have their preferences.

Practice organisation

We have two surgeries. One was acquired when I absorbed another practice. In both premises we adopt a common policy of open surgeries each morning and appointments for the evening surgeries. Unlike many of our neighbouring colleagues, we embrace the concept of daily availability to our patients; hence the open morning surgery. So often in the past, and indeed still, have we heard the complaint that it takes a week to get an appointment to see the doctor that we are determined to maintain open access. Undoubtedly this is popular: although we are located 100 yards from a new purpose-built health centre that runs a system of appointments only we are embarrassingly deluged by a constant flow of patients wishing to change—not to us, we believe, but to our system, where the doctor can be seen, if necessary on impulse, on the same day.

Political views may change and social engineering may occur, but it is my belief that the fundamentals remain: the average patient wishes to see his family doctor not because he wishes to remain healthy, but when the occasion arises he wishes to see the doctor the same day and all the pretentious claptrap trotted out by the medical politicians is irrelevant. Family doctors are family doctors, and they fail in their function if they are not available to their patients when they are needed. None of the partners has an ex-directory telephone number, and on the whole this freedom is not abused.

Our work load is divided equally among the partners, with regard to their commitments to clinics, hospital sessions, half-days, and so on. The partner who first sees the patient with an acute condition normally follows that patient through but the next acute episode may be dealt with by one of his colleagues unless the patient requests one of the other partners, and patients who are visited regularly for chronic conditions are seen by all of us at some stage. In this way, although most patients see their favourite doctor, most of the patients in the practice know all the doctors and we all know most of the patients.

We happily do not argue about money. All partners know how much their share is, and we employ a good accountant, pay his bills, and take his advice. We find this system works very well. With three partners taking part in a rota we find there is little need to use deputising services, which we reserve for special occasions or when one partner is on holiday or ill. It is interesting but true that by not employing a deputising service the number of out-of-hours calls is reduced, and this we attribute to the fact that the patients know that one of their own doctors is on call and are less likely to disturb him unless they think that their illness warrants an out-of-hours call.

We attempt to run the practice as personal family doctors while managing to get the benefits of partnership, such as adequate time off duty, cross consultation, and the pleasure and satisfaction of working with like-minded colleagues. With a list of between 7000 and 8000 patients and our outside commitments—hospital work, police work, and approved school work—we find ourselves stretched.

If we had a larger number of patients necessitating an increase in the number of partners beyond three, I do not think that we could maintain the old tradition of personalised family medicine and fulfil the concept of the personal doctor. I have been fortunate for a quarter of a century in living and working in a happy practice, and I cannot see any way in which enlarging it beyond the number of three would enable me to continue this happy professional life.

If you can get it right, three is the magic number.

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Practice Research

Original contributions to this section are always welcome for consideration.

Do patients cash prescriptions?

ALY RASHID

The idea that some patients may not cash prescriptions must cross the minds of most general practitioners. Patient compliance may be divided into primary compliance, where the patient cashes in the prescription at the chemist, and secondary compliance, where the patient takes the medicine prescribed. I thought that a study into primary compliance might show how primary health care may be given more efficiently.

When this study was done the prescription fee was 70p (now £1·00) for each item. I wanted to know: would the patient actually go to the pharmacist, spend money, and obtain the prescribed drug? There have been many studies on secondary drug compliance,[1–4] but only Cartwright and Dunnell[1] have produced a report on primary compliance in general practice. They concluded that between 2 and 5% of patients failed to cash a prescription. Because they asked patients to keep a diary (and thus the study was not single-blind) this may have influenced the patients to cash the prescription. I eliminated this in my study, because the patients were not aware that the study was being carried out.

Both doctors and patients often wonder why patient compliance does not improve.[5–7] The doctor's success in getting patients to take their drugs depends on patients cashing prescriptions, the efficacy of the drugs, how effectively they are presented, and side effects. If drug treatment fails there are several variables to consider: (*a*) Is the treatment wrong? (*b*) The patient is not taking the medicine.[1,8] (*c*) The patient never cashed the prescription. (*d*) There has been failure of communication between the general practitioner and patient.[9]

I set out to find out what proportion of prescriptions were not cashed by patients, the social class distribution of these patients, and what types of drugs were on the prescriptions.

Methods

A simple questionnaire was given to three general practitioners (A, B, C) in Preston. It was designed to cause the minimum amount of distraction for the doctor so that the patient would not know that it was being completed for the survey. The questionnaire asked for (i) date of birth; (ii) severity of the disease as judged by doctor (I-V severe); (iii) occupation of head of household; (iv) diagnosis. Carbon copies of each prescription also gave (i) the date on which the prescription was given by the doctor; (ii) the items prescribed; (iii) the name of the doctor who issued the prescription.

