DIETITIANS IN THE COMMUNITY

REPORT OF AN EXPLORATORY STUDY

by

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February 1974

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Acknowledgements

I would like to express my thanks to all the dietitians employed in hospitals, local health authorities or general practices who co-operated so enthusiastically in supplying information about their work; to the medical officers of health, secretaries to hospital management committees and clerks to boards of governors of teaching hospitals who replied to the postal questionnaires; and to the chairman (Miss Creina Murland), the past chairman (Mrs. Noreen Thompson) and the vice chairman (Miss Pam Brereton) of the British Dietetic Association, and the dietetic adviser of the Department of Health and Social Security (Miss Pat Torrens) for their interest in the study and the generous help and advice which they have given to me throughout.

This study has been carried out as part of the research programme of the Health Services Research Unit and financed by the Department of Health and Social Security.

I would like to thank Professor Michael Warren and other colleagues of the Health Services Research Unit for their advice and criticism, and Mrs. E.V. Browne for her secretarial assistance throughout the study and in preparing this report.

Summary

The current provision of dietary services in the community and the demands falling on dietitians working in the community was studied by means of postal questionnaires to all medical officers of health of local health authorities, secretaries to hospital management committees and clerks to boards of governors of teaching hospitals in England, and by interviews with selected dietitians.

Considerable differences were found between regions in respect of the employment of hospital dietitians, as well as in the involvement of hospital dietitians with the community. It was learnt that 379 dietitians (whole time equivalents) were employed in hospitals in England, that 42% of H.M.C. groups did not employ dietitians, and that 23.5% of established posts were unfilled. Only nine local health authorities and three general practices were found who employed dietitians and most of these appointments were recent innovations.

Most hospital dietitians gave dietary advice outside the hospital, though this was in each case of limited extent and in many cases was carried out as an 'off-duty' occupation. The dietitians employed by local health authorities varied in their methods of working, some being almost exclusively involved in consultations with individual patients while others were largely committed to teaching nutrition and to the supervision of group sessions organised by others, e.g. slimming clubs.

Obesity was the most frequently occurring condition referred to the dietitians, stated by some to comprise 99% of their workload. Many of the dietitians considered that dietary advice in some dietary and nutritional disorders could be given by other professional workers but that further training in these subjects was necessary for these workers. The change in emphasis from advising on specific therapeutic diets for individual patients to that of giving advice on diet and nutrition to large sections of the community and more particularly to "high risk" groups such as the housebound elderly, obese children and families on low income was widening the field of work of the dietitian. Dietitians are employed in the health service in insufficient numbers to meet these changing needs entirely by consultations with individuals, and consideration must be given to effective methods of presenting expert opinion on nutrition and diet to large numbers of people.

It is recommended that careful thought is given by employing authorities to the needs of the community in respect of advice on diet and nutrition before employing dietitians in the community, and before a national extension of community dietetic services takes place.

Introduction

In recent years, a number of hospital dietitians have begun to extend their services into the community,[1] a few local health authorities have established posts for dietitians,[2] and a small number of general practitioners have employed dietitians.[3] The development of primary care teams has been gathering momentum over the last few years, and suggestions have been made that further additions could be made to such teams, e.g. members of the Professions Supplementary to Medicine.[4][5]

In certain disorders, specific therapeutic agents have been discovered which have replaced therapeutic diets, e.g. vitamin B_{12} in pernicious anaemia, while continuing doubts are expressed about the relevance of specific diets in the treatment of some diseases, e.g. peptic ulcer.

The identification of inborn errors of metabolism such as phenylketonuria and the increased understanding of coeliac disease and other malabsorption diseases, however, have resulted in new areas of application of specific diet therapy as have the developments in medical and surgical treatment of certain conditions, e.g. chronic renal disease.

Nutritional problems in the community, of which obesity is by far the most frequently encountered, are causes for concern. High risk groups may be identified, such as the elderly (particularly those who are housebound), the immigrant population and families with low incomes, all of whom may present problems relating to inadequate nutrition and who may require dietary advice.

The developing emphasis on community care and the changing nature of the problems presenting to dietitians suggest that a review of the work and deployment of dietitians is timely.

The objectives of this study, therefore, were to:-

1. Assess the extent of existing dietetic services in the community.
2. Examine the experience of dietitians working in the community.
3. Consider the nutritional and dietary problems presenting to dietitians.
4. Make comments and recommendations concerning future developments in the organisation of dietetic services and the training and recruitment of dietitians.

METHODS

Questionnaires were designed to identify those local health authorities, hospital management committees and boards of governors of teaching hospitals in England who had an establishment for dietitians and currently employed or had recently employed dietitians.

The questionnaires to local health authority medical officers also asked for their opinions on the adequacy or otherwise of dietetic services to their community and invited suggestions for improving any perceived inadequacies in the delivery of dietetic advice. A question was included to elicit information about the employment of dietitians by other local authority departments. (Appendix I).

The questionnaires to secretaries of hospital management committees and to clerks of boards of governors of teaching hospitals were in two sections, (i) a one-page section, to be completed by the hospital secretary or clerk, aimed at eliciting information about the establishment for dietitians in the group, the number of dietitians currently employed, and whether any existing vacancies were being advertised; and (ii) a seven-page section, to be filled in by the group dietitian (or most senior dietitian employed in the group), and composed of questions about the content of their work particularly that which involved giving dietary advice to patients residing outside hospitals and to individuals and groups working in the community. (Appendix II).

It was anticipated that only a few general practitioners would employ dietitians in their practices, and in order to contact these general practitioners, letters were placed in various medical journals requesting any general practitioner who employed a dietitian in his practice to inform the project director.

Interviews were carried out by the author with those dietitians found to be employed by local health authorities, those who were employed by general practitioners and a selected number who were believed, from answers to the postal questionnaires, to be involved in extension of their services outside hospitals.

PROCEDURE

A list of medical officers of health employed by county councils and county borough councils in England, and those employed by London boroughs were obtained from the 1972 edition of the Municipal Year Book. This list was stated to be accurate as at 30th September 1971 and was updated where possible from personal and printed knowledge of changes.

Questionnaires were posted in October 1972 to all 156 local health authority medical officers of health in England (45 employed by county councils, 78 by county borough councils and 33 by London borough councils). Each questionnaire was accompanied by an introductory letter, addressed to the medical officer of health by name, and a stamped-addressed envelope in which to return the questionnaire.

A reminder was posted in December, 1972 to the eight medical officers of health who had not replied to the initial approach, all of whom replied to this reminder.

The list of hospital management committees and of boards of governors of teaching hospitals in England was obtained from the Hospital Year Book 1972.

The questionnaires were posted in November 1972 to all 321 hospital management committee secretaries and clerks of the boards of governors of teaching hospitals listed, each questionnaire being accompanied by an introductory letter addressed to the secretary or clerk concerned, and a stamped-addressed envelope in which to return the questionnaire.

Reminders were posted in January, 1973 to the 23 secretaries who had not replied to the first mailing.

From the replies, it was learnt that 8 out of the 321 groups listed in the Hospital Year Book had subsequently amalgamated with other H.M.C. or teaching hospital groups, and these 8 were excluded from the total, leaving a total of 313 hospital groups functioning at the time of the survey.

Three general practitioners replied to the letters placed in medical journals requesting general practitioners who employed dietitians to contact the project director.

Following a preliminary analysis of the questionnaires, four hospital dietitians and seven dietitians employed by local health authorities who had reported that they were involved in giving dietary advice to the

community were interviewed during May 1973 by the author, as were the three dietitians employed by the general practitioners who had answered the requests in the medical press.

Responses to Postal Questionnaire

By January 1973, replies had been received from all 156 medical officers of health, and by February 1973, replies had been received from all but three secretaries and one clerk to the board of governors of a London postgraduate teaching hospital. (Table 1).

RESULTS

Dietetic Establishments and Employment of Dietitians

The number of local health authorities, hospital management committees and boards of governors of teaching hospitals who had establishments for and who employed dietitians is shown in Table 2.

(a) Local health authorities

The employment of dietitians by local health authorities and the dates of the commencement of such employment is shown in Table 3 where it is seen that whereas one county borough council has employed a dietitian since 1949, five of the remaining eight authorities which employed dietitians commenced employing dietitians during 1972.

One full-time dietitian employed by a county council was stated to be terminating her appointment in December 1972 on moving to another part of the country. This vacancy was being currently advertised, as were vacancies for dietitians by two county borough councils who had not previously employed dietitians.

Only one authority, a county borough council, had discontinued the establishment for a dietitian, no details being given about the reasons for this change, or for how long a dietitian had been employed.

The number of other local authority departments who employed dietitians, as stated in the replies from the local health authority medical officers of health, is shown in Table 4, in which it is seen that 16 local authorities employed dietitians in departments other than health departments, and that in two London boroughs dietitians were employed in health departments and were also employed in either education or social services departments.

Thus, a total of 23 local authorities employed dietitians, of which 7 employed the dietitians only in health departments, 1 employed dietitians in health and education departments and 1 in health and social service departments, 10 employed dietitians only in education departments, and of the remaining 4 authorities 2 employed dietitians only in social service departments and 2 in both social service and education departments.

(b) Hospital authorities

Established posts for dietitians were reported by 164 (59%) of the secretaries to hospital management committees, by all nine clerks to boards of governors of provincial teaching hospitals, and by 18 (72%) of the clerks to boards of governors of London teaching hospitals. (Table 2).

The teaching hospitals at Nottingham and Southampton who were without boards of governors, were included in the replies from hospital management committees. The London teaching hospitals which had no establishments for dietitians were all postgraduate teaching hospitals.

Table 5 shows that 91 establishments (48% of the total) were for single-handed (part-time or full-time) posts, and that whereas all provincial teaching hospitals and 13 (72%) of London teaching hospitals with establishments were for more than two dietitians (whole time equivalents), only 43 (26%) of the H.M.C. groups possessed as large an establishment.

Considerable differences in the proportion of hospital groups who had established posts for dietitians was seen to exist. In the Newcastle and East Anglia R.H.B. areas, two-thirds of the H.M.C. groups had no established posts for dietitians while at the other extreme only two of the H.M.C. groups in the Liverpool R.H.B. area had no establishment.

The number of established posts for dietitians by career grade is shown in Table 6, (expressed as whole time equivalents) where it is seen that 379 posts (81.6% of the total), were for basic grade or senior dietitians. Where a hospital group employs only one full time or part-time dietitian, the established post must be that of senior dietitian grade.[6] This probably explains why more senior grade dietitians, than basic grade dietitians, were employed by R.H.B. groups.

The career grade of a dietitian is otherwise dependent upon the size of the establishment for dietitians, thus there was a higher proportion of group, chief and deputy chief dietitians' posts in teaching hospitals which possessed, in general, larger establishments than did H.M.C. groups.

All established posts for dietitians, however, were not filled, and Table 7 indicates the extent of the employment of dietitians (expressed as whole time equivalents). The shortfall was most marked in R.H.B. groups, where 23.5% of established posts were unfilled, compared with the teaching hospitals where only 8.1% were unfilled posts. (Table 9). The vacancies appeared to exist at all career grades, though at basic grade level there were greater shortages in the H.M.C. groups than in the teaching hospitals, perhaps reflecting the ability of these latter hospitals to retain student dietitians after qualification. The table shows that 37.7% of all dietitians were employed in teaching hospitals and that nearly one-fifth of hospital dietitians in this country were employed in the N.W. Metropolitan region, a region which included eight teaching hospitals with dietitians in employment.

The distribution and recruitment of dietitians have changed over the past two decades. There has been a steady increase in the employment of dietitians in hospitals in England and Wales (see graph, Appendix 5), and the figures produced by the then Ministry of Health and the British Dietetic Association for 1956 were:- 72 full-time and 15 part-time therapeutic dietitians and 8 caterer/dietitians employed in H.M.C. hospitals in England and Wales and 106 full-time, 2 part-time therapeutic dietitians and 4 caterer/dietitians employed in teaching hospitals.(7) (It must be borne in mind that this refers to persons, not to whole time equivalents). In 1967, as result of a survey carried out for the British Dietetic Association, 132 (51%) dietitians (w.t.e.) were reported to be employed in non-teaching hospitals and 128.91 (49%) in teaching hospitals in England and Wales.(8) There has, therefore, been a change in the distribution of hospital dietitians, between H.M.C. groups and teaching hospitals though marked differences still existed between regions.

The number of hospital dietitians employed in proportion to population, to occupied hospital beds and to hospital discharges and deaths is shown in Table 8. In England, on average, one hospital dietitian served a population of 128,000 but marked differences were seen between R.H.B. areas. In Birmingham R.H.B. there was one hospital dietitian employed for every 220,000 population while in the N.W. Metropolitan region there was one dietitian per 60,000 population.

Similarly, over the country as a whole, there was a ratio of one dietitian per 893 hospital beds, but whereas in the Oxford region the proportion was 1 to 490 beds, in the Liverpool region the proportion was 1 to 1,695 beds, though it must be remembered that although nearly all H.M.C.'s in the region had establishments for dietitians the Liverpool region contains more hospital beds per population than any other region.

Again, if one relates the number of dietitians with the number of hospital discharges and deaths, marked differences were seen between regions.

In terms of the contribution by hospital dietitians to the needs of the community, the ratio of dietitians to the population must be considered, but the figures for the distribution in dietitians per hospital beds and hospital discharges indicates the potential workload variation between regions of hospital dietitians towards patients attending or residing in hospitals.

(c) Employment of Dietitians by General Practitioners

Only three general practitioners reported the direct employment of dietitians. In one practice a three-man group, the dietitian attended two sessions per week, and in the remaining two practices the dietitian was employed for only one session per week.

Two other practices had reported the experimental employment of a dietitian but both had discontinued this service. In one of these practices, it was found over a three-month period that 38 patients had made a total of 95 attendances at a cost of £1.75 per patient and "In view of the fact that the study was financed by the doctors themselves it was abandoned after three months trial".(3)

COMMUNITY INVOLVEMENT OF HOSPITAL DIETETIC DEPARTMENTS

(1) Open access - Referral of patients by general practitioners

The number of hospital groups who permitted open access by general practitioners to their dietetic departments and the number of patients said to have been referred in one calendar month are shown in Table 10. Of the 171 groups who employed dietitians, 106, permitted open access, but in only 30 of the 106 hospital groups at which open access was available did the general practitioners refer more than five patients each week, and in 14 groups no patients had been referred to the dietetic department during the month. One group dietitian made the comment that she "did not consider open access referrals by general practitioners as satisfactory without the help of supporting services, e.g. pathology reports, patients notes, etc." One dietitian who was in a part-time single-handed post commented that she had been asked by the H.M.C. to discontinue open access, presumably due to pressure on her services, and one dietitian commented, "This is a sore point .... permission was refused by the Medical Committee".

(2) Patients outside hospital - Attendance by hospital dietitians

Some hospital dietitians attended individual patients in premises outside the hospital (Table 11). Dietitians in four hospital groups visited general practitioners' surgeries at least three times per month to attend individual patients and in another three groups the dietitians visited health centres with equal frequency. In 74 groups dietitians visited individual patients in their own homes, though in 62 of these groups, less than one visit per month was made.

During subsequent interviews with hospital dietitians, it was learnt that one hospital dietitian visited patients in their homes who were unable to attend her sessions at general practice surgeries, and in another, the dietitian visited patients, referred by general practitioners, who were unable to attend the dietetic department or could be seen more conveniently in their own homes.

(3) Visits to institutions by dietitians

Dietitians from seven hospital groups visited institutions at least once per month to give general dietary and nutritional advice (Table 12).

One group dietitian commented that the premises mentioned had been visited by the hospital dietitians in the group before a county health dietitian was appointed, and in another the dietitian commented that the school meals organiser in her area was a state registered dietitian. In one hospital group, the dietitians visited a prison regularly to give general nutritional advice.

(4) Informal discussions with community workers

There was some contact between the dietitians in most hospital groups and general practitioners and health visitors. (Table 13). In the three groups in which informal discussions were held between the dietitians and district nurses at least three times per month, equally frequent discussions were held in these groups with both general practitioners and health visitors. In another three groups dietitians held informal discussions with both general practitioners and health visitors at least three times per month.

In respect of other community workers, there is less contact, both in terms of the number of hospital dietitians involved in informal discussions with these workers and in the frequency of such discussions.

Eleven respondents mentioned informal discussions with social workers in the "other" category, while another reported that the dietetic department was involved in supplying 25 diabetic meals-on-wheels each week to elderly patients living in the hospital catchment area. Five other respondents reported occasional discussions with headmasters and school teachers about the dietary problems of schoolchildren.

(5) Attendance at outpatient sessions by dietitians

Table 14 presents the responses by the dietitians to the question "How often are patients with each of the following conditions, who attend the outpatient department, seen by you or your colleagues in the group?". In 112 hospital groups the responding dietitians claimed that all patients attending outpatient departments because of obesity were seen by the dietitian every time they attended, whereas in only 49 groups did they claim to see diabetic outpatients every time the patient attended. In spite of the reservations one must make about the accuracy of these responses, particularly as to whether a dietitian would be aware or informed of every attendance by an outpatient, it would seem that many more respondents believed that they saw obese patients at every attendance than they did those patients with other conditions.

