Personal Paper

Are follow-up consultations at medical outpatient departments futile?

G N MARSH

Abstract

Of 260 follow-up medical outpatient consultations analysed by 12 general practitioners in the Northern Region, a large proportion appeared to be a complete waste of time. One follow-up consultation should be the normal for the great majority of cases and if more are necessary specific reasons should be given. Great economies could be made in the National Health Service by reducing medical outpatient follow-ups.

Introduction

The initial opinion of a consultant colleague regarding a patient seen for the first time is of tremendous help to a general practitioner but many general practitioners think that the continuing follow-up at outpatient departments is of far less value.^{1,2} Indeed many complain that consultants or sometimes junior staff "cling on" to patients and appear to be duplicating their own care. Different junior staff—often junior to the general practitioner himself—carry out a considerable proportion of these consultations, and sometimes patients are confused by the contradictory advice they receive and the many people they see. To them the consultation appears not infrequently to be a waste of time and effort. Expensive NHS resources—nurses, secretaries, ambulances, outpatient clerks, etc, not to mention doctors' time—are wasted. Most importantly, however, the volume of follow-up appointments prevents new patients being seen and results in long waiting lists.

Since the damning indictments of follow-up consultations five years ago^{3,4} there appears to have been little change.^{5,6} In an attempt to measure the scale of the current problem a group of general practitioners decided to analyse what occurred at follow-up outpatient appointments (tests, diagnoses, change of treatment, etc) and what value these consultations had to the general practitioner and his patient. Medical outpatient departments were chosen because they contain much of the mainstream of general practitioner work.

Method

Twelve general practitioners from the research committee of the Northern Region Faculty of the Royal College of General Practitioners collected the data. They came from eight different practices and worked in six different health districts. Each doctor analysed about 24 consecutive follow-up letters received from medical outpatient

departments. The latter were defined as general medicine, geriatrics, chests, neurology, rheumatology, gastroenterology, nephrology, and radiotherapy. Psychiatry, paediatrics, and dermatology were excluded.

Results

Of 126 male and 134 female follow-up consultations analysed, 43 patients were aged under 30, 172 were 31 to 70, and 45 were over 71.

Altogether 151 consultations were done by a consultant, 68 by the registrar, 35 by the senior house officer or below, and six were "unsure." Fifteen per cent (39) were first follow-up consultations and 85% (221) second or later. In 44% (113) patients were told to return within three months (table I). A new diagnosis was made in 9% (23) of consultations.

TABLE I—Period waited to next follow-up appointment by 260 patients

No of months:	0-1	1-3	3-6	>6	Discharged	Not stated
% of patients:	17	27	17	6	20	15

Sixty-seven patients had blood tests, 35 x-ray examinations, and 36 "other tests"—for instance, ECG—carried out. Drug treatment was unchanged in 77% (201). New treatment was started in 15% (38), and changed but to the same type of drug in 8% (21).

In 200 the general practitioner thought that "the patient's condition had not changed much since his last outpatient appointment." In 158 the general practitioner "did not learn anything useful from this consultation that he did not already know about the patient." In 235 the general practitioner "would make no alterations to the patient's management (excluding the drug changes)" as a result of that consultation. Fifty-six per cent of patients (145) had seen their general practitioner in the month before the appointment (table II).

TABLE II—Period since patient's last visit to the general practitioner

≤1 week	8 days-1 month	>1 month-3 months	>3 months
21% (54)	35% (91)	35% (91)	9% (24)

Although some cell sizes were small, cross tabulation showed that whether the patient saw a consultant or another member of staff there was no appreciable difference as to whether a new diagnosis was made, treatment changed, or management altered. Of the 51 patients (20% of total) discharged from follow-up, 29 had been seen by the consultant and 22 by junior staff (two unsure). Treatment and management were altered roughly twice as often in a first follow-up consultation compared with a second or later one. There was no appreciable relationship between change of treatment or management and the time since the patient had last seen his general practitioner.

Seventy patients (27%) had no new diagnosis made, no further

Stockton-on-Tees TS20 1AN

G N MARSH, MD, FRCP, general practitioner

tests done, and no change in drug treatment. There had been no change in their condition since last attending, the general practitioner learnt nothing new about the patient, and their management was unchanged. Forty-eight of these patients were given a further follow-up appointment. A further 52 patients (20% of the total) were identical to the above group except that they had a further test done; and 42 of these were given a further follow-up appointment.

Discussion

The results describe overall an escalating catalogue of futility. Only tiny numbers of patients received a new diagnosis (9%) and even the ubiquitous laboratory tests and x-ray examinations were fairly small in number. Changes of treatment and changes in patients' conditions were uncommon. In 61% (158) the general practitioner learnt nothing useful from the consultation that he did not already know about the patient and in 90% (235) he would not alter the patients' management as a result of that outpatient consultation.

Not surprisingly for consultations about problems that have already been seen and presumably sorted out, whether the patient saw a consultant or another member of staff made no appreciable difference to the value of the appointment. Junior staff were just as likely to discharge patients, exploding the myth, at least in this study, that it is they who are responsible for the large number of follow-ups.⁷ There was evidence that the first follow-up was more beneficial than second or later ones.