The project ran for three consecutive days in November 1980. The three general practitioners were selected so that their practice populations fell into social class "areas": Dr A social classes III-V; Dr B II-IV; Dr C I-III. Thus social class was compared with other variables to detect possible trends. These three practice areas are recognised for their social class spread by doctors who practise in Preston.

All prescriptions in Preston end up at the Prescription Pricing Authority (Preston). I looked through more than 100 000 prescriptions at the PPA offices for the coded prescriptions belonging to my study. This was the most accurate method for collecting the data. The PPA calculated that I could trace 98% of all prescriptions cashed during the three-day study period. The data, collected in January 1981 to allow sufficient time for prescriptions to arrive at the PPA, gave the number of prescriptions cashed for each doctor, and the date the prescription was cashed. The drugs on the prescription sheets were grouped using a modified version of the classification in MIMS and in Cartwright and Dunnell's book.[1]

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TABLE I—*Age and sex of the patients in the study*

	Age (years): 0–4	5–14	15–24	25–34	35–44	45–54	55–64	65–74	75–89	85–94	Total No
No of men	2	7	7	4	5	1	14	13	4	2	59
No of women	5	5	13	11	13	18	11	12	11	4	103
Total No	7	12	20	15	18	19	25	25	15	6	162

TABLE II—*Social class (Registrar General's classification) of patients according to sex*

	Social class: I	II	III non-manual	III manual	IV	V	No classification	Total No
No of men	6	10	21	15	5	2		59
No of women	9	23	37	19	5	9	1	103
Total No	15	33	58	34	10	11	1	162

Results

Most of the comparisons were done using the χ^2 test with relevant variables and narrowly missed significance ($p = 0{\cdot}005$). There were some important trends, however, and I hope that they will stimulate further research into primary compliance.

One hundred and sixty-two patients took part in this study: 103 women and 59 men (table I). Most of the patients belonged to social class III (non-manual), and only one patient's occupation could not be classified (table II). Fig 1 shows the number of patients in each social class who failed to cash a prescription. Patients in social class IV had the highest rate of non-compliance. Although nearly 20% of patients failed to cash their prescriptions, 65% cashed them within the first two days of receiving them (fig 2). The uncashed prescriptions were often for psychotropic drugs and antibiotics rather than "placebo"-type drugs, such as ascorbic acid and aspirin, as might have been expected.

If patients had diseases that the doctor judged as less severe, then they were more likely not to cash their prescriptions.

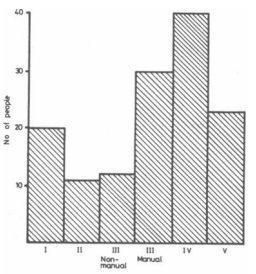

FIG 1—Percentage of people in each social class who failed to cash a prescription. The numbers are expressed as a percentage of the total number of people in each social class.

Discussion

There is evidence[1] that failure to cash a prescription may be attributable to one of the following reasons: (*a*) the patient went to the doctor for a chat; (*b*) the patient went to the doctor to confirm his own suspicions that he did not have a serious illness; (*c*) the patient has no confidence in the doctor; (*d*) the patient dislikes taking drugs; (*e*) the patient has had the same drugs before and recognises the name, or someone has told him that they were of no use. Other reasons have also been given[1,3,7,10]: (*f*) the patient feels that the pharmacy is too far away, and his illness is not worth the effort; (*g*) the patient, having consulted the doctor, thinks that the condition will get better of its own accord; (*h*) the patient cannot afford the cost of the prescription; (*i*) the patient has lost, misplaced, or forgotten about the prescription; (*k*) the patient is worried about the side effects of the medicine. Other influences intervene—for example, in my research perhaps the fact that old age pensioners, children under 16 years, and disabled people are exempt from prescription charges or have a prepayment certificate. A final reason for non-compliance may be that the patient went to the doctor to get a sick note and was given a prescription as well or instead of it.

The results of this study in Preston show that primary non-compliance in general practice may be as high as 20%—that is, about one in every five prescriptions were not taken to the pharmacist. The highest rate was in social class IV and was for prescriptions for psychotropic drugs and antibiotics. Patients in social class I may be more discerning about cashing prescriptions, perhaps knowing more about side effects and preferring to use the National Health Service for prevention than for treatment. On the other hand, the high rate of non-compliance in social class IV may indicate an economic factor.

Though many people in lower socioeconomic groups receive supplementary benefits and pay no prescription charges if they are old age pensioners, disabled, or young children, others may find a prescription of several items expensive. One pharmacist said that many patients ask for only the most important item on the prescription. The lack of education generally and about health in particular may also be a factor.[11] Patients who require time off work often go to their general practitioners for a sick note, which is usually accompanied by a prescription. These are often not cashed since the aim may have been to have time off work. Other patients may only seek psychological support from their general practitioner, but present with symptoms. The general practitioner, failing to recognise this, may issue a prescription to alleviate the symptoms—which is not cashed. As Dr Rees-Jones said[11,12]: "The most important drug in general practice is the doctor himself." Thus the failure to cash a prescription may be due to one or a combination of poor doctor-patient communication,[3,8,13] economic factors,[1,10] or educational factors.[11,12]

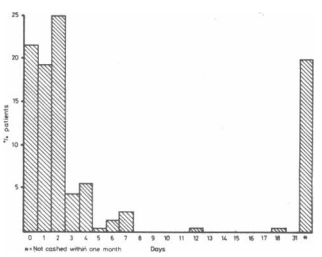

FIG 2—The number of days that it took patients to cash their prescriptions after receiving them.

Perhaps one of the most important findings was that prescriptions for psychotropic drugs and antibiotics were often not cashed. The inference is that the need for these drugs is less than the rate and extent to which they are prescribed indicates.[4] It has been suggested that doctors should spend more time on simple health education,[14] and thus reduce their future work load and the nation's drug bill. Doctors entering general practice should be taught to spend more time listening and to prescribe more judiciously. For, as one cynic said, "The main purpose of a prescription is to close a consultation."

Before trying to improve patient compliance doctors should consider two questions[15]: Do we know that low compliance interferes with the clinical goals of treatment? Is it established that treatment would do more good than harm to those who do not comply? One way to overcome non-compliance is to give out medicine after the consultation in the surgery dispensary.[4] Furthermore, if the patient is concerned in making decisions about treatment and knows why he is receiving the treatment he is more likely to comply.[14] The studies that have been done to find out why patients do not take the medicines they are prescribed need to be re-examined in the light of these findings.

Conclusions

One hundred and sixty-two patients who were given a prescription after a consultation with their general practitioner were followed up to see how many cashed their prescriptions (primary compliance). Nearly 20% of the patients failed to cash the prescription within a month of receiving it. The patients with the highest rate of non-compliance were in social class IV, and the prescriptions not cashed were often for psychotropic drugs and antibiotics. Of the prescriptions that were cashed, 65% were taken to the pharmacist within two days of issue.

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Clinical Curio: parasuicide

There is little worse than acute illness in the family, especially in a child. I arrived at breakfast one morning to discover that our 4-year-old had managed to leap over the top of his pen and crash land three body's lengths below. I could imagine only that the impulse for such a suicidal leap was born of high spirits, which he had always had. He lay motionless, gasping infrequently for breath, and, indeed, I had no doubt he would die. But despite my fears and distress he responded well to oxygen and rehydration, and although grossly ataxic for over four hours he gradually recovered. The extensive bruising was clearly painful; it appeared during recovery particularly in the left flank and the lower part of the body, and he still moves gingerly though it is now three days since the episode. His appetite has recovered completely, and at mealtimes he is if anything more excited than his sister. Youngsters have remarkable recuperative powers. I am more than grateful. Disposing of the dead is a mournful thing, especially when the neighbours' cats are in the exhumation business.

Our 4-year-old is a goldfish. He was adopted after a score of four playing cards with four darts at Bridgwater Fair and has put up with dirty water, starvation during our holidays, and several moves without any apparent signs of distress. He seems now to have developed ischaemic necrosis of his tail fin as a result of his dry four-hour stint on the draining board and the clotting (or haemorrhage?) at the tail base. Most of the fin has now dropped off but he seems unimpaired by this loss. I hope he will not develop an opportunistic fungus infection at the site of injury, but perhaps some Domestos in the water will prevent this.

Why, though, did he suddenly jump from his tank? Was it an accident, or was this a genuine attempt at suicide? Was it truly parasuicide—an act that nearly went very wrong because of its poor timing? I am not sure that any of my psychiatric colleagues will be able to help with treatment. A little tricyclic in the water perhaps? Electric convulsion treatment is certainly not on, and the thought of sectioning him reminds me uncomfortably of sardines on toast.—ANDREW BAMJI, MRCP, Middlesex Hospital, London.