A request for comments on this question elicited a considerable response. A number of other disorders were quoted as being seen by the dietitians, e.g. inborn errors of metabolism, hepatic, gastro-intestinal, oesophageal and gall bladder disorders and anorexia nervosa.

Eight respondents mentioned that they held dietetic outpatient clinics and arranged appointments within their department for patients who required follow-up; of these eight respondents four specified that the clinics were for obese patients. One respondent commented, "My colleagues and I hold our own diabetic clinics and patients are referred to our clinics. I cannot say how many are not referred". Yet another commented, "We have a system whereby we could see each patient every time they attend, but we do not:- (1) They don't all need to come every time, and (2) If they did I would need twice my establishment of staff".

Many factors appeared, from the comments, to influence the involvement of hospital dietitians with outpatients. In some cases the dietitians attended outpatient sessions as part of the medical team, whereas in others the dietitians held their own clinics and either arranged for patients to see them or awaited referrals from a consultant. In others it would appear that the pressure of work restricted the involvement in outpatient departments.

(6) Continuation of dietetic advice to patients after their discharge from hospital

Follow-up by hospital dietitians of inpatients who had been discharged from the hospital and who had received dietary advice during their stay, was most commonly carried out by the dietitian requesting the patient to return to the dietetic department. (Table 15).

In 57 groups every patient who had been discharged from hospital and who had received dietary advice from the hospital dietitian was requested to return to the dietetic department. This may reflect the long-term nature of the work. One respondent commented, "All patients who have received dietetic advice are given my telephone number and the times they can contact me for further advice or for an appointment with me", while another stated, "Most patients who need to continue diet at home are seen on at least one occasion after discharge".

Of the 30 respondents who made a comment about their "other" method of following-up patients, 13 stated that they retained contact with patients by post or by telephone, of whom 7 specifically mentioned that this mainly applied

to patients on reducing diets. Six respondents stated that they occasionally contacted school meals organisers or school teachers, and one mentioned contact with the local health authority dietitian working in the area.

7. Formal lectures on nutrition and diet

The hospital dietitians appeared to devote a considerable time to lecturing on nutrition and diet to community workers in different fields and to groups and organisations in the community. Of the 164 fully completed questionnaires returned by the dietitians, only 46 (28.0%) of the respondents stated that the dietitians in the hospital group did not lecture outside the hospital. As well as the types of audience specified in Table 16, lectures on nutrition and diet were given to women attending ante-natal clinics in 49 of the hospital groups, and in the "other" category respondents quoted lectures given by hospital dietitians to nursing, domestic science and home economics students as part of the formal training of these students.

The most commonly occurring group receiving lectures on nutrition and diet were the voluntary organisations, almost half the respondents reported that lectures on nutrition and diet had been given to these organisations by the dietitian in the hospital group.

In 31 hospital groups the respondents reported that they had given lectures to general practitioners, and in 39 groups lectures were stated to have been given to health visitors. The respondents in 13 of these hospital groups had given lectures to both types of audience.

Table 17 indicates the range of involvement by the hospital dietitians in respect of lectures on nutrition and diet. In general, the lectures delivered by the hospital dietitians were carried out on a voluntary, spare-time basis and were usually given as a result of a request from the organisation or group concerned. It would appear, therefore, that there was a perceived commitment, by more than just a few enthusiasts, amongst the hospital dietitians to lecture on nutrition and diet, both to other professional workers and to members of the community.

Summary (Hospital Dietitians in the Community)

Some involvement of the hospital dietitians with both professional workers in the community and with patients or others living outside the hospital was seen to occur in many of the hospital groups. This commitment varied between hospital groups and with the type of involvement; very few were found to report a widespread involvement with the community.

Two or more patients were seen weekly on average at the direct request of general practitioners in only 30 hospital groups. In 6 hospital groups dietitians were attending patients in health centres or general practice premises at least three times per month on average and in 78 groups the dietitians reported visiting patients in their homes. Frequent (3 or more times per month) contact with general practitioners and health visitors was reported in 38 hospital groups, though in 127 hospital groups, less frequent discussions were reported between the dietitian and the general practitioners while equally infrequent discussions with health visitors about patients were said to take place in 117 groups.

Only two respondents claimed to contact the general practitioner concerned on every occasion that a patient who had been receiving dietary advice was discharged from hospital, and one claimed to notify the health visitor concerned. In 57 groups the general practitioner was not contacted and in 75 groups the dietitians never contacted the health visitor about such patients. The more usual method of follow-up was to request the patient to return to the dietetic department.

In 31 groups the respondents reported that they had given lectures on nutrition and diet to general practitioners and in 39 hospital groups lectures on the subject were given to health visitors. Of these, 13 reported lectures to both these professions.

All but four of the respondents attended outpatients', either with the consultant concerned or by organising special diet clinics.

About half the respondents stated that they had given lectures on nutrition and dietetics to groups and organisations in the community.

An involvement with all aspects of contact with the community by the hospital dietitians was not apparent, though cooperation with the staff of local authority Health and Social Service Departments and the delivery of dietetic advice to inpatients on discharge and to outpatients and/or their relatives is specified as part of the functions of hospital dietitians.[9]

As a crude measure of the extent of community commitment of an individual hospital group dietetic department, a simple scoring was applied to the different categories of involvement. Each section of questions 2 - 7 inclusive, and question 9 were scored (see Appendix 3). A maximum of 3 points was possible for question 2, 15 points for question 3 and 4, 26 for question 5, 24 for question 6, 16 for question 7 and 10 for question 9. The distribution of scores (out of a possible total of 109) for individual

hospital groups is represented in Table 18. Only four hospital groups achieved a score of at least 40, the highest being 47, and only in these four hospital groups was the highest score achieved in more than one category. In general, most respondents claimed to be involved in at least one aspect of the community involvement specified in the questionnaire, but there was no evidence to suggest that a few hospital dietetic departments carried out extensive work in all or even most of the different categories. Those who were giving lectures on nutrition and diet, for instance, were not those who visited patients in the community or allowed open access to the dietetic department and in fact most respondents who stated that they had given such lectures did so to only two or three of the groups and organisations listed in the questionnaire.

Thus, some extension of the work of hospital dietitians is fairly widespread, though in many instances, as for instance, in lectures to groups and organisations in the community it is carried out as an "off duty" occupation rather than an integral part of the working day.

COMMUNITY DIETETIC SERVICES

Opinions of L.H.A. Medical Officers of Health

The postal questionnaire addressed to L.H.A. medical officers of health included the question "Do you consider that groups and individuals in your community can, in general, obtain adequate dietary advice?".

Of the 139 who replied to this question, 97 (70% of those responding to the question) considered the services adequate (Table 19). The opinions did not appear to be significantly related to the type of employing authority, or to whether a local health authority dietitian was employed (Table 20). The number of local health authorities employing dietitians is too small to allow any great significance to be attached to this finding however.

In response to the question:- "If 'yes' who is mainly supplying the service?", answers were received from 95 of those 97 who stated that they considered the services adequate. Twenty-seven considered that the health visitor and local health authority nursing staff and/or the general practitioner were the main supplies of dietary advice to the community. A further 18 included the hospital dietitian amongst those giving dietary advice to the community, and 14 considered that the hospital dietitian alone was providing an adequate dietary service to the community.

The health education officer, either alone or in conjunction with others was quoted by 25 respondents as the main source of dietary advice to the community. Other sources of dietetic advice mentioned were medical officers of health, school nurses, slimming clubs and the mass media.

The replies received to the request for suggestions for improving the dietetic service to the community came from 35 respondents, of whom 16 suggested the employment of dietitians in the community. An additional 6 recommended further instruction in nutrition and diet for local health authority professional workers, and others offered a variety of suggestions including the increase in employment of local health authority nursing staff, the promotion of health education programmes and the extension of hospital dietetic services into the community.

General comments on community dietetic services were made by 36 respondents. Five of these respondents recommended the employment of dietitians in health education and one commented in some detail - "The role of the dietitian in the community can best be fulfilled as a member of a team concerned to ensure that vulnerable groups in society are provided with the most suitable foods to maintain and promote health. Looking to the future there is much to be said for developing a more closely knit nutritional service linking the activities of dietitians inside and outside the hospital with the educational efforts of others working in the field of health, education and welfare. Such a concerted approach is essential if an integrated health educational effort is to be mounted in the twin fields of prevention and treatment".

This respondent also mentioned, as did two others, that the reorganisation of the N.H.S. in 1974 offered an opportunity to "take a fresh look at the key subject of nutrition with particular reference to the contributions of the dietitian to the health of the community at large".

Four respondents felt that there was a need for the services of a dietition to advise professional workers in the community, e.g. "There is a place in the Local Health Authority Service for a dietitian, to whom health visitors, nurses and others, including general practitioners could turn for advice and help". "Health visitors do a great deal of work in this field but more expert advice is required from time to time.

Two respondents suggested that it would be an advantage if more dietitians were employed in peripheral hospitals and seven commented on their ability to obtain the assistance of hospital dietitians whenever necessary through informal links.

Groups specified by the respondents as being most in need of dietary advice were obese schoolchildren, expectant mothers, Asian immigrants, the elderly, obese workers and the residents of welfare homes. Supervision of school meals and home meals and advice on nutrition and diet to the organisers of these services was also mentioned.

The general comments are given in full in Appendix 4.

RESULTS OF INTERVIEWS WITH DIETITIANS

Hospital dietitians

From the postal survey, four hospital groups were identified as providing comparatively extensive dietary services to the community, i.e. those four groups who scored 40-47 on the scale shown in Table 18. Visits were made to these four dietetic departments and the dietitians were interviewed.

In one of these four hospital groups, the move to a new hospital since the postal survey had caused the dietetic department to curtail its activities in order to concentrate on organising the dietetic services within the hospital. The appointment of a local health authority dietitian in the area had further affected the extended role of the hospital dietetic department as it was considered that the need for community involvement by the hospital dietitians was lessened as a result of this local health authority appointment. Liaison between the hospital dietitians and the L.H.A. dietitian was good and it was hoped to strengthen this by arranging a part-time secondment of the L.H.A. dietitian to the hospital dietetic department. The group dietitian believed such a secondment would improve the continuity of care of those patients who received dietary advice within the hospital.

The dietetic department was involved in advising general practitioners about the diets of patients. This was a purely informal arrangement carried out as a result of telephone requests from the general practitioners and was almost invariably concerned with patients who had been discharged from hospital and who had received dietary advice during their stay. These telephone requests were said to occur about once a month on average. The dietitians hoped to start an outpatient obesity clinic in the near future as they believed that groups of 10-20 patients could be more effectively treated in group sessions.

The three other dietetic departments visited, although defined from the postal questionnaire as having comparatively extensive community commitment, showed considerable variation in their involvement with the community. Two of the departments involved were each staffed by a single-handed dietitian and the third department employed three dietitians.

All three provided open access to general practitioners, visited old people's residential accommodation and visited the homes of patients.

In the case of the two single-handed dietetic departments, about two patients were seen each week at the request of general practitioners and in the third department about four patients were seen each week.

One of the single-handed dietitians estimated that 90% of the referrals from general practitioners were of patients suffering from diabetes; almost all the remaining patients were referred for reducing diets. The other two dietetic departments were said to be almost exclusively involved in seeing patients with obesity. In one case the dietitians estimated that 98% of the patients referred by general practitioners were referred for advice about obesity, 1% for diabetic advice, all other conditions making up only 1% of the referrals.

In all three hospital dietetic departments where open access was provided, patients referred from general practitioners were accompanied by a letter giving brief clinical details and the reasons for the referral.

In two of these three dietetic departments, approximately one patient per month was seen at the request of a health visitor. Such patients were usually referred for advice aimed at correcting faulty eating habits or were referred for further advice concerning therapeutic diets which had been advised while the patient was in hospital.

Much less frequent were the referrals from general practitioners and health visitors of patients suffering from malabsorption conditions, chronic renal disease, hyperlipidaemias, gastric tube feeding, and digestive disorders. In response to a request to list any conditions which the dietitians considered should be referred and which were not at present being referred, one dietitian was unable to specify any such problems, while a second dietitian suggested that infants' and children's dietary-problems were "the greatest deficiency in the people referred".

Infant feeding and the diet of children were also mentioned by the dietitians in the third (larger) dietetic department as being important subjects not at present referred but which the dietitians believe would benefit from expert dietary advice. They added five other groups or conditions which they considered were in need of expert dietary advice:-

(a) Gastric disorders - patients often need advice on "liberalisation" of strict dietary regimes. The dietitians believed that many patients who had, in the past, received advice on severely restricted gastric diets were still adhering to such diets and that this was both unnecessary and potentially harmful in respect of adequate nutrition.

(b) Intestinal disorders - patients need advice on sensible eating, and, in some cases, there is a need to correct the advice given formerly about low residue diets.

(c) Mild diabetes - many patients were believed to have received insufficient dietary advice and were therefore unnecessarily restricted in their freedom of choice of diet and were also at risk of receiving an inadequately balanced diet.

(c) Low income families - it was believed that this group would benefit considerably from dietetic advice about obtaining an adequate, balanced diet from low-priced foodstuffs, and

(e) Patients who had received inadequate dietary advice - the dietitians believed that many patients received diet sheets or only the most cursory instructions about diet, and that there was a need for much deeper discussion about therapeutic diets than could be gained from such methods.

In the larger dietetic department, but not in the case of the two single-handed departments, visits were made to buildings outside the hospital in order to attend patients. A dietitian held two evening sessions per month in one group practice, one evening session per month in another practice, a morning session once a month in a health centre and one morning session per month in a local health authority clinic.

The sessions held by these dietitians in general practice surgeries usually lasted 2 hours, during which time 8 - 10 patients were seen, by appointment. New patients were given a 20 minute appointment and return patients were given 10 minute appointments. Approximately two new patients and two follow-up patients were seen at the sessions held by the dietitian in the health centre and the local authority clinic.

As stated previously obesity was the predominant condition presenting to these dietitians, and the great majority of patients seen were adult females though all age groups and both sexes were represented. Obese patients were usually seen at monthly intervals for six months, this

procedure being adjusted by the response, attitude, etc. of the individual patient.

No group sessions were held by any of the three selected hospital dietetic departments, though one of the single-handed dietitians stated that she held twice-weekly sessions of 20 - 30 minutes duration in the outpatient department for 4 - 5 obese patients, and in the larger dietetic department, a dietitian attended one session of a ten-session course organised by health visitors for obese patients.

Lectures on nutrition and diet had been given by the dietitians of all four hospital dietetic departments visited. These lectures ranged from individual lectures to such organisations as Townswomen's Guilds and Rotary Clubs to series of lectures to health visitors as part of the health visitor training course. In one dietetic department a two-day conference for health visitors, nurses and general practitioners had been organised and guest speakers had been invited to talk on nutrition and diet. In another department, the dietitian had been involved in seminars held as part of the vocational training scheme for general practitioners.

None of the hospital dietitians who were interviewed were involved in catering outside the hospital, but all expressed a willingness to advise those involved in catering in the community health and social services if requested.

The opinions of the dietitians about nutritional and dietary advice in the community were found to show marked differences. Only one dietitian considered that the work of a dietitian in the community did not differ from that of the hospital dietitian, and carried this point of view further by stating that she believed that all dietitians should be employed in hospitals, though they should extend their present role by continuing to give advice to patients following their discharge from hospital, and allow open access to the dietetic departments by general practitioners and health visitors.

In the three other hospital dietetic departments which were visited, the dietitians expressed the view that the role and function of a dietitian in the community differed greatly from that of the hospital dietitian, but in one case the dietitians believed this was due largely to the deficiencies of the hospital dietetic services which placed too great an emphasis on therapeutic diets and paid insufficient attention to the preventive and nutritional aspects of patient feeding. There was agreement by the dietitians of these three departments that the dietitian in the community was

required to undertake a stronger educational role than did the hospital dietitian, and conversely should spend less time on individual patient consultations.

During the interviews with these hospital dietitians it was obvious that they perceived large areas of unmet needs in the field of nutrition and diet, and that they considered that the medical, nursing and para-medical professions were inadequately trained in these subjects. The dietitians were conscious of the pressure of hospital work which prevented them from extending their role outside the hospital, an extension which was not a primary function of a dietitian employed in and by a hospital group.

Dietitians in General Practice

The three general practice dietitians who were interviewed were found to be carrying out the work in general practice as an extra to their work as hospital dietitians. Two were currently employed full time as group dietitians, one of these, who had been employed in a group practice of three doctors for over five years, carried out two three-hour sessions per week in the practice, the other who had been employed in a three-man group practice for eighteen months, held one two-hour session in the practice per week. The third dietitian worked sixteen hours per week in hospital as a senior dietitian andheld three or four sessions per month in a practice of five doctors. She had been employed in the practice for two years.

All three saw patients by appointment and all had full use of a consulting room and other practice facilities including access to patients medical records. The dietitian who worked in a three-man group practice recorded that, on average, sixteen patients per month were referred by the general practitioners, the same number of patients as those referred to the dietitian in the five-partner group practice. The third dietitian estimated that twelve outpatients were referred per month by the three doctors in the practice.

In the three-man group practice however, records were available which showed that only two-thirds of the patients referred to the dietitian were suffering from obesity, while one-fifth were referred for peptic ulcer diets, eight per cent for diets related to metabolic disorders and five per cent for diabetic diets. The work of the dietitian in this practice was being analysed by one of the general practitioners and the dietitian at the time of the interview and the findings have now been published[10]. The dietitian in this practice also carried out a group session twice monthly for 15 - 20

obese patients, the only general practice dietitian to do so, though one of the others attended the practice ante-natal clinic and gave talks on "sensible eating" and prevention of obesity.

In all three practices patients were followed up at monthly or twice-monthly intervals depending on personal and other factors of individual patients, and the patients continued to attend until "the patient decides to stop coming or the workload becomes excessive" or "as long as the patient is willing to attend".

One of the dietitians had given seven lectures on nutrition and diet in the previous six months - to nurses, general practitioners, and as part of a district nurse refresher course. No lectures had been given by the other two dietitians.

None of the three general practice dietitians had been involved in health education displays, in school meals centres, luncheon clubs or other community catering, nor had they carried out any surveys or been involved in health education.

In answer to the question:- "How does the work of a community dietitian differ from that of a hospital dietitian?", the three dietitians gave the following answers:- "They differ only in the manner in which they impart the knowledge and to whom, e.g. community work involves group sessions, lectures. Hospital work involves personal contact with patients". "There is a greater emphasis on nutritional advice in the community and less emphasis on therapeutic diets". "I am not sure what a dietitian in the community is supposed to do".*

All three commented on the informal or "homely" environment in general practice premises, one of the dietitians believing that this produced a more receptive attitude and helped the patient to retain information and advice more readily.

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*This latter response perhaps indicating most clearly the lack of a job description of community dietitians and the fact that such appointments are recent innovations.

Local Health Authority Dietitians

Dietitians who were employed by seven local health authorities were interviewed during May 1973. The two remaining authorities who had been identified from the postal survey as employing dietitians were not visited as in one case the dietitian had been appointed to the post for only a few weeks and was attempting to organise her work and define her role, while in the other case the dietitian was on extended sick leave.

Two sharply defined methods of working were observed. In the case of three authorities little of the dietitian's time was spent in face-to-face consultations with patients, whereas the dietitians employed by the other four authorities were almost exclusively involved in individual consultations.

One local health authority employed two dietitians on a part-time basis whose main responsibility was to the meals-on-wheels service. The first appointment had been made as a result of the initiative of a local councillor in 1965. The dietitians were employed for 3-hour sessions each day to provide nutritional guide lines for the 1,500 meals supplied each week and to supervise the 10% of these meals which were for special diets. The service aimed at delivering five mid-day meals per week to each recipient, the meals being designed to provide one-third of the daily nutrients and one-half of the daily iron requirements.

To allow the dietitians freedom from too great an involvement with food preparation and direct supervision, in-service education was given to the catering staff. Monitoring of the meals by the dietitians was carried out by occasional sampling of prepared meals, and the attachment of student dietitians for six-month periods enabled small surveys to be carried out in the borough.

Special diets were provided on request from the medical officer of health or general practitioner. However the dietitians occasionally held discussions with the referring doctor and/or the patient concerned in order to clarify the diagnosis or the more detailed nature of the diet, and on occasions the patient was visited by the dietitian if it was thought that dietary advice should be given or further explanation about the diet was required. It was estimated that 30% of requests were for reducing diets, 27% were for diabetic diets and most of the remainder were for light diets.

The delivery of 1,500 meals each week, of which 500 were supplied to luncheon clubs and 150 were delivered at weekends, demanded considerable resources in transport and produced problems of rapid despatch and delivery of the meals after preparation, as well as a constant anxiety that the nutritional content may be diminished by delays.

The dietitians also gave lectures to those attending luncheon clubs usually on the subject of balanced diets and involving the demonstration of easily prepared supper dishes of high nutritional content. Talks on nutrition to the staff of welfare accommodation had been carried out and it was hoped to commence lectures on nutrition to home helps.

The dietitians had endeavoured to provide leaflets and other information about nutrition and diet to health visitors, nurses and social workers, and had given talks in various schools and other educational establishments. All of this work was with the objective of providing as many outlets for nutritional advice to the population as possible, the load of the dietitians being too great to allow a personal involvement with individuals.

The dietitians in two other local health authorities spent little time with individual patients, believing that they should act as consultants and advisers to other professional workers in the health and social services who in turn would give dietary advice to individuals.

In one case, a dietitian had been employed by the local health authority since 1949, originally as a consulting service to patients in health centres and local authority clinics, but this had changed into an educational service to the community and had so expanded that a second full-time dietitian was appointed in 1971. The dietitians in this county borough spent only two sessions per week in face-to-face consultation with individual patients, usually a referral from general practitioners though they did receive a few referrals from health visitors and an occasional referral from school teachers. Again most of these referrals were of patients suffering from obesity and follow-up was arranged with the health visitor concerned, not with the dietitian. A few diabetic patients had been referred and on one or two occasions during the past year patients with coeliac disease, malnutrition or cystic fibrosis had been referred. Discussions with the dietitians at the local hospital were occurring with a view to transfer of patients from hospital attendance and supervision to the local health authority dietetic department. The dietitian carried out two slimming clinics per week, these were held during the evening with an average attendance of forty people. They were organised by the dietitian with the assistance of a lay assistant and a 'keep fit' instructress, and were scheduled by the local educational

authority as adult education classes. Both sessions were over-subscribed.

A course entitled "Keep Fit in Retirement" had also been organised by the dietitian. This course took place on Wednesday afternoons and was held on six consecutive weeks. At the previous course, 153 people aged 65 years or over had attend and it was felt that such a course could be repeated regularly. Each session involved a talk or film, a meal cooked and served by schoolchildren who also acted as hostesses, and a cookery demonstration indicating methods of providing nutritious meals at low cost and with little effort. The meals provided by the schoolchildren were also intended to demonstrate both to the attenders and to the schoolchildren the basic essentials of balanced diets. Considerable assistance had been sought and obtained from commercial firms who provided demonstrations as well as "free gifts" of their products for those attending the course. Plans were being made at the time of the interview for another such course to be organised and to consider the extension of such courses to other parts of the city.

The dietitian had initiated a health educational project aimed at discouraging the selling of sweets, chocolate and biscuits at school tuckshops and encouraging schoolchildren to eat more fruit and cheese. Talks had been given to a meeting of primary school teachers, displays set up to demonstrate an "ideal tuckshop" and a nutrition section was provided for a health education display at the annual flower show.

The dietitian had developed a close relationship with the local radio, press and television, and had given a series of talks on the local radio and had written a series of articles on slimming.

A display on nutrition was also the prime concern at the time of the interview with a dietitian employed by a county council. This display was part of a health education project devoted to coronary artery disease which was to be set up in a marquee in the centre of the county town. Posters, film strips and cartoons were being prepared to demonstrate aspects of atherosclerosis and the possible relationship of diet to coronary thrombosis.

The dietitian devoted a considerable amount of her time to the setting up and supervising of slimming clinics. At the time of the interview six such clinics were held each week, and one more was being organised. The slimming clinics were run by health visitors and others including one schoolchildren's slimming clinic run by a domestic science teacher, and in each case about 12 people attended a session.

She saw only about three individual patients per week, and of these, most were patients suffering from obesity who had been referred by a general practitioner. The medical officer of health was carrying out a campaign to identify children with diabetes with the intention of referring these children, and their parents, to the dietitian for advice on diet, and the dietitian believed that a useful extension of her work would be to organise group sessions for diabetic patients.

Personal consultations with individuals formed almost the total work of the remaining four of the dietitians who were interviewed. One of these four dietitians, employed by a county health authority, had been in a post for six months and worked a twelve hour week, visiting three health centres and one group practice surgery as well as paying visits to patients in their own homes. In one health centre, twelve new patients and fifteen return patients were seen by appointment at each session, three sessions being held each month. Sessions were held once per month at the other two health centres, approximately twelve patients per session being seen at one centre and six at the other. One session per week was spent by the dietitian at the group practice surgery at which, on average, three new cases and six return cases were seen. In visiting the group practice, the dietitian was involved in a round trip of 52 miles, and when visiting two health centres on the same day as her visit to the group practice, she was involved in driving a total of 69 miles.

Another dietitian employed for 19 hours per week since October 1972 by a county borough spent virtually all her time visiting four practices in the town. Two practices were visited each week, in order to hold appointment sessions for, on average, five patients per session. At the other two practices visited, one-hour sessions were held every other week at which five patients were seen by the dietitian.

Yet another dietitian employed by a county borough worked full time, and was almost exclusively involved in holding clinics at which she consulted individual patients. She worked from a central L.H.A. clinic, a peripheral clinic and from the medical room of a secondary school, holding six such sessions per week. At the central clinic, about 40 patients were seen each week.

The fourth dietitian involved held a joint hospital/local health authority appointment. In respect of her half-time appointment to the local health authority, she held one session per week at which 10 - 12 school-children were seen by the dietitian after referral from the school medical officer.

In all these four cases, the dietitians who were almost entirely involved in face-to-face consultation with patients were also almost exclusively involved with the problems of obesity. The patients presenting were predominantly adult females aged from 20 - 50, with the exception of the dietitian involved with obesity in schoolchildren, and were seen at intervals ranging from once per week in the case of schoolchildren to once per month. One dietitian in fact stated that she did not make routine follow-up appointments but merely offered patients the opportunity of returning at any time if they wished. All commented on the high rate of defaulting and although one dietitian wrote to defaulters, the usual method was to offer the service to those patients who had been advised to attend and to continue follow-up for as long as the patient continued to attend. All four dietitians quoted other conditions for which they gave dietary advice, e.g. "one infant for milk-free diet, one or two gastric diets and one or two underweight adults", "two patients with coeliac disease, one or two gastric diets", or "rarely a diabetic patient referred by a G.P."

Only one of these four dietitians held regular group sessions. These sessions, for people wishing to lose weight, were each held fortnightly, the dietitian organising two such group sessions during the day and two during the evening. On average 25 people attended each session. A group session usually consisted of a weigh-in, low calories refreshment, a discussion period of three or four minutes,exercises and a film or demonstration. People attending were either self-referred or had attended with a relative or friend who had been referred by a general practitioner or health visitor.

None of these four dietitians were involved in the supervision of catering though all had, at some time, given advice on request.

Six of the seven local health authority dietitians who were interviewed had given lectures on diet and nutrition. In one case, the dietitian had given 30 lectures and talks in the previous six months - to health visitors, home nurses, clinic assistants, school teachers, old-age pensioners and parent/teacher associations. Another had given lectures to home helps, welfare home officers, voluntary organisations and church clubs as well as to nurses and health visitors.

The opinions of the seven dietitians concerning their perception of how their services could be expanded if more time or staff were available,

were, with one exception, related to education. The one exception stated that she would wish to spend more time in consultation with obese school-children, the housebound handicapped, problem families and children on diets in special schools.

All seven dietitians were conscious of the importance in community work of gaining the cooperation of the person receiving the dietary advice. This they perceived as being of much greater relevance than in hospital practice where the patient was "less independent" and "under greater control".

Apart from the generally expressed problems of shortage of time and the size of the problem facing the community dietitian, all expressed anxiety about the lack of a job description. The initiative for introducing a community dietetic service had come from different sources, and the perceived requirement for a dietitian varied from authority to authority. In some cases the dietitian had continued the work, in others the dietitian had expanded her role beyond that originally intended, whilst in others the work had altered considerably from that originally suggested.

CONCLUSIONS

The traditional role of the dietitian as a professional worker employed to give advice to individual patients who require or are thought to require a special diet as part or all of their treatment is undergoing considerable change.

The effectiveness of many specific diets is being questioned and a number of such diets are being discarded, while the tendency to provide diet therapy by modification of "normal" diets is increasing. Dietitians in hospital practice are much less involved in preparing as well as formulating special diets, and the special diet kitchen has ceased to exist in many hospitals. Such special diets as are required are now prepared by modification of diets prepared in the central catering establishment of the hospital.

Against this trend towards less rigid diet therapy based on the 'debunking' of many special diets for some of the commoner diseases, has been the increasing awareness in recent years of the nature of a few uncommon disorders, e.g. inborn errors of metabolism, which require specific and often complicated dietary regimes in their management. Similarly, recent advances in surgery, particularly in the renal and oesophageal field, have demanded the employment of carefully constructed dietary regimes to allow adequate nutrition of the pre-operative and post-operative patient. Intensive care units are another innovation which imply a need for very specific nutritional care of the patient, especially for the intra-venous or intra-gastric feeding of an unconscious patient.

At the same time that these changes have been occurring in the hospital service, there has been an increase in the attention paid to dietary and nutritional problems in the community.

Throughout the study the problem of obesity has been seen to be by far the most frequently met condition requiring dietary advice. The dietitians working in the community as well as those in the hospitals spend much of their time dealing with patients referred to them for advice on reduction of weight. Difficulties exist in defining obesity and in the lack of accurate evidence of the extent of the problem, but it has been suggested that, "it is likely that up to one-half of the women over 30 years old in Great Britain are at least 10% over-weight, and that no less than 10% of adult males are over-weight".[11] Obesity is generally agreed to be a major health hazard in this country and much consideration is given to its effective treatment.

Diabetes mellitus was the commonest disorder, apart from obesity, dealt with by the dietitians. Estimates suggest that there are 500,000 diabetics

in the country,[12] all of whom require life-long dietary control, and that 80% of patients with diabetes belong to the category of mature onset diabetes, many of whom are treated exclusively by dietary restriction. How comprehensively and how frequently do such patients require and receive dietary advice? The trend to greater variety in the diabetic diet and other changes in the dietary regimes required in the condition would infer that a regular review of the patient's diet was necessary.

In certain groups and individuals in the community, there is a need for dietary and nutritional advice both to prevent ill-health and as a means of improving the health of the person concerned. Such people as the housebound elderly, immigrants, and the physically handicapped may require advice concerning their diet. People with comparatively low incomes might benefit from advice on the formulation of nutritious diets at low cost. Advice on adequate nutrition during pregnancy and on infant feeding was suggested by the dietitians as an important field of work.

The following list is not intended to be a comprehensive list of diet-related disorders, but is an attempt to indicate, in approximate numbers, the prevalence of those disorders which have been quoted in this report.

	Disorder		Prevalence per 100,000 population
1.	Obesity (i.e. more than 20% overweight)		15,000 - 20,000
2.	Diabetes mellitus		1,000 - 1,400
3.	Post gastrectomy deficiences		1,500 - 2,000
4.	Diverticulitis		250 - 1,000
5.	Renal failure		135 - 140
6.	Coeliac disease	children under 16 years of age	5 - 12
7.	Inborn errors of metabolism		1.25 - 2.5
8.	Malnutrition in the elderly		400 - 500

These figures, obtained from various sources,[11-20] do not represent the number of people who would benefit from, or in fact require, expert dietary advice.

The many varied potential demands as a result of these and other disorders and of those groups or individuals who require dietary advice, must be related to the deployment of resources and methods of delivery of dietary advice.

Recruitment of dietitians

At the time of the survey there were 537 students in training in the United Kingdom compared with 481 in 1971 and 431 in 1970. In 1972 the number of students qualifying in the United Kingdom was 102, compared with 98 in 1971 and 106 in 1970.(21)

As the number of members of the British Dietetic Association practising in the United Kingdom in 1973 was 747, it would appear that the number of dietetic students recruited and trained is far in excess of the numbers required to replace retirements and resignations.

Whether this is a deliberate policy to counteract an expected wastage of large numbers of students after qualification or with an expectation that many more posts for dietitians would become available in the near future is a question outside the remit of the present survey. The number of dietitians employed as dietitians outside the health service is not known. There is no indication at the present time that a large increase in the number of posts for dietitians is contemplated either within or outside the health service. It would appear reasonable, however, to suggest that there is a need for manpower studies to be carried out, to establish the relationship between the number being trained and the manpower needs of the service.

Training of dietitians

Training is carried out in England at the University of Surrey, at Leeds Polytechnic, at the Queen Elizabeth College in London and at the North London Polytechnic. Until 1973 training was also carried out at Ealing Technical College in London.

Three different courses are available, (a) a comprehensive four-year course leading to a degree, (b) a comprehensive three-year course, and, (c) an intensive eighteen-month course for students who already possess a specified degree or nursing or diploma qualifications. The emphasis in the training is not unnaturally, on science, including food science and nutrition (61% of recommended hours) and food preparation (23%), the remaining time being spent in learning administration, management, teaching methods, and behavioural sciences. There is a minimum requirement of twenty-four weeks practical training in a hospital dietetic department.

Deployment of dietitians

It has been recommended that, "so far as is practicable, a senior or chief grade dietitian should be employed as Group Dietitian to cover the whole of a Hospital Management Committee or Board of Governors group of hospitals, and that dietitians working under her supervision should be located in individual hospitals where the volume of work justified such appointments."(9) From the survey, it appeared that only 163 (58.4 %) of hospital management committee groups employed dietitians and that almost half the establishments were for single-handed posts.

With the trend towards involvement with the nutrition and diet of all hospital patients, and of groups or individuals in the population together with reorganisation of the National Health Service, thought should be given to the possibility of providing dietary services at Area Health Authority rather than district level. The provision of "area dietetic departments" could produce a potential for providing training posts on hospital dietetic departments which cannot be recognised individually because of the shortage of supervising staff. Such training posts could increase the variety of experience gained by the students and may encourage a more even distribution of dietetic services over the country.

Functions

Information obtained from the survey suggested that there was an increasing tendency for dietitians to play a supporting and advisory role to other workers who in turn delivered dietary advice to individual patients.

Dietetic advice is given to a patient in many cases by a doctor, nurse or para-medical worker, and the content of the advice is such that the skills of a trained dietitian are unnecessary. With the exception of certain rare diseases and of specialised units, e.g. metabolic, renal, or intensive care, much advice on diet relates to that of adequate nutrition rather than specific diet, and this applies to patients in hospitals no less than groups and individuals in the community.

The survey has found that there was an extensive involvement by dietitians in the weight reduction of obese patients, yet there is little evidence to show that the delivery of dietetic advice to such patients, either when given by a

dietitian or by any other agency, produces long-term benefits. Without such evidence, or of evidence to support the view that the skilled dietitian achieves greater success than other workers in this field of advice on weight reduction, there is no justification for referring so many cases of obesity to the dietitian, or of the dietitian becoming so extensively involved in treating such patients.

The functions of dietitians in hospitals were defined in an official memorandum in 1971[9] and several recommendations were made. It would appear from the present survey that the uneven distribution of dietitians between different regions, mentioned in the memorandum, is still present and that the recommendation that "dietitians should be encouraged to co-operate with the staff of local authority Health and Welfare departments", has been implemented to a varying degree in different hospital groups. The changes which have occurred in recent years suggest that a review at National and local level is needed to examine the nature of the implementation of the recommendations contained in the memorandum.

Some extension of the work of the hospital dietitians into the community, the comparatively recent innovation of the employment of dietitians in a small number of local health authorities and an even smaller number in general practice was observed in the study. These efforts at introducing skilled dietary advice in the community and to patients residing in the community were perceived by the dietitians concerned as being unlikely to make much impact on the needs of the community for dietary and nutritional advice.

The needs for a job description of a dietitian in the community was expressed by those interviewed and by the other respondents. The dietitians employed in local health authorities and in general practice as well as those hospital dietitians who had extended their work outside the hospital were each working in different ways.

There would appear to be three separate, though by no means mutually exclusive, aspects to the functions of a dietitian in the community that might be developed, provided they could be shown to be efficient and effective:-

(i) Therapeutic diets

A number of patients, though probably many fewer than was thought formerly, still require therapeutic diets. Some of these patients will benefi-

from direct individual consultations with a skilled dietitian while many will continue to receive dietary advice from doctors, health visitors and nurses. The dietitian should be available to work in close association with the primary care team by providing advice and help for such patients in compiling suitable diets.

(ii) Vulnerable groups

Dietary advice alone cannot correct the nutritional deficiences which may exist in vulnerable groups. Nutritional problems may be due to one or more varied reasons, e.g. the housebound elderly who are unable to shop for food, or the low income families or individuals who are unable to purchase adequate quantities of food. The prime concerns are the identification of such groups and individuals and an awareness, by all community care workers of the importance of eliciting information about the nutritional intake of such people.

The delivery of much dietary and nutritional advice will continue to be carried out by the many varied workers, both professional and non-professional who provide health care in the community. The function of the dietitian could be to provide advice to these workers on specific dietary problems when required, and by supplying suitable material on nutrition and diet for display purposes or for issue to patients and others.

The skills and expertise of the dietitian could also be used in advising on the nutritional aspects of meals supplied by the home meals and school meals services, at luncheon clubs, day centres and welfare homes.

(iii) General Nutritional Advice

Information and advice on nutrition and diet is presented extensively by the mass media. In many cases this is related to the advertising of products and in some cases is heavily biased. There is a need for objective information to be given in nutrition and diet, particularly in relation to the frequency of obesity and the problems of over-eating. The dietitian in the community might be involved in health education as it relates to nutrition. The study has shown that many dietitians both in hospital and community employment were delivering lectures on diet and nutrition. This however, was in most cases a spare-time activity, not an integral part of the working day.

If the dietitian is to become involved in the health education field a close association with teachers, health education officers, where these exist, and with health visitors is necessary. Much greater emphasis must be placed in the training schedules of dietitians on the understanding of habit formation, methods of persuasion, and on effective teaching techniques.

The aims of the community dietitian have been specified recently (October 1973) by the British Dietetic Association as:-

(a) to promote health
(b) to prevent disease

by promoting improved nutrition in the population at large and notes for guidance have now been produced (see appendix 6).

The emphasis in these notes is quite clearly towards that of providing an advisory service to other workers in the community and of assuming an educational role. As stated in the preamble to the notes, they are not intended to provide a job description. The extent and volume of the work listed would appear to be too great for any one dietitian, but serves to highlight those areas of potential activity and to indicate the relationship between the dietitian working in the community and other professional or non-professional workers. The notes also demonstrate the acceptance by the executive of the British Dietetic Association that the role of a dietitian in the community is not that of giving advice on therapeutic diets to patients, but is one of stressing the importance of adequate balanced nutrition to all members of the community.

However, further developments in the field of community dietitians require that:-

1. The objectives, in terms of outcome, must be defined in respect of those recommendations expressed by the British Dietetic Association.

2. The specific skills and role of the dietitian must be clearly identified and related to the objectives, and

3. A limited number of experiments is set up to evaluate the effectiveness and to measure the efficiency of the dietary services which would result from implementation of the recommendations.

It is recommended that these actions should be taken before a national extension of community dietetic services occurs.

TABLE 1

Responses to Postal Questionnaire - by authority and type of response

	Local Health Authority	Hospital Management Committees	Teaching Hospitals
From first mailing	148 (95%)	260 (93%)	30 (88%)
From reminder	8 (5%)	16 (6%)	3 (9%)
Non response	0	3 (1%)	1 (3%)
Total	156 (100%)	279 (100%)	34 (100%)

TABLE 2

Number of authorities who have establishments for dietitians

By authority, establishment and employment of dietitians

	Authorities					
	County council	County borough council	London borough council	Hospital management committee	Provincial teaching hospitals	London teaching hospitals
Dietitian employed	2 (4%)	4 (5%)	3 (9%)	147 (52%)	9 (100%)	16 (64%)
Unfilled establishment	0	2 (3%)	0	17 (6%)	0	2 (8%)
No establishment	43 (96%)	72 (92%)	30 (91%)	111 (40%)	0	6 (24%)
Not stated or no reply	0	0	0	5 (2%)	0	1 (4%)
Total	45 (100%)	78 (100%)	33 (100%)	279 (100%)	9 (100%) *	25 (100%)

Percentages are in parentheses and are down each column

* Does not include Nottingham and Southampton teaching hospitals.

TABLE 3

EMPLOYMENT OF DIETITIANS BY LOCAL HEALTH AUTHORITIES IN ENGLAND

Employing authorities	Total number	No.with established posts	No.with 2 full-time dietitians	No.with 1 full-time dietitian	No.with 2 part-time dietitians	No. with 1 part-time dietitian	No.with established posts but no dietitians	Total no.of dietitians employed
County councils	45	2	0	1 (1970)	0	1 (1972)	0	2
County borough councils	78	6	1 (1949) (1971)	1 (1969)	0	2 (1972,1972)	2	5
London borough councils	33	3	0	1 (1972)	1 (1965)	1 (1972)	0	4
Total	156	11	1	3	1	4	2	11

N.B. The dates of appointment are quoted in parentheses

TABLE 4

EMPLOYMENT OF DIETITIANS BY OTHER LOCAL AUTHORITY DEPARTMENTS

Department	County councils	County boroughs	London boroughs	Total
Social services	0	2	1*	3
Education	3	5	3**	11
Education & social services	0	1	1	2
None	26	47	20	93
No reply	16	23	8	47
Total	45	78	33	156

* Also employs LHA dietitian

** One authority also employs two LHA dietitians

TABLE 5

Number of hospital groups in England
who have established posts for dietitians

(R.H.B. areas and teaching hospitals shown separately)

Area	Number of groups	Number with no established posts	Number with only one part-time post	Number with only one full-time post	Number with two full-time posts	Number with more than two full-time posts	Non response or no reply
I Newcastle	30	20	1	8	-	1	-
II Leeds	18	5	2	4	2	4	1
III Sheffield	28	10	3	7	3	5	-
IV East Anglia	12	8	-	1	1	2	-
V N.W. Met.	23	8	1	5	3	6	-
VI N.E. Met.	19	5	-	4	4	5	1
VII S.E. Met.	22	7	1	7	3	3	1
VIII S.W. Met.	23	10	-	8	1	3	1
IX Wessex	11	4	-	3	1	3	-
X Oxford	11	3	1	3	3	1	-
XI S. Western	24	13	1	6	2	1	1
XII Birmingham	18	6	-	7	1	4	-
XIII Manchester	29	10	3	7	5	4	-
XIV Liverpool	11	2	-	4	4	1	-
Provincial teaching hospitals	9	0	-	-	-	9	-
London teaching hospitals	25	6	1	3	1	13	1
Total	313	117	14	77	34	65	6

TABLE 6

Number of established posts for hospital dietitians in England

(By career grade and showing R.H.B. and Teaching Hospitals separately)

Area	Group dietitian		Chief dietitian		Deputy chief dietitian		Senior dietitian		Basic grade dietitian		Total	
	RHB	TH	RHB	TH	RHB	TH	RHB	TH	RHB	TH	RHB	TH
I Newcastle	1	-	1	2	-	1	8	-	3.4	7.5	13.4	10.5
II Leeds	3.3	1	2	-	1	1	6.5	-	14.5	7	27.3	9
III Sheffield	6	1	2	-	-	-	11.3	3	12.6	2	31.9	6
IV East Anglia	1	-	1	-	-	-	2	2	6	3	10	5
V N.W. Met.	1	4	2	2	1	4	13.5	11.2	15.6	16.8	33.1	38.0
VI N.E. Met.	4	1	1	1	-	2	14	1	11	9	30	14
VII S.E. Met.	1	1	1	1	-	1	11.7	2	9	7	22.7	12
VIII S.W. Met.	1	3	2	-	-	1	10.1	4	7.0	13.2	20.1	21.2
IX Wessex	3	/	-	-	-	/	7.5	-	4.2	-	14.7	-
X Oxford	2	1	-	1	-	-	5.9	2	5.5	8	13.4	12
XI S. Western	3	1	-	-	-	-	6.8	1	5	3.3	14.8	5.3
XII Birmingham	1	1	1	1	-	-	13.4	2	11.6	4.8	28	8.8
XIII Manchester	4	-	2	-	-	1	14.5	2.4	14	3	34.5	7.4
XIV Liverpool	1	1	-	-	-	-	10	2	4	3.5	15	6.5
Total	32.3	16	15	8	3	11	135.2	32.6	123.4	88.1	306.9	155.7
	48.3		23		14		167.8		211.5		464.6	

TABLE 7

Dietitians (w.t.e.) employed in hospitals in England

(By career grade and showing R.H.B. and Teaching Hospitals separately)

Area	Group dietitian		Chief dietitian		Deputy chief dietitian		Senior dietitian		Basic grade dietitian		Total	
	RHB	TH	RHB	TH	RHB	TH	RHB	TH	RHB	TH	RHB	TH
I Newcastle	1	-	1	2	-	1	3	-	2.3	7.5	7.3	10.5
II Leeds	3.3	1	2	-	1	1	6.5	-	9.1	5	21.9	7
III Sheffield	2	-	2	-	-	-	10.2	2	9.1	1	23.3	3
IV East Anglia	1	-	1	-	-	-	2	2	6	2	10	4
V N.W. Met.	1	4	2	2	1	4	13.5	11.2	14.3	16.5	31.8	37.7
VI N.E. Met.	2	1	1	1	-	2	10.5	1	7.3	9	20.8	14
VII S.E. Met.	1	1	-	1	-	-	11.7	1	6	7	18.7	10
VIII S.W. Met.	1	3	2	-	-	1	9.7	4	6	13.2	18.7	21.2
IX Wessex	3	/	-	/	-	/	6.5	-	4.2	-	13.7	-
X Oxford	2	1	-	-	-	-	6.5	2	5.5	8.1	14.0	11.1
XI S.Western	2.5	1	-	-	-	-	5.8	1	4	3.3	12.3	5.3
XII Birmingham	1	-	-	1	-	-	9.8	2	4.5	4.8	15.3	7.8
XIII Manchester	3	1	2	-	-	1	10.5	1.4	6.4	3	21.9	6.4
XIV Liverpool	-	1	-	-	-	-	5.5	2	1	2	6.5	5
Total	23.8	14	13	7	2	10	111.7	29.6	85.7	82.4	236.2	142
	37.77		20		12		141.3		168.1		379.2	

TABLE 9

Distribution of hospital dietitians (w.t.e.) employed in England

R.H.B.* Area	Dietitians per 100,000 popn.	Dietitians per 10,000 hosp. beds	Dietitians per 10,000 discharges **
I Newcastle	0.58	7.7	0.5
II Leeds	0.89	10.6	0.8
III Sheffield	0.57	9.1	0.6
IV East Anglia	0.79	11.8	0.9
V N.W. Met.	1.68	20.3	1.3
VI N.E. Met.	1.03	13.5	0.9
VII S.E. Met.	0.81	10.5	0.7
VIII S.W. Met.	1.23	10.9	1.0
IX Wessex	0.67	9.4	0.7
X Oxford	1.25	20.4	1.1
XI S.Western	0.55	6.4	0.5
XII Birmingham	0.45	6.4	0.5
XIII Manchester	0.62	8.3	0.6
XIV Liverpool	0.52	5.9	0.4
Total	0.78	11.2	0.3

* Teaching hospitals are included in relevant R.H.B. area.

Source of popn. and bed and hospital discharge statistics: Health and Personal Social Services Statistics 1972 H.M.S.O.

** Based on "Discharges and deaths during 1970"

TABLE 9

Number of current advertisements (w.t.e.) for hospital dietitians in England

(By career grade and showing R.H.B. and Teaching Hospitals separately)

Area	Group dietitian		Chief dietitian		Deputy chief dietitian		Senior dietitian		Basic grade dietitian		Total	
	RHB	TH	RHB	TH	RHB	TH	RHB	TH	RHB	TH	RHB	TH
I Newcastle	-	-	-	-	-	-	4	-	0.36	-	4.36	-
II Leeds	-	-	-	-	-	-	-	-	1	2	1	2
III Sheffield	2	-	-	-	-	-	2	-	2	-	6	-
IV East Anglia	-	-	-	-	-	-	-	-	-	1	-	1
V N.W. Met.	-	-	-	-	-	-	1	-	1	0.27	2	0.27
VI N.E. Met.	1	-	-	-	-	-	2	-	2	-	5	-
VII S.E. Met.	-	-	1	-	-	1	-	-	2	-	3	1
III S.W. Met.	-	-	-	-	-	-	-	-	-	-	-	-
IX Wessex	-	/	-	/	-	/	1	/	-	/	1	/
X Oxford	-	-	-	-	-	-	-	-	-	-	-	-
XI S. Western	-	-	-	-	-	-	-	-	-	-	-	-
XII Birmingham	-	1	1	-	-	-	2	-	1	-	4	1
III Manchester	-	-	-	-	-	-	4	1	1.73	-	6.73	1
XIV Liverpool	-	-	-	-	-	-	2	-	2	1	4	1
Totals	4	1	2	-	-	1	18	1	13.09	4.27	37.09	7.27
	5		2		1		19		17.36		44.36	

TABLE 10

Open Access to Hospital Dietetic Departments by General Practitioners

Number of hospital groups by number of patients referred in one calendar month (October 1972)

Referrals in calendar month	Number of hospital groups
5 patients or more referred	30
1 - 4 patients referred	62
No patients referred	14
No open access	58
Not stated	7
Total number of hospital groups employing dietitians	171

TABLE 11

Patient contact outside hospital

Number of hospital groups in which dietitians attend individual patients outside hospital

By place and frequency of attendance

Frequency of attendance by dietitian	Patients located in			
	G.P. Surgeries	Health centres	Welfare accommodation	Own homes
3 or more times per month	4	3	1	2
1-2 times per month	-	2	2	10
Less than once per month	2	6	14	62
Not at all	158	153	147	90
Total	164	164	164	164

N.B. 1. No hospital group appears more than once in the "3 or more times per month" category

2. Only two groups appearing in the first row across also appear in the second row

TABLE 12

Visits to institutions

Number of hospital groups in which dietitians visit institutions to give general dietary advice

By place and frequency of visit

Frequency of visit by dietitian	School meals centres	Schools	Special schools	Welfare accommodation
3 or more times per month	-	-	2	2
1-2 times per month	-	1	1	2
Less than once per month	4	20	20	13
Not at all	160	143	141	147
Total	164	164	164	164

N.B. 1. Only one hospital group appears twice in the first two rows across

TABLE 13

Informal Discussions with Community Workers

Number of hospital groups in which dietitians hold informal discussions with community workers

By type of community worker and frequency of discussions

	General practitioners	Health visitors	District nurses	District midwives	School meals organisers	Home meals organisers	Welfare accommodation staff	Other
3 or more times per month	16	22	3	-	-	1	-	9
1-2 times per month	40	27	11	2	7	1	4	8
Less than once per month	71	68	47	18	41	25	46	25
Total	127	117	61	20	48	27	50	42

N.B. Based on 164 fully completed questionnaires

TABLE 14

Attendance at Outpatients by hospital dietitians

Number of hospital groups in which dietitians attend patients in outpatient depart ent

By disease category and by frequency of consultation

Disease category	Every time patient attends	Occasionally	Never
Obesity	112	47	4
Diabetes	49	108	6
Coronary artery disease	17	125	21
Chronic renal disease	68	85	10
Malabsorption	42	105	16
Vitamin deficiencies	22	99	42
Obstetric	12	101	50
Other	32	53	73

N.B. Based on 163 replies to this question

TABLE 15

Provision of dietary advice after patient is discharged from hospital

Number of hospital groups by method used and by frequency

	Dietitian visits patient's home	Dietitian requests patients to return to diet.dept.	Dietitian contacts G.P.	Dietitian contacts H.V.	Other
For every patient	-	57	2	1	1
Occasionally	59	102	105	88	37
Never	105	5	57	75	125

TABLE 16

Lectures on nutrition and dietetics

Number of hospital groups in which hospital dietitians lecture
By type of audience

Type of audience	Number of hospital groups
General practitioners	31
Health visitors	39
District nurses	33
District midwives	19
Social workers	10
Home helps	8
Home meals organisers	4
School meals organisers	3
Schoolchildren	29
School teachers	7
Voluntary organisations	81

Based on 164 fully completed questionnaires

TABLE 17

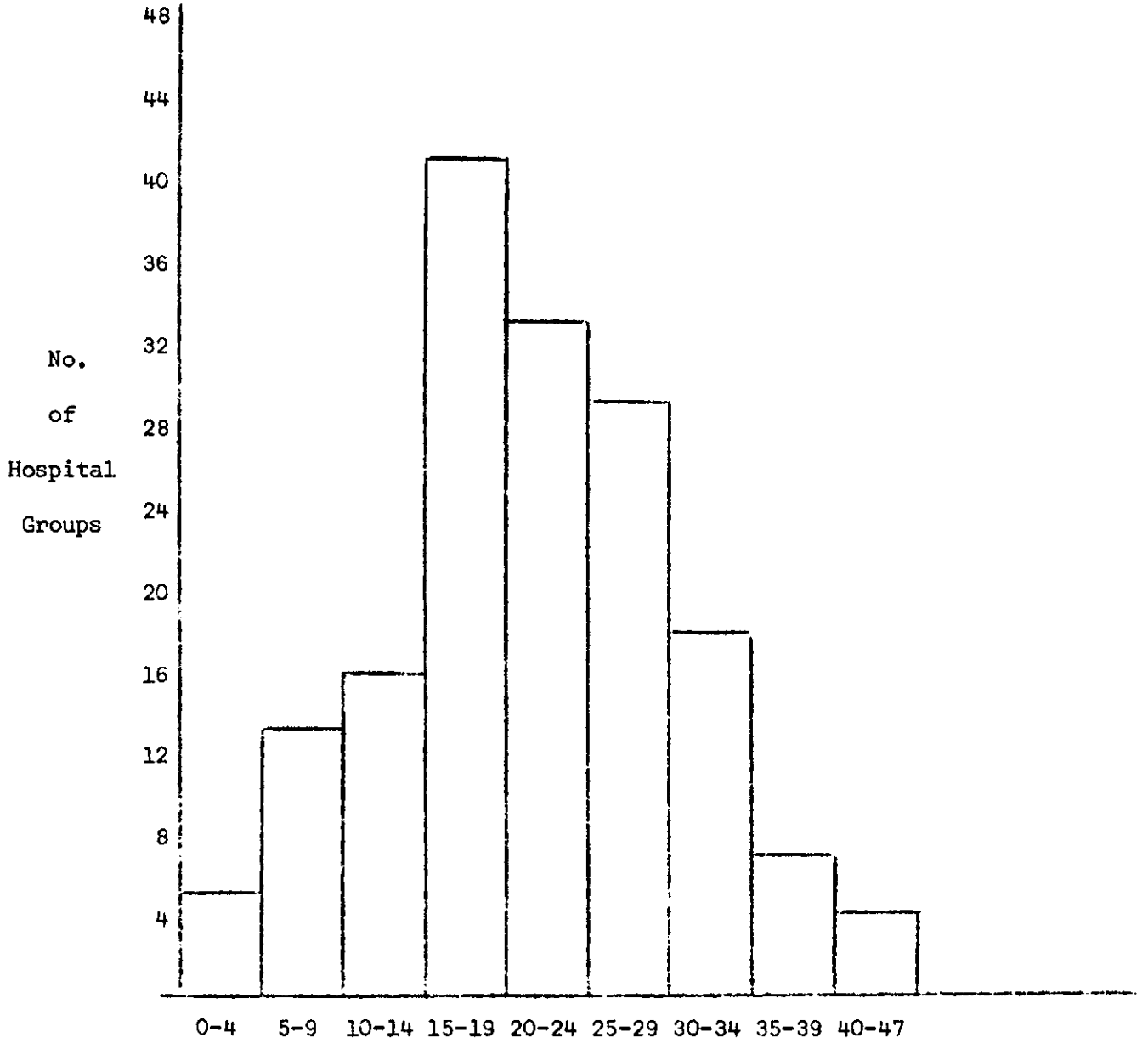
Lectures on Nutrition and Diet

Number of hospital groups in which hospital dietitians lecture, by numbers of different types of audience receiving lectures by the dietitians in each group

Number of different types of audience	Number of hospital groups
7 or more	2
6	10
5	6
4	16
3	20
2	27
1	37
0	46
Total	164

TABLE 18

EXTENT OF COMMUNITY COMMITMENT OF HOSPITAL DIETITIANS



(Possible Total = 109)

Based on 164 fully completed questionnaires

TABLE 19

Adequacy of Dietetic Services to the Community

Opinions of Local Health Authority M.O's.H.
by employing authority

Employing authority	Services adequate	Services inadequate	No answer
County councils	29	10	7
County boroughs	47	23	8
London boroughs	21	9	3
Total	97	42	18

TABLE 20

Adequacy of Dietetic Services to the Community

Opinions of Local Health Authority M.O's.H.
by employment of LHA Dietitians

	Services adequate	Services inadequate	Total
Dietitian employed	7	3	10
Dietitian not employed	90	39	129
Total replies	97	42	139

PROGRAMME

11.00 a.m.	Coffee
11.25 a.m.	Introduction
11.30 a.m.	Paper: Exploratory Study of Dietitians in the Community. Dr. K. Sheridan Dawes
12.40 p.m.	Sherry
1.00 p.m.	Lunch
2.15 p.m.	Discussion: Size and nature of the nutritional problems in the country. Differences between diet and nutrition
2.35 p.m.	Discussion: Contribution of dietitians to the problems. Contribution of Health Visitors. Health education on nutrition for vulnerable groups in the population and for individuals.
3.00 p.m.	Discussion: Organisation of services. Location of dietitians, relationships with hospital dietitians and community professional workers.
3.30 p.m.	Discussion: Education and training of dietitians and health visitors.
3.50 p.m.	Conclusion
3.55 p.m.	Tea

List of Participants

J.M. Bevan	Deputy Director, Health Services Research Unit, University of Kent at Canterbury.
Miss P. Brereton	Chief Dietitian, Northwich Park Hospital, Watford Road, Harrow, Middx. Vice Chairman. British Dietetic Association.
Dr. K. Sheridan Dawes	Senior Research Fellow, Health Services Research Unit, University of Kent at Canterbury.
Mrs. R. Dowie	Research Fellow, Health Services Research Unit, University of Kent at Canterbury.
Dr. T. Eimerl	Department of Health and Social Security.
Dr. A.J. Essex-Cater	County Medical Officer, Monmouthshire County Council.
Miss Jean Marr	M.R.C. Social Medicine Unit, The London School of Hygiene and Tropical Medicine.
Miss B. Maurice	Senior Health Visitor Tutor, Medway and Maidstone College of Technology
Miss C. Murland	Group Dietitian, North Middlesex Hospital. Chairman, British Dietetic Association.
Miss J. Okell	Dietitian, Health Education Department, Hertfordshire County Council.
Mrs. N. Thomson	Group Dietitian, Ipswich Hospital.
Miss P. Torrens	Department of Health and Social Security.
Dr. K.O. Vickery	Medical Officer of Health, County Borough of Eastbourne.
Professor M.D. Warren	Director, Health Services Research Unit, University of Kent at Canterbury.
Dr. R. Yorke	General Practitioner, Maghull, Lancashire.
Dr. J. Wilkie	The London School of Hygiene and Tropical Medicine.

Professor Warren welcomed the participants and gave a brief account of the background to the study. He pointed out that the original possibility of carrying out an evaluation of dietetic services in the community was found to be seriously hindered by a lack of recorded evidence of such activities, and by the difficulties of obtaining suitable indices of measurement. It was therefore decided to carry out a study to examine the current experience in the field of community dietetic services.

The objectives of the conference were to obtain the reactions to the preliminary findings of the study of those professional workers who were involved in community care or the delivery of dietetic services and to provide a basis for discussion of the present situation with experts in these fields.

Dr. Dawes then presented a paper summarizing the preliminary results of his study following which there was a discussion relating to the findings.

Dr. Yorke raised the subject of the observed frequency of attendance of obese patients in hospital dietetic departments, as he had believed that few obese patients were referred to hospital except in extreme cases, but the hospital dietitians were unanimous in confirming the findings of the survey, as their own experience suggested that many cases of simple obesity were referred to hospital dietitians.

Dr. Eimerl expressed his interest in the observations concerning the uneven distribution of hospital dietitians, and wondered about the reason underlying such differences; whether the provision of this as with other services was related to the expectations of the people in an area and the perceptions of the role of those delivering the service or whether one could discover other social and environmental factors which influence the provision of health services.

Miss Torrens mentioned the problem arising from the fact that many dietitians were married women whose geographical location depended on the location of employment of their respective husbands, and that vacancies were often filled only when the husband of a dietitian became employed in that area. Another factor was that in those hospital groups where failure after a period of time to attract applicants for dietetic appointments produced the tendency to re-allocate funds, thus making it difficult to employ a dietitian if one moved into the area.

Dr. Vickery suggested that appointments were often made as the result of

local individual initiative, that if someone was sufficiently interested and enthusiastic about a subject, steps were taken to establish a post or a department.

Mr. Bevan asked whether in those areas which were relatively short of dietitians lecturing and group sessions were carried out by the dietitian in order to maximise the distribution of her services.

Dr. Dawes replied that from the interviews, it would appear that the method of working was related entirely to the personal preference of the dietitian, that some preferred individual consultation while others preferred to spend their time in education and supervising groups.

Miss Okell stated that this raised a fundamental issue: Who should deliver the advice? In view of the shortage of dietitians it would seem better for health visitors and others to give dietary advice than for the dietitian to attempt this herself. In this way the service could be delivered to a much larger proportion of the population.

Miss Maurice commented on the results of the survey which showed that the district nurse was rarely contacted by the hospital dietitian and suggested that in many ways the district nurse was a more suitable source of dietary advice than the health visitor, particularly in respect of special diets.

Dr. Essex-Cater, however, disagreed with the view and stated that not only in the preventative aspects but in contacts with the hospital and attachments to general practice, it was the health visitor who assumed a major role. The link between diabetic clinics and health visitors had existed for many years and some authorities had appointed health visitors to deal exclusively with diabetic patients.

Professor Warren asked if this point could be left over until later in the day as the aim at this stage was to discover whether everyone agreed that the study had presented a reasonable picture of the present situation in order that we could take up the issues highlighted by the findings.

Dr. Vickery stated that he was surprised at the extent of community involvement of the dietitians that had emerged, and expressed surprise that they could find time to carry out this work.

Dr. Dawes commented that many of these activities were carried on outside working hours, as, for example, in the lectures on nutrition given by dietitians and attendance at slimming clubs which were evening activities. It was obvious during the course of the study that dietitians worked for much longer periods than the statutory 37-hour week.

Miss Marr commented on the recent trends towards the delivering of dietetic advice in the community, stating that until very recently only three dietitians were known to be employed in local authorities.

Professor Warren asked if the work in the community which was carried out by the hospital dietitians attracted fees or whether, as for instance with lectures, the arrangement was a purely personal one.

Dr. Vickery said that the extent of work in the community carried out by the hospital dietitians was made an even more remarkable finding by the fact that in general terms there was no remuneration for this extra work.

Miss Torrens also commenting on the recent nature of community dietetic services felt that the impetus usually came from the medical and administrative staff who, if community orientated, allowed the hospital dietitian to develop these links with the community, and that this community orientation had been developing rapidly in the past five or six years.

Miss Marr stated that the most interesting result of the survey was that a considerable change had occurred in staffing over the past six years. A study of the deployment of dietitians which she had undertaken in 1967 showed a much greater concentration of dietitians in the teaching hospitals.

Miss Torrens agreed with this view of the change in distribution in the past six years and suggested that the establishments in teaching hospitals had remained at the same level while any increase in employment had taken place in non-teaching hospitals.

Professor Warren in closing the morning session, stated that it would seem that the results of the study had stood up well to criticism and that we could discuss the problems highlighted by the study during the afternoon session.

Professor Warren, in opening the afternoon session, said that the conference should now focus on meeting the needs and on the implication, as for example in organisation and education, of improving the service. This must be considered with reference to the impending reorganisation of the health service in 1974. Initially we must be clear about what problems we are trying to solve before discussing the implications.

Dr. Dawes stated that the subject of obesity had already been mentioned during the morning session and that, numerically, this was the most important problem facing the dietitians. Problems existed in obtaining acceptable definitions and measurements of obesity, and claims of the prevalence of the condition varied, some authorities even suggesting that 40% of the adult population in this country was overweight. The importance of obesity lay in its association with degenerative disorders and with increased mortality, and recent work on adipose cells and on infant obesity suggested that the problem should perhaps best be tackled in patients in their first year of life. Commercial interests in the food and drug industry and the success in the sales of magazines and "special" slimming foods indicated both the interest in the subject and the pressures applied to the population. Claims of success in the treatment of adult obesity tended to be overestimated, often because these claims related to people who completed a course and did not take into account those who defaulted.

Diabetes mellitus is said to affect 500,000 people and possibly 7% of the population has a raised blood sugar level. He was sure the delivering of dietary advice to these patients could be improved by improved organisation.

Problems exist with the diets of the immigrant population. Recent work had suggested a relation between the high phytic acid content of chapates with rickets and osteonalacia, and the possibility of genetic influences on the ability to synthesise Vitamin D in a country with a reduced amount of sunshine somewhat less than their native land.

The work of Exton-Smith and Stanton had indicated problems in the nutrition of the elderly, particularly those who were housebound, and concern is expressed, though no figures are available, of the problems of families on low income.

There are still areas of doubt and discussion about mild vitamin deficiences and whether some groups, particularly the elderly, are receiving an inadequate intake of these substances.

Inborn errors of metabolism and the malabsorption diseases are being increasingly understood and require expert dietary advice. Continuity of care is a problem in this field, for the affected child eventually terminates care by paediatricians at a time when social pressures and other factors tend to produce a reaction against continuing a strict dietary regime.

New dietary problems are arising with the modern treatment of chronic renal disease and in intensive care units, when highly complicated specific dietary regimes are required.

Professor Warren then asked if the conference could offer any other problem areas which they considered important.

Miss Torrens suggested that a large area of need lay in giving dietary and nutritional education to those who were caring for the mentally handicapped patients. She stated that in many cases hospitals did not realise the need for attention to the nutritional intake of psycho-geriatric and the mentally affected, physically handicapped patients.

Dr. Essex-Cater expressed surprise at this, as in his experience he considered obesity was the major problem in these patients, unlike other countries he had visited in which the money available for feeding mentally ill patients was less than in this country.

Dr. Wilkie suggested that patients with tumours of the gastro-intestinal tract were a vulnerable group, particularly where treatment with radiation had been carried out. These patients were often restricted to a fluid or semi-solid diet for long periods and were at risk of inadequate nutritional intake.

Dr. Vickery agreed with the statements about vulnerable groups and individuals, but said that we should also focus on the preventive aspects of nutrition. The mother of a family tended to feed her family on foods which were stocked at the supermarket and was influenced by the advertisements of the mass media. People with somewhat less than adequate resources tended to concentrate on eating a diet high in refined carbohydrates and low on other nutritive items. The work of Burkitt and Painter concerning diverticulitis and many other disorders which they have claimed result from inadequate roughage in the diet, and the extent of dental caries imply that for many people the dietary intake is less than satisfactory. I would see the dietitian in the community as someone associated with the health education officer and the health visitors, concentrating her skills on the preventive aspects of nutrition.

Dr. Eimerl in agreeing with the importance of the preventive aspects of nutrition quoted the experience of countries like Japan where a change to Western-type diets had been accompanied by the appearance of new disorders though this could not, as yet, be accepted as a cause and effect situation.

Dr. Yorke asked for the opinion of the dietitians on diet in peptic ulcer patients, as dietary advice to these patients formed the second largest category seen by his practice dietitian. He felt that there was a definite place for advice on dietary habits to these patients.

Mrs. Thomson agreed that there was a place for dietary advice in these conditions, but stated that this advice must be on dietary habits, not on special semi-solid diets or on swallowing large quantities of milk as had been advised in the past.

Dr. Dawes said that most of the dietitians who were interviewed stated that they spent a considerable time taking people off diets which had been prescribed many years ago which were now thought to be too restricting or were actually unnecessary. It appears that what is now needed in many disorders is advice on nutrition and correction of faulty diets rather than on specific therapeutic diets.

Mrs. Dowie commented on the problems of food allergies, particularly in children and wondered whether this was an important problem for the dietitian.

Mrs. Thomson stated that this was a problem and was one in which there needed to be close co-operation between dietitian and health visitor.

Professor Warren then asked if the conference could now deal with diet and nutrition.

Dr. Dawes quoted the W.H.O. definition of nutrition as "the process whereby living organisms take in and transform extraneous solid and liquid substances necessary for the maintenance of life and growth and the normal function of organs and the production of them". Human nutrition is the scientific discipline of dealing with nutrition in man. Dietetics is defined as the interpretation and application of the scientific principles of nutrition to the human subject in health and disease.

The differences between nutrition and dietetics, on the one hand, are often misunderstood while on the other hand there is generally a lack of liaison and co-operation between the workers in these two separate fields.

Professor Warren stated that it would appear that in the past we tended to think of dietetics in terms of individual advice to a patient and to consider nutrition as a public health activity of promoting "healthy" diets, and wondered whether we should continue to divorce the two activities.

Dr. Yorke said that he felt that the important difference lay in that the former dealt with knowledge while the other dealt with application of that knowledge.

Miss Marr considered that one of the major problems in this situation was a result of the different training programmes for dietitians and for nutritionists, and that dietitians, who have training in nutrition as well as dietetics, are reluctant to allow nutritionists to enter the dietetic field without further training.

Miss Torrens replied that if the nutritionist was to become involved in dietetics they need to have dietetic training, and that although the two professions are separate, this did not preclude close cooperation between the two.

Professor Warren said that the trends shown in the survey were that dietitians were becoming involved in nutrition in the community and that this trend appeared to have general approval. Clearly it is necessary to understand the terms and at the same time not prevent changes which are beneficial becoming hampered by rigid definitions.

Dr. Wilkie asked what were the implications on manpower, and whether nutritionists could be employed to relieve the shortage of dietitians.

Miss Marr commented that in fact there was a dearth of employment for nutritionists and food scientists and many were taking the dietetic diploma course.

Miss Torrens agreed and said that in those areas in which nutritionists were trained, the demand for dietetic diploma courses was increasing. Formerly people attending these courses came about exclusively from institutional management and catering graduates with a few entrants from nursing, whereas at present the greatest proportion of entrants came from graduates in food science and nutrition.

Professor Warren suggested that although the situation had not been clarified, the discussion had certainly emphasised the importance of the problem.

Mrs. Thomson added that the difference was less obvious at individual level, for the dietitian when advising on a specific diet was subconsciously giving consideration to the nutrition of the family, the implications of one of its members being on a diet, the various financial problems involved and the manner in which the diet of one member affected the feeding habits of the family.

Professor Warren suggested that the conference should turn to the problem of the dietitians and the role of other professional workers, particularly with reference to the treatment of obesity.

Miss Okell stated that the prevention of obesity was easier than treating the condition and less time should be spent on the latter. In this field the co-operation between dietitian and health visitor was vitally important, for the health visitor could contribute so much to the knowledge of the social background of the patient and to examining and defining the possible reasons for the obesity.

Miss Gastrell suggested that this was an area in which attachment of health visitors was of great benefit, and provided opportunities for joint action by doctor, health visitor and dietitian.

Miss Maurice agreed with this and expressed the feeling that the most effective method of dealing with obesity was carried out in the patient's home by the health visitor who could then be involved in both the therapeutic and the preventive aspects of the problem. She wondered whether group sessions could be effective as individual problems could not be discussed in such sessions, though one supported the concept of group because it was economical in time and staff.

Miss Torrens also agreed with the importance of dealing with a family unit, as this method ensured that the various problems, including financial, of the family were taken into account and discussed. Widespread effective health education could be carried out in this way.

Professor Warren asked for clarification and elaboration of what could be done to prevent obesity.

Miss Maurice said that experience both as midwife and health visitor had caused her to believe that an excellent time for giving dietary advice was to women during their ante natal attendances. However, this advice appeared to be less often given and less often taken up by the mothers after the birth of their children. One needed to link this ante natal advice with the dietary advice to the mothers and later to the children, preferably advice given by someone who has attended the family throughout the period and who has close liaison with school teachers.

Dr. Yorke agreed that this, from the general practitioner point of view, was an extremely important function of a health visitor, though refresher courses in dietetics and the updating of knowledge was required, for the pressures from commercial interests must be counteracted and developments in the field of nutrition and dietetics must be learnt.

Miss Maurice accepted this need for updating knowledge and suggested that a very useful role of the dietitian would be that of giving lectures on nutrition and dietetics to groups of health visitors as well as to other groups. She was sure that health visitors would welcome this as a more satisfactory way of keeping up-to-date than by reading the literature produced by commercial firms.

Professor Warren said that it appeared there was general agreement that the health visitor should play a major part in delivering dietary advice but that she must have support from a dietitian, both as an expert to whom referrals can be made and as someone who provided continuing education.

He also asked for the views of the conference on the activities in clinics in respect of infant weight gain. Do the staff of clinics use the percentile charts and give advice on the correction of obesity?

Dr. Essex-Cater said that in his own area weighing of infants was only rarely carried out, and was only performed if the mother expressed a strong desire to know the weight of her baby.

Dr. Vickery confirmed this attitude in respect of his area, and said that the health visitors were well enlightened and did not over-use the scales or emphasise the value of the infant's weight, and that the health visitors in his area stress that they are weighing the baby to ensure that he or she has not gained too much weight.

Professor Warren questioned whether the information was widespread and whether mothers were acting upon the advice when it was given.

Dr. Essex-Cater said that the problem of pressures from commercial organisations was again a feature in this situation.

Dr. Vickery agreed and said that he noted the point about the reaction of mothers and that it was something which should be examined.

Dr. Dawes added that concern was being expressed about the increasing number of obese infants, and that this suggested that the message was either not being given or was not being acted upon.

Dr. Essex-Cater stated that he agreed that efforts to prevent obesity must be concentrated on mothers of infants; the damage was done by the time the child started school. School meals he felt contributed little to the calorie or carbohydrate daily intake of schoolchildren because of the money available for supplying these meals.

Dr. Dawes agreed with this, adding that tuck shops and sweet shops in the vicinity of a school contributed much more to the intake of carbohydrates. The dietitians employed by Bristol Health Authority had organised a campaign to try to encourage children to eat fruit and cheese rather than chocolate and sweets.

Miss Okell also agreed that school meals were not a problem but that the "bits and pieces" consumed during the day were a major contribution to obesity.

Professor Warren suggested that the discussion was touching on the point raised by Dr. Vickery about the nutrition of the population generally, for if the population were consuming proper diets the problem of obesity would largely disappear. Other vulnerable groups existed, however, such as the house-bound elderly, the immigrants and low income groups. What was the best approach in these cases? Are we to look to the health visitor for primary advice backed up by the dietitian?

Dr. Essex-Cater answered that in view of the shortage of dietitians the health visitor must be taught by the dietitian to carry out the work.

Miss Marr mentioned the earlier comment about the district nurse being contacted less often than the health visitor, by the dietitian and felt that district nurses could play an important part in delivering dietary advice as they were in close contact with many of the house-bound elderly.

Dr. Essex-Cater disagreed with this and stated that the district nurse only came into contact with people who were ill. Many of the vulnerable groups were not ill and these people should be visited by the health visitor. There were many other demands on the health visitor, however, and not all could be given the time that one would like.

Dr. Vickery in agreeing with Dr. Essex-Cater, added that we should ensure that others in contact with these vulnerable groups such as the increasing number of social workers should be trained to spot nutritional problems and to elicit information about the diets of the elderly living alone.

Dr. Essex-Cater mentioned that home helps were another group of workers who could greatly assist in eliciting vulnerable groups, and commented on the difficulties of liaison now that they were no longer employed by the health department and were not trained by the health authority.

Miss Torrens said that the community dietitian should be concerned in the teaching of nutrition to all local authority department staff.

Dr. Yorke added that he considered it essential that the health visitor should be attached to general practice and that they had a far greater role to play in the field of delivering dietary advice, but was still uncertain of their role and their relationship with the dietitian.

Miss Maurice stated that health visitors were taught basic nutrition and the essentials of diets, usually by dietitians.

Miss Marr commented that not all people visited by the health visitor were in need of dietary advice. The problem was to identify those people who were nutritionally vulnerable, and, most importantly, to be able to offer advice which would be acted upon.

Dr. Essex-Cater suggested that a visit to the home at meal times enabled the health visitor to assess the situation, and Dr. Vickery added that a health visitor could observe the nutritional behaviour of the person visited by examining the larder. It was agreed, however, that these were crude

measures and that further research was needed to define indices of nutritional vulnerability and of methods of screening for high risk individuals.

Miss Brereton commented on the habits and religious principles of many immigrants who required specialised dietary advice which took account of these factors.

Miss Maurice added that those families with social problems generally required financial management advice rather than dietary advice. The greatest difficulty here was in "reaching the person", and in having advice accepted.

Professor Warren said that a project in the computing laboratory at the University was devised to correlate nutritive values of foodstuffs with current costs. Prices of foodstuffs were updated weekly by visits to local shops and costs of diets could be obtained very rapidly. If this was developed and extended a print-out of "best buys" could be made and circulated to the local press each week.

Dr. Essex-Cater stated that his department had tried to produce a weekly list of "best buys" for the elderly. A health visitor compiled the list from her experience of available foodstuffs, making a list of specimen meals to be distributed via the local authority publicity department. The cost of this exercise, however, was found to be prohibitive.

Professor Warren suggested that the cost of the exercise must be largely that of distribution of the information, and that this could be drastically curtailed if the press, both local and national, were willing to print the information without charge. The newspapers would, at least, provide information to the health visitors, if not the vulnerable groups.

Miss Maurice said that we were still faced with the problem of getting the message across to these groups.

Mrs. Dowie asked who these people, especially the families with social problems, listened to. It would appear they do not listen to advice from the health visitor. Do they accept advice from the general practitioner? Is he the person who should be given the training in nutrition and dietetics?

Dr. Dawes said that we should realise that these groups are influenced by certain pressures - Bingo halls are full, people are affected by commercial television and other advertising. We need to emulate these methods and techniques if we are to reach the public. Too much health education is devoted to telling people not to do things, a more positive approach is needed.

Professor Warren suggested that the conference should now turn to the disease groups, of which diabetes appeared to be a major problem in the dietetic field. There were half a million diabetics in this country, mortality rates were increasing particularly in the older age groups. Could it be that there was now less attention paid to diet since the advent of hypoglycaemic drugs?

Miss Murland felt that present hospital diabetic clinics were too crowded to be a satisfactory method of dealing with diabetic patient diets. In her own clinic, a consultant, registrar and dietitian may deal with 80 patients during an afternoon session. Advice on diet to a diabetic patient attending for the first time was ineffective due to the emotional state of the newly diagnosed patient. The dietitian needs to give the dietary advice at a follow up visit, but did not otherwise see the need for subsequent follow up by a dietitian unless problems presented.

Dr. Essex-Cater agreed and said that in many areas it was the health visitor, usually attached to a diabetic clinic, who followed up the patient, and tended to give the advice in the patient's home which allowed the health visitor to take home, financial and other factors into account.

Miss Murland added that it would seem unnecessary for the dietitian to visit the patient's home as the patient was already being visited by the health visitor and possibly the general practitioner.

Mrs. Thomson said that on rare occasions when she had visited patients in their homes she realised how much easier it was to give dietary advice in the patient's kitchen. She suggested that what was really wanted was closer liaison between the professional worker in the community and the hospital diabetic clinic.

Professor Warren commented that this suggested a concept of employing the consultant and dietitian in the hospital providing support and backing for the general practitioner and health visitor who would supply the service to the patient in the community.

Dr. Eimerl stated that we were suggesting a new concept which was still based on existing methods of delivering advice, and wondered whether we should be thinking now of new methods and techniques of delivering the advice rather than merely on which person should be employed to give this advice.

Mrs. Thomson remarked that one of the most important aspects in long term illness was that there must be continuity of care, the patient required to receive the advice from one expert, not from a number of sometimes conflicting experts.

Dr. Eimerl said that we had already touched on the influences and pressures in modern society - television commercials, advertising techniques and impulse buying. Perhaps we are wrong in continuing to exert our influence on a one-to-one basis.

Professor Warren replied that he believed 'modern' approaches should be tried, but one was most worried about the individual in a group session, whether everyone present absorbed the information.

Dr. Vickery claimed that because of the incidence of diabetics and taking account of such problems as the incredible increase in the disease of those Indians who emigrated to South Africa and presumably changed to a new diet, there was an urgent need to develop mass public health programmes.

Dr. Yorke quoted the work of Dr. Midgely who was examining the use of programmed learning techniques in general practice.

Miss Okell, however, pointed out that with diets, it was essential to develop motivation. The knowledge by the patient that someone cared was a prime factor in developing sufficient motivation to continue a diet. It was true that there was a need to disseminate information about nutrition and diet, but feeding was an extremely personal habit and a personal approach was still required in delivering the advice.

Professor Warren commented that what appeared to be developing from the comments was that technological methods can be used as well as personal consultation. Programmed learning could be used to replace some of the follow up consultations or replace part of a consultation.

Dr. Dawes added that with diabetes we had so far identified certain groups as for instance the juvenile diabetic or the mature onset diabetic, but there is still a tendency to manage all diabetics in the same way, irrespective of their ability to absorb advice or cope with diets. There were those within these groups whose intelligence, learning ability, financial status, etc. made them especially vulnerable, yet they were often "swamped" by the numbers attending a clinic, many of whom need not attend for advice.

Professor Warren added that this presented a new area of research work, to identify those groups within vulnerable groups, who by their personalities or other problems required concentrated attention.

We still had two items to discuss: the organisation of dietetic services and the question of training.

In 1974 the three branches of the services were to be unified, and we shall consider the implications of this, particularly in respect of the deployment of dietitians.

Miss Torrens suggested that we needed to develop a service for the whole community, and we should utilise our existing and future resources to this end.

Miss Marr added that a suitable career structure for dietitians must be made an integral part of our thinking on the subject.

Miss Torrens pointed out that the career grading had been under consideration for some time and, in view of the imminent reorganisation of the health service, the need for decisions was becoming increasingly urgent.

Dr. Essex-Cater saw two functions of a dietitian. One was that of delivering advice to individual patients, the other was part of a professional group occupied with preventive medicine. The emphasis on prevention should and must be increased in the future, and therefore the dietitian should be seen as a member of the community care team first and a therapeutic hospital dietitian second.

Miss Torrens asked whether the dietitian needed to be so rigidly divided into two; could she not play both roles? At present dietitians were hospital orientated; is it possible to alter this?

Dr. Essex-Cater said that this depended on numbers of dietitians available and whether they wanted to work in the community.

Miss Torrens added that the hospital medical staff would not welcome withdrawal of dietetic services.

Mrs. Thomson believed that hospital dietitians were in a position to state their views now on dietetic services in the future. Where long-standing arrangements for community dietetic services were in existence, it was probably unwise to make a major upheaval, but any new arrangements and organisation must be carried out with the concept of delivering a service to the whole community.

Dr. Vickery asked for the views of the dietitians present on how they saw their optimum deployment. Where a dietitian was employed by a local health authority medical officer there was a hierarchical relationship. Does she have any such relationship in hospital work? Does she feel professionally isolated? Do dietitians see themselves as members of a team of dietitians separate from and having no wish to belong to medical or nursing teams?

Miss Okell felt that in local health authority employment the dietitian was closely associated with a medically organised team, but in hospital work she merely worked in co-operation with the medical and nursing staff.

Miss Torrens added that, at present, the hospital dietitian is directly responsible to the senior administrator, but works for a number of individual consultants, and that this system appeared to work satisfactorily.

Dr. Yorke suggested that this system would still apply after re-organisation, the dietitian being responsible to the District Administrator, but would carry out the "prescriptions" of the clinicians.

Professor Warren stated that it could be said that the dietitian was responsible, managerially, to the district management team in general matters and to the administrator for detail. The community physician would be another consultant "prescribing" for community dietary and nutritional problems. If more than one dietitian was employed in a district, one of these would be the usual recipient of "prescriptions" from the community physician.

Dr. Essex-Cater commented on the differences in personalities and attitudes and was doubtful of the ability or willingness of some hospital dietitians to accept a community role. He did not accept that the local health authority medical officer was in an hierarchical relationship with the community dietitian. There was a close professional relationship and co-operation, the dietitian working as a professional in her own sphere and occasionally seeking support or guidance from the MOH.

Miss Brereton outlined the system at Northwick Park Hospital whereby a dietetic advisory group, which included medical members and which could discuss such problems as the workload of the dietetic department and uneven referral patterns from consultants.

Miss Torrens asked if the conference was quite certain that the district was the focal point for dietetic services. Was there a need for an area dietitian in a multi-district area?

Miss Marr expressed the hope that an area dietitian would be an acceptable appointment in the not too distant future. The area dietitian would be needed to co-ordinate the dietetic services.

Dr. Yorke asked if the dietitians felt it was a viable concept to employ dietitians in health centres which housed, say, ten to twelve general practitioners, and dealt with a population of around 30,000?

Professor Warren suggested it was essential for the dietitian to at least visit such centres, to talk to doctors and health visitors and to learn of the problems, If there were several districts in an area, which will occur in a few areas, he saw a need for a co-ordinating area dietitian, and this re-introduced the subject of career structure. He did not see a need for a regional dietitian (a view which was agreed by all participants).

Miss Marr reiterated her views on the importance of the career structure and mentioned the possibility of recruiting males into the dietetic profession, with a resultant pressure for a more realistic career grading. The recruitment and retaining of dietitians was a vitally important factor in meeting the needs and demands of a dietetic service.

Professor Warren added that some of the problems we had discussed were those which needed to be tackled at area level. Once or twice the subject of research needs had been mentioned, and it would be most useful to have

a dietitian working with a research intelligence unit in order to look at specific problems and to observe changes and developments in the service.

We should now turn to the important subject of education and training though many aspects had already been discussed. There would appear to be a need for re-orientation courses for hospital dietitians for further training in nutrition and dietetics for health visitors and doctors, and for education of the public.

Miss Murland said that the profession was very aware of the need for training of dietitians in community and preventive care, in communication and educational methods. At present the number of student dietitians was increasing but the problem of providing suitable places in hospital dietetic departments was causing concern.

Dr. Yorke commented on the new "workshop" in community dietetics set up by Professor Truswell at Queen Elizabeth College which had resulted from discussions with the British Dietetic Association.

Dr. Eimerl asked if he could proffer one or two thoughts before the conference ended: "We have heard that we are in a rapidly changing situation. There was still a need for dietitians to give advice to individual patients but there is a larger need for dietetic and nutritional advice to the population. One must seriously question the ability of some 1,100 dietitians being able to cope with such a problem. We have the situation of a small cadre of highly skilled professionals who need to disseminate their knowledge through others. Firstly, we need to know what are the specific skills of a dietitian. Secondly, what function can she alone carry out. Thirdly, what training is required. We may also add, how to implement changes in training most effectively. It may be helpful not to restrict our thinking to the professional approach but to look at the methods and techniques used in industry and commerce when faced with problems of change and of limited resources. Similarly workers in operational research are those who par excellence can examine a skill and suggest methods of meeting defined objectives. Industry, faced with the need to disseminate large quantities of information to a wide audience, employ new techniques such as audio-visual programmed learning. Perhaps we should think of package programmes of dietetic instructions for patients and for other professional workers involved in the care of patients. I may add, with particular relevance to our presence here at a research unit, that we also need monitoring of innovations, of evaluation of changes, and recurrent or even continuous assessment of needs."

Professor Warren, in closing the conference, thanked the participants for their contributions and hoped that the benefit we had gained from the conference had not been one-way, but that those attending had found benefit in attending.

APPENDIX 3

EXTENT OF COMMUNITY INVOLVEMENT OF HOSPITAL DIETITIANS

Scoring Method

		Score
(1)	Open access to general practitioners	
	No answer or no direct access	0
	Yes, but number of patients referred not specified	1
	No patients referred in previous month	1
	One to four patients seen in previous month	2
	Five or more patients seen in previous month	3
(2)	Visits to institutions, formal lectures, informal discussions	
	No answer or never	0
	Less than once a month	1
	Once or twice a month	2
	Three times or more a month	3
(3)	Outpatients seen, advice to patients after discharge	
	No answer or never	0
	Occasionally	1
	Every patient	2

APPENDIX 4

GENERAL COMMENTS OF L.H.A. MEDICAL OFFICERS OF HEALTH

1. L.H.A. Dietitian employed

047 It is only a few weeks since a dietitian took up her appointment with us. My own thinking on the subject is that initially she would be used as as a nutritionist teaching people about nutrition and it would only be secondarily that I would use her to advise patients on diets.

052 The Social Services Directorate and the Borough's Catering Department may also ask for advice from the community dietitian who is on the staff of the Medical Officer of Health.

058 It is worth explaining the position of the dietitians especially in their relationship to the Catering Officer. The two dietitians, whom you will notice are both part-time, share the week Monday - Friday by each working half a day, totalling five half-days. Their primary task is to supervise the preparation of the dietary meals (120 - 140 per day) and they also take part with the Catering Officer in the compilation of the Luncheon Club, Meals-on-Wheels menus. The dietitians are Health Service employees, but the Catering Officer comes under the Director of Administration.

092 In spite of my answer to question (6), I think there is much scope for a greatly improved dietetic advisory service at the eight health centres we have provided (and there are seven more in the pipeline). General practitioners would refer patients who at present receive fragmentary and often only intermittent advice from hospital outpatient dietitians, e.g. coeliacs, diabetics, hypertensive and obesity patients. This would mean employing further dietitians.

2. No L.H.A. Dietitian employed

004 On question 5, although we do not actually employ a dietitian in this department, we have from time to time made use of the services of the dietetic staff based at Addenbrookes Hospital, e.g. to help draw up diet sheets for parents of school children, to advise on diet at school dinners in the case of a child with coeliac disease.

On question 6, the medical staff feel that the answer should be "NO". Groups and individuals in the community may get advice from health visitors, district nurses, health education officers, and also from local authority medical officers at child health clinics and schools. However, in the case of the nurses and health visitors, very little nutrition is taught in this training and even less in the health education training. The Hospital Service is an in-patient one, and the extent to which it is used by the consultants varies with the particular consultant.

As to improvement, it is felt that there is a place in the Local Authority Health Service for a dietitian, to give guidance in matters of nutrition, and to whom health visitors, nurses and others, including general practitioners, could turn for advice and help. At present, the feeding of immigrants is being spotlighted in certain areas, where the dietitian is most useful.

Subject to financial considerations, it is felt that there is a place for dietitians in the Public Health field.

006 More dietitians could with advantage be employed by the peripheral hospitals.

008 Probably the health visitor service should be a sufficient source of advice but for this they will need further training and more reorientation to and among the elderly.

013 Without mounting a special survey I could not estimate either the total unmet need for dietary advice in the county, nor the extent of the work carried out. Health visitors give a great deal of general dietary advice, some are attached to diabetic clinics, nearly all help in interpretation and fulfilling of advice given by dietitians.

018 The present H.M.C. have authority to appoint a hospital dietitian shortly. This should be the nucleus under the Areas Medical Officer of a community Dietary Service, with responsibilities in Health Centres and General Practitioners' Group Premises, and in training of nursing and health visiting staff.

Education staff are already covered by the School Meals Organiser.

The inclusion of the dietitian in the Preventive Services would emphasise the positive aspects of sensible diet in the prevention of certain diseases, as well as the narrower field of merely planning menus for sick people.

019 So far as my knowledge goes from observation of schoolchildren and the extensive nutritional survey undertaken in conjunction with St. Thomas' Hospital and the Department of Health and Social Security, the evidence available to me indicates that adequate nutritional standards exist.

041 This is included in the Health Visitor's training but the Health Visitor's contact with the general public is limited.

The information is available if it is asked for or if it is required by an exisiting patient.

057 Because of the large number of Jewish faith in our community there would be special difficulty in this area.

062 I agree that the appointment of a dietitian would be helpful. I would make such an appointment as part of the staff of our specialised Health Education Unit, which consists of two professional staff supported by a technician. Specific dietary advice could then be given to expectant mothers, to schoolchildren where obesity is a real problem and in industry from whom requests are currently received for slimming advice. Some education of the elderly would also be appropriate.

078 The role of dietitian in the community can best be fulfilled as a member of a team concerned to ensure that the vulnerable groups in society are provided with the most suitable foods to maintain and promote good health. Apart from the dietitian others involved include the general practitioner, the local authority doctor (embracing maternal and child welfare and school health), the health visitor, the midwife, the home nurse, the school nurse, the biology or domestic science teacher, and those giving dietary advice in relation to the school meals service, luncheon clubs for the elderly and the meals on wheels service.

Advice on diet following an illness which has necessitated specialised investigation and treatment is best provided by a dietitian closely linked with the hospital concerned.

Looking to the future there is much to be said for developing a more closely knit nutritional service linking the activities of dietitians inside and outside hospital with the educational efforts of others working in the field of health, education and welfare. Such a concerted approach is essential if an integrated health educational effort is to be mounted in the twin fields of prevention and treatment. 1974 offers an excellent opportunity to take a fresh look at the key subject of nutrition with particular reference to the contribution of the dietitian to the health of the community at large, of which the hospital forms part.

083 This is an industrial area with big families living in corporation estates - the cutting of the School Milk Grant has been felt. Not only for the health of the children but for the mothers as it would seem that many of the mothers are on an inadequate diet.

100 In an authority of this size there would not be sufficient work for a full-time dietitian. As the local authority has very close ties with the clinicians at the hospital, the present arrangement appears to be working quite satisfactorily.

107 Health visitors do a great deal of work in this field but more expert advice required from time to time.

108 When requiring advice from hostels, O.P. homes, sheltered workshops, day centres, etc., I have always been able to call on personnel of the hospital service for such advice, owing to the fact that I am part in the employ of the R.H.B. as well as being M.O.H.

I would agree that there is immense scope for advice to the community over and above what normally passes for Health Education.

109 When the new Area Health Authorities are established in 1974, the hospital dietitians will probably become available for giving advice.

110 I have been M.O.H. for nearly 20 years and none of the women's organisations have ever asked for dieting advice although I include it in a favourite talk - "healthy living". The obese schoolchild is the main problem, and we do encourage them to diet and a printed guide is handed out.

117 In a Utopian society one could do with more dietitians but as the situation exists these services are best used in the hospital field.

123 The Senior Hospital Dietitian, acts as honorary dietitian to health visitors in the department, who are in turn involved in advising patients of the doctors to whom they are attached. I understand the Department of Social Services has a similar arrangement for advising Meals on Wheels service and also catering in the old persons' homes.

There is in my view a considerable opportunity for deployment of dietetic skills within the community.

125 It is thought that more dietary advice could be given through health education programmes.

129 Although we have no post on our establishment for a dietitian we have nevertheless, been investigating the possibility of establishing a project between ours and one of the local hospitals as part of our Health Education Programme. This will involve the organisation of a Weight Reduction Clinic at which advice on diet and food values generally would be promulgated. At the moment, however, these discussions are in a very preliminary stage and we have no copy of a firm scheme which we could show you.

131 (1) Nutrition should be accepted as a subject of public health importance in our society, (2) Education of doctors and nurses, (3) Better teaching of nutrition at undergrad stages (4) Employment by l.h.a's of dietitians, (5) M.O.H. department to provide skilled nutrition advice to other departments - using dietitians in medical/nursing/science team.

I am delighted this subject is being looked at.

136 Information about nutrition is provided through the general health education programme, as follows:-

Ante and post-natal clinics	-	by health visitors
School groups	-	through the general health education programme at the Health Education Centre and in 'Health in Adolescence' courses.
		materials are also provided for teachers including leaflets, films, and background information
General public	-	in response to specific requests for information on 'Diet' in general. Dissemination through leaflets, films,etc. and inclusion of the subject in specifically titled lectures or in connection with 'modern hazards to health ' topics.

Whilst most of the professional staff are in a position to give general information, there is no-one to whom we can turn who has a State Registered qualification or an advanced training in this field. We have, on occasions, made use of graduate dietitians from such organisations as the National Dairy Council, the Gerber Baby Council or the Milk Marketing Board. These visiting specialists have talked to groups of the staff and, on a very limited number of occasions, to clinic groups.

138 The only dietitians employed in the area are in the Hospital Service. They provide a good service to patients referred to them from consultant clinics only, but are willing on a personal basis to give advice to organisations or professional individuals who seek it.

My own department is asked for advice by internal organisations such as the Schools Meals Service and the Social Services, Residential Section, and we cheerfully give general advice based on medical rather than dietetic expertise.

We have occasionally suggested that the D.H.S.S. advisory service should be consulted.

140 While I can see the desirability of having a qualified dietitian available, it is extremely doubtful if there would be enough work to justify this appointment. When this was a combined health and welfare authority we did have visits from a dietitian from the Department of Health to talk to the matrons of day nurseries, residential homes, etc.

With the attachment of nursing staff to general practices I forsee that they are liable to be asked to give advice to diabetics etc. from time to time. At the present time I am exploring the possibility of some inservice training from a hospital dietitian.

141 The hospital is willing to supply special diet sheets to general practitioners.

151 Clearly there is inadequate dietetic advice to certain groups, e.g. Asian immigrant babies and the old. A dietitian could not prevent this. She could reinforce and help Health Visitors but in general to these groups very general advice is appropriate which is within the reasonable capacity of Health Visitors, etc.

Where a dietitian can help is in regard to advice to staff of residential establishment, e.g. home for the elderly, with regard to dietary advice to the overweight child in clinics for this purpose, to the diabetic outpatient and patient under care requiring any specific dietary limitation.

To my mind therefore a dietitian is of value if based actually with two functions:

1. General (i) on diets in residential establishment

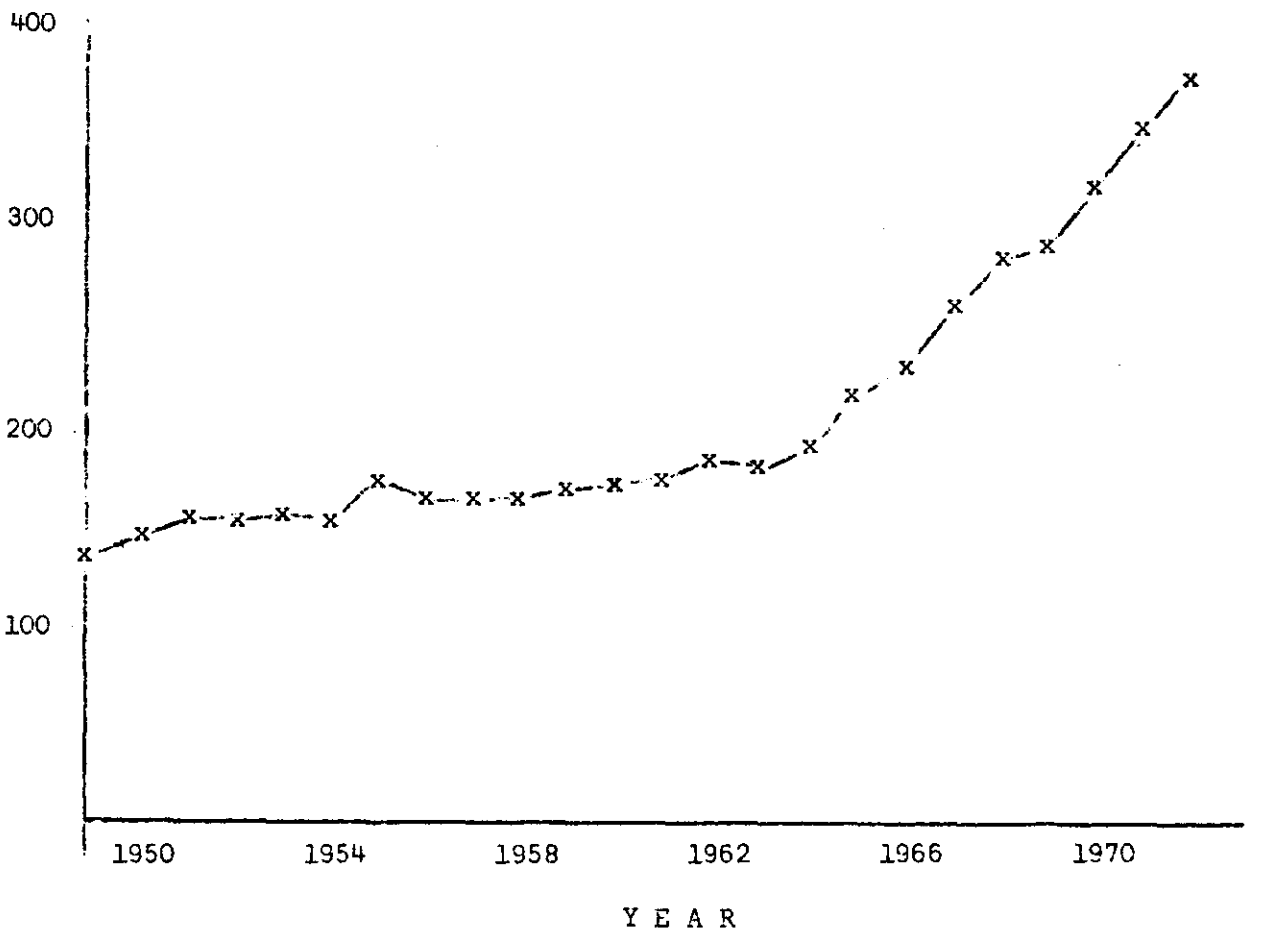
   (ii) to staff dealing with general advice on particular problems. e.g. Asian diet group

2. Specific In association with clinics for the overweight, the diabetic or any other group with marked dietary problems. For this purpose she must work at the clinic (hospital or otherwise) dealing with the medical care of such persons

155 In a compact County Borough advice is easily obtained from hospital consultants for the more difficult cases. Health department staff have a good knowledge of dietary needs and the G.Ps. often have printed diet sheets for a variety of conditions. (These are based either on hospital advice or culled from the multiplicity of medical journals).

APPENDIX 5

NUMBER OF DIETITIANS EMPLOYED IN N.H.S. HOSPITALS IN ENGLAND AND WALES 1949 - 1972



Source: D.H.S.S. Annual Reports

N.B. 1. Figures for 1955 - 1972 represent whole-time equivalents

2. Figures for 1949 - 1954 (inclusive) represent full-time dietitians

3. The numbers of part-time dietitians employed in 1949 - 1954 were 5; 4; 6; 12; 15; 18 respectively

APPENDIX 6

THE BRITISH DIETETIC ASSOCIATION

251 Brompton Road, London SW3 2ES

NOTES FOR GUIDANCE FOR DIETITIANS WORKING IN THE COMMUNITY

This guide has been formulated from the ideas of dietitians already working in this field. It is not intended as a job description but it is hoped that it will provide a basis from which others may work and also inform those interested in the scope of dietetics in the field of community health.

1. The main aims of community work are:

   (a) To promote health

   and

   (b) To prevent disease
   by promoting improved nutrition in the population at large

2. The principal fields of work could include:-

   (A) Community health The role of the community health dietitian is to work in conjunction with:

   (i) Community physicians: by -

   (a) advising on nutritional problems

   (b) providing up-to-date specialised nutritional data

   (c) attending meetings when appropriate

   (d) providing nutrition education material when required for:

   Chief dental officers
   School doctors and school nurses
   Public health inspectors

   (e) liaising with GP services and GP attached health visitors

   (ii) Nursing services: by -

   (a) participating in training schemes for health visitors, district nurses and midwives

   (b) having group discussions with trained staff

   (c) advising on individual dietetic problems working, as far as possible, through a health visitor or nurse and using domiciliary visiting for demonstration purposes if necessary

   (d) giving talks in clinics, e.g. in maternity and child health clinics

(iii) Health education services: by -

(a) evolving nutrition education material such as leaflets promoting good nutrition, and diet sheets

(b) assessing nutrition literature, films, loops and film strips available from other sources

(c) advising on displays promoting nutritional topics in clinics, schools and GP surgeries

(d) participating in health education campaigns

(e) giving talks on nutrition in health education courses

(iv) Working with groups e.g. obesity therapy and anti-smoking

(B) The social services department: The role of the community health dietitian is to:

(i) have formal and informal talks with social workers

(ii) advise on catering, dietary modification and nutritional requirements in residential homes and to participate in in-service education of cooks

(iii) have group discussions with home helps

(iv) participate in training courses for matrons of residential homes

(v) talk to groups of physically handicapped and elderly people

(vi) advise on menus and nutritional requirements for "meals-on-wheels", luncheon clubs and day centres

(vii) work with mentally handicapped, their parents and their supervisors in adult training centres

(viii) have discussions with day nursery matrons

(C) The education services: The role of the community health dietitian is to:

(i) liaise with school meals organisers, advise on dietary modification and participate in courses for cook-supervisors

(ii) work through schools at:

(a) primary level - by direct contact with children and through teaching staff

(b) secondary level - by liaison with home economists and science teachers; by diet counselling to children

(c) by giving talks to parent-teacher associations

(d) further education - by participating in pre-nursing and nursery nurse courses

(iii) arrange relevant practical experience for student dietitians and give talks to dietetic, medical and other groups of students

(iv) contribute to pre-retirement and "cookery for one" courses

(v) organise seminars on nutrition for professional colleagues

(vi) participate in other projects as requested

(D) Specialist services: The role of the community health dietitian is to:

(i) advise and give talks as requested to voluntary organisations, voluntary work organisers and women's organisations

(ii) work with organisations such as the British Diabetic Association and the Coeliac Society at national and local level

(iii) liaise with gas, coal and electricity boards

(iv) maintain contact with and provide mutual support for other dietitians in the area

(E) Research: The role of the community health dietitian is to initiate and participate in appropriate projects.

November, 1973

APPENDIX 7

Report of a Conference on Dietitians in the Community at the University of Kent at Canterbury

28 June, 1973

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THE PURPOSE AND SITING OF CONSULTANT OUTPATIENT SESSIONS

INTERIM REPORT

Robin Dowie

July 1975

H.S.R.U. Report No. 17

CONTENTS

LIST OF TABLES

Note that there are no tables accompanying Section 2.

ACKNOWLEDGEMENTS

Many sources have been drawn upon in the compilation of this overview of the issues surrounding the purpose and siting of consultant outpatient sessions. I am greatly indebted to those people who have either made available copies of unpublished reports or commented about their own experiences.

Very special thanks are due to the Regional Hospital Boards/Regional Health Authorities of England who, at a time of considerable stress, submitted statistics relating to peripheral outpatient clinics - often this entailed a special search of their hospital returns. Valuable comments were received about the feasibility of such an exercise and the interpretation of the data from Mr. V.A. Kempner, Mr. B.B. Bonner, Dr. R.L. Lindon, Mr. R.P. Sanger, Dr. G. Webster, Mr. T.S. Portus and Mr. B. Brookes. Mrs. E. Oxborrow, Mrs. J. Millyard and Mrs. B. Wall undertook the data processing while Mrs. E. Browne and Mrs. S. Woodward provided much appreciated secretarial assistance.

Encouragement and help was extended by Professor M.D. Warren and other colleagues in the Health Services Research Unit, while the finance was provided by the Department of Health and Social Security. To all, I am most grateful.

Robin Dowie

INTRODUCTION

The idea of siting some consultant outpatient sessions away from the confines of general hospitals has been mooted for many years. Lord Dawson of Penn with the members of the Consultative Council on Medical and Allied Services recommended in 1920 that primary health centres should accommodate outpatient clinics conducted by visiting consultants and specialists (MOH 1920). Their concern was for the general practitioner - "Those doctors, (who staffed primary centres) instead of being isolated as now from each other, would be brought together and in contact with consultants and specialists; there would develop an intellectual traffic and a cameraderie to the great advantage of the service" (page 11). The isolation of general practitioners was also mentioned in 1942 by the Medical Planning Commission of the British Medical Association (BMA).[1] Amongst the difficulties seen to be facing general practitioners were the advance of medical science and the increasing complexity of medical practice coupled with "the isolation of the general practitioner from consultant and specialist services." (Medical Planning Commission 1942, pages 7 and 8). Thus this draft interim report supported the concept of health centres where general practitioners would arrange consultations with specialists, some of whom might attend at the centre. More specific were the recommendations for the rural practitioner whom they felt should have opportunities to present patients to consultants in different specialties who travelled into the area periodically to hold sessions.

A precedent for consultant involvement in decentralised clinics had already been established for the 1912 National Insurance Act encouraged local authorities to construct tuberculosis dispensaries by offering to meet four-fifths of the costs, (Abel-Smith 1964). (Many of the clinics established became chest clinics later so that by the end of 1963 there were in England and Wales 554 chest clinics, 175 of which were outside the curtilage of hospitals and administered separately by Hospital Management Committees,[2] MOH 1968.)

The National Health Service Act, 1946 embodied the principle of health centres which were to be established by local health authorities, and the possible services to be provided in these premises included specialist outpatient activities.

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[1] This committee was set up with the cooperation of the Royal Colleges and the Royal Scottish Corporations. The terms of reference were to study wartime developments and their effect on the country's medical services both present and future.

[2] Under the 1946 National Health Service Act regional hospital boards assumed responsibility for treatment of broncho-pulmonary diseases while local health authorities retained control of preventive and after-care measures (MOH 1968).

However, support for consultant involvement in health centres was not at this time universal amongst professional bodies. A committee of the Central Health Services Council, set up in 1948 under the chairmanship of F. Messer to consider health centres development,[1] were very conscious of the possible misuse of specialists' time expended when travelling to clinic sites away from the general hospital. Likewise the provision of special accommodation and equipment in health centres was thought to be justified only when it was used to such an extent as to be in all the circumstances economical, (MOH 1951). An emotive rather than reasoned condemnation of the principle was offered in 1951 by a special committee of the Council of the British Medical Association (two-thirds of whom were general practitioners) which had been set up to report on group practice. It was their feeling "that no advantage would be gained by specialists, working exclusively as such, holding sessions at health centres." (BMA 1951, p.113).

Few health centres were established in England during the 1950s and early 1960s (only 17 between 1949 and 1963, DHSS 1974b), and discussion about consultant involvement seemed to abate.[2] Three reports published between 1962 and 1966 did though make unsubstantiated references favouring some consultant outpatient sessions being held in both health centres and general practitioner hospitals, i.e. The Field of Work of the Family Doctor, prepared by a sub-committee (chaired by Annis Gillie) of the Standing Medical Advisory Committee to the Central Health Services Council (MOH 1963), A Hospital Plan for England and Wales (NHS 1962), and the 1966 Revision of the hospital building programme (NHS 1966). However, the economics of transporting consultants and other specialist staff from the district general hospital to day hospitals and outpatient clinics in peripheral centres was seen as doubtful (presumably for the NHS) by the Bonham-Carter committee reporting to the Central Health Services Council in 1969 on the functions of the district general hospital, (DHSS 1969). Further study was seen to be necessary.

Probably the earliest of the recently argued cases supporting the decentralisation of outpatient clinics because of the convenience to the patients as well as the general practitioners, was the paper by Draper (1967). He felt the crucial issue was that inpatient and outpatient services did not need the same catchment area, nor did they need to be housed on the same site. So he envisaged a network of community-care units (C.C.U.s) peripheral to inpatient units - a scheme not unlike that proposed in the Dawson Report (MOH 1920). A C.C.U. would resemble a health centre or group practice but have an outpatient department

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1 The findings were presented in the Report of the Central Health Services Council for the year ending 31st December, 1950, (MOH 1951).

2 e.g. The Report of the Committee of Enquiry into the Cost of the National Health Service, (Chairman C.W. Guillebaud) (MOH 1956), merely reiterated the recommendations in the annual report for 1950 of the Central Health Services Council, (see above).

attached. Each one would serve a population of 20 - 50,000 and be a base for 10-20 general practitioners. In estimating the population bases, Draper drew on the statistics in a paper by Mackenzie (1967), which detailed the average population required to support one outpatient session per week for selected specialties. (Unfortunately Mackenzie did not document the method used in arriving at his estimates, and they differed from the results published in the following year by Carstairs and Skrimshire (1968) who calculated population bases per specialty for once-weekly sessions in Scottish health centres, using the routinely collected workload data for Scotland (HS 10 statistics) plus results from various studies.) The Office of Health Economics (1970) and Cochrane (1972) have also made statements emphasising the benefits to patients - for example, "there is, in economic terms, no justification for assuming that the patient's time is expendable and that he must always bear the inconvenience when seeking medical attention." (Office of Health Economics 1970, page 22).

It was not until 1971 that both advantages and disadvantages of holding outpatient clinics in peripheral sites were presented in a discussion document. This was a report on the organisation of group practice from a sub-committee chaired by Harvard Davis of the Standing Medical Advisory Committee to the Central Health Services Council, (DHSS 1971). The advantages of such sessions were seen to encompass: convenience to the patients coupled with the reassurance of being seen in a setting already familiar to them; the promotion of personal contact between hospital and community personnel at the most logical time - referral; the opportunities for mutual education and professional improvement between doctors; and the fostering of continuity and interdependence within the health service. The disadvantages cited were even more speculative: there might be a dispersal of consultants' time and effort; it might necessitate an increase in medical staff of all grades to provide sufficient cover in the hospitals while peripheral clinics are in session; and there would be a need to persuade hospital personnel of the advantages of such schemes especially as the widely held view (supported by the Bonham-Carter committee, see above) was that consultants' time was better used when concentrated in one locus of activity. On balance though, the Harvard Davis committee felt the advantages outweighed the disadvantages and they recommended that pilot schemes of community-based consultative clinics should be established. In reaching this judgement they were little helped by reports of practical experience because so few schemes were in operation. This was a problem which also faced Arthur Andersen & Co. when in conjunction with the Operational Research Unit of the Department of Health and Social Security they constructed a patient care event model of the outpatient sector intended as a basis for the assessment of community outpatient units (Arthur Andersen & Co. 1972).

Other professional bodies have expressed support in the past five years for the decentralisation of some consultant outpatient activities. A working party on primary medical care (chaired by Margot Jefferys) of the BMA Planning Unit (BMA 1970) believed that continuity in patient care would be enhanced if consultants were to conduct periodic clinical consultative sessions in larger primary medical care units. This general proposition was later restated although with the qualification that there may be more benefit if consultants at peripheral sites saw only those cases whom the general practitioner wished to discuss (the routine referrals being seen at the nearest hospital outpatient department), in a report from the panel on primary health care teams of the BMA Board of Science and Education, (BMA 1974). It should be noted however, that neither of these two BMA documents necessarily reflected BMA policy. A joint committee of the Royal College of Physicians of London and the Royal College of General Practitioners felt concerned that with the increasing centralisation of hospitals opportunities for meetings between specialists and general practitioners would be further diminished unless there were schemes whereby consultants saw patients in general practitioner hospitals, health centres and in group practice premises (RCP and RCGP 1972). Their conclusion summed up the situation:

> "Published reports have been favourable but little research has been done to determine whether such consultative clinics make efficient and economic use of resources, which include not only the consultant's time but the saving in patients' time and the value of contact with general practitioners. There is great need here for experiment." (pages 6-7).

It was the apparent need for an evaluative inquiry into the siting of consultant outpatient clinics (as highlighted by the above reports) which prompted the Health Services Research Unit to approach the Department of Health and Social Security for funding to undertake such a study in England.[1] It was proposed that the study would have as its ultimate objective the making of recommendations as to the ways in which consultants might usefully liaise and work with general practitioners in health centres or similar buildings. (A health centres research programme had been pursued by certain members of the research staff in the Unit for a number of years.)

This interim report represents a preparatory stage in the development of the research project. An awareness of the general issues surrounding both the purpose and siting of consultant outpatient sessions was deemed necessary before any perceptive field study could be designed. Thus the report attempts to provide an overview of the current situation compiled from published and unpublished

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[1] The Scottish Home and Health Department sponsored an investigation into the outpatient services in the Scottish Border Counties, and the report was published in 1972 (Gruer 1972).

sources. It is in four sections. The first section reviews reports detailing consultant outpatient clinic experiments in health centres and general practice premises, while in the second section, research studies which have examined issues relating to community outpatient services are discussed. The absence of any data indicating the current national distribution of consultant outpatient clinics at peripheral sites lead to a survey of all regional hospital boards/regional health authorities in England with the purpose of assessing the situation in 1972. The results are presented in Section 3. The final section grapples with the more fundamental question of the purpose of outpatient sessions and in particular, the roles of the patient, general practitioner and consultant, as evidenced in British literature.

SECTION 1

A REVIEW OF REPORTS DETAILING CONSULTANT OUTPATIENT CLINIC EXPERIMENTS IN HEALTH CENTRES AND GENERAL PRACTICE SURGERY PREMISES

Despite the apparent enthusiasm for the concept of community-based outpatient clinics expressed by reports from authoritative working parties and the Department of Health and Social Security, guidelines regarding the planning and operation of such clinics have never been elaborated. A survey to gauge opinions about the functions of health centres (Dennis 1973) amassed queries about the organisation of such clinics from health centre administrators, local health authority and regional hospital board representatives and hospital management committee secretaries. Problems raised included the selection of specialties, the frequency of sessions necessary to justify such schemes, the rights of doctors to refer patients to peripheral clinics, and the range of diagnostic equipment needed to back up sessions. The management of appointment booking systems and medical records can also provide anxieties.

Published reports describing the experiences of health centres and group practices in which consultant outpatient clinics have operated, are few and the authors have usually been clinicians, either hospital or community-based, participating in the schemes. Selected papers in which the central theme has been the detailing of experiments are summarised in Table 1.1[1,2]

Selection of specialties for decentralisation

Specialties described included orthopaedics, psychiatry, obstetrics, urology, gynaecology, paediatrics, surgery and medicine, plus diabetic clinic schemes. Many papers offered reasons as to why these peripheral clinics were set up. The most specific was a lack of outpatient accommodation in the district general hospital. Some were initiated by administering bodies such as regional hospital boards, or health centre committees while other clinics were prompted by the enthusiasm of the consultants and participating general practitioners.

There were only two experiments where any attempt had been made to estimate the 'need' by the collection of data. At Street in Somerset the general practitioners in the local health centre and in another nearby,

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[1] An additional experiment entailed the transference of a paediatric clinic to a group practice premises in Newcastle-upon-Tyne, (Walker 1974).

[2] For a summary of a small survey of outpatient facilities in health centres, see Bolden (1972).

screened all referrals and hospital follow-up appointments of patients over a four-month period to identify the specialties in greatest 'demand'. Orthopaedics and general surgery were selected (Forth 1974).[1]

The ante natal clinic at Cymmer Health Centre in Glamorgan, was set up for an experimental three month period. Before the trial began, the Welsh Hospital Board (1972) undertook a small survey of attenders at ante natal clinics at the Neath general hospital who were resident in the catchment area of the health centre. The response was very poor but the completed questionnaires indicated that patients were heavily dependent upon the ambulance service for transport to the hospital ante natal clinics. This apparent heavy usage was confirmed by the Glamorgan County ambulance authority. The bus service to Neath from Cymmer and neighbouring villages was hourly but the journey to the hospital took approximately 45 minutes, with the inconvenience of having to change buses. The Welsh Hospital Board estimated the costs of the ambulance service per week for transported ante natal patients to the Neath general hospital. This worked out