The most futile consultations were those for the 70 patients in which nothing new appeared to have happened at outpatient clinics nor was the knowledge or management altered in any way, yet 48 were given a further follow-up appointment. Almost as futile were the consultations for the 52 patients who were identical with the previous group except that they had a "test" carried out and 42 of them were given a further follow-up appointment. Thus it would seem that 35% (90) patients were making appointments for the future that would almost certainly have no value whatsoever.

HOW SHOULD THE SYSTEM BE CHANGED?

The general consensus appears to be that standards of general practice are improving as practices are better organised and primary health care teams are more fully developed.⁸⁻⁹ Increasing numbers of vocational training programmes have furthered this, and they are now compulsory for all new entrants. So with the standards of general practice improving, specialists should now be able to return to their proper role as consultants.⁴ They must be far more rigorous and selective with regard to the continuing follow-up of patients with chronic illness, and the need for follow-up should become an aspect of the consultation requiring far more thought than previously. Junior staff too will need instructions regarding the new style of outpatient care and their so-called "training" by the sporadic review of chronic patients will come to an end. Surely they can do something more rewarding with their time.

Some patients with severe, intractable, painful, crippling, or rare conditions are reassured by attending outpatient departments that all is being done for them that can be done. Nevertheless, examination of the diagnoses of the futile follow-ups in this study showed that the numbers of this type of case were very small. Most were standard conditions—ischæmic heart disease, chronic chests, diabetes, etc—the routine "stuff" of general practice.

For most patients there should be one follow-up consultation at which the diagnosis may be reviewed and treatment assessed. The results in this paper suggest that this consultation has some value. Thereafter the general practitioner should continue care, which would present little extra work for him since these patients are seeing him anyway (table II). If further follow-up appointments are ordained then the reason should be spelled out in the

letter to the general practitioner.¹⁰ It should be a reason beyond the scope of the general practitioner himself. The final letter from medical outpatient departments might suggest a possible follow-up protocol for the general practitioner to carry out as well as indications for rereferral.

RESULTS OF REDUCING FOLLOW-UP ATTENDANCES

This study shows a deplorable overuse of the follow-up system by many consultants and a serious waste of NHS resources. If follow-up appointments could be reduced by the large proportions suggested more consultation time would be available for truly difficult problems, more new patients could be seen, and waiting lists could be reduced. The flight from NHS to private outpatient appointments largely ordained by waiting lists would no longer be necessary. So far as outpatient work is concerned there is no evidence here to sustain the belief that more consultant posts are necessary.¹¹

I am most grateful to the members of the research committee of the Northern Region Faculty of the Royal College of General Practitioners for collecting the data. I am indebted to Mrs J Parker for analysing them and typing several drafts of the paper.

References

- 1 Loudon ISL. A question of numbers. *Lancet* 1976;ii:736-7.
- 2 Southgate K. A question of numbers. *Lancet* 1976;ii:854.
- 3 Anonymous. To come again—three months. *Lancet* 1976;ii:1168-9.
- 4 Anonymous. Out-patient follow-up. *J R Coll Gen Pract* 1976;26:792-3.
- 5 Department of Health and Social Security. *Health and personal social services statistics for England, 1978*. London: HMSO, 1980.
- 6 Shaw CD. The problem of out-patient visits. *Health Trends* 1981;14:107-8.
- 7 Zadik FR. A question of numbers. *Lancet* 1976;ii:853.
- 8 Jones RVH, Bolden KJ, Gray DJP, Hall MS. *Running a practice*. Revised ed. London: Croom Helm, 1980.
- 9 Marsh GN, Kaim-Caudle PR. *Team care in general practice*. London: Croom Helm, 1976.
- 10 Olsen ND. A question of numbers. *Lancet* 1976;ii:853-4.
- 11 Social Services Committee on Medical Education with special reference to the number of Doctors and the Career Structure in Hospitals. *Fourth report*. London: House of Commons, 1981.

(Accepted 11 March 1982)

What is evening primrose oil and has it any therapeutic use?

Evening primrose oil contains the essential fatty acids linoleic acid and γ -linolenic acid. Linoleic acid is common in the diet but is inactive until converted to γ -linolenic acid. This conversion appears to be limited and is said to be inhibited by some dietary fats and by alcohol. Evening primrose oil is the only rich natural source of γ -linolenic acid.¹ Essential fatty acids are necessary for normal cell membrane function, and for the synthesis of prostaglandins, in particular PGE₁. Thus it is not surprising that several disorders have been attributed to a functional deficiency of γ -linolenic acid and that various therapeutic uses have been suggested for it.¹ It has, for example, been suggested that dietary supplementation with linolenic acid might protect against arterial disease, that evening primrose oil may produce weight loss in obesity, and that it is effective in patients with atopic eczema.² It has also been used to treat multiple sclerosis.³ This is based on the hypothesis that there is an inborn error of metabolism of unsaturated fatty acids of the linoleic type in this disease, which may be corrected by treatment with γ -linolenic acid. Trials in multiple sclerosis have been inconclusive: there is some indication that such treatment may lessen the severity and duration of relapses, but it appears to have no effect in chronic established disease.—LINDA BEELEY, consultant clinical pharmacologist, Birmingham.

- 1 Tudge C. Why we could all need the evening primrose. *New Scientist* 1981 November 19:506.
- 2 Lovell CR, Burton JL, Horrobin DF. Treatment of atopic eczema with evening primrose oil. *Lancet* 1981;ii:278.
- 3 Hallpike JF. New treatments for multiple sclerosis. *Br J Hosp Med* 1980;23:63-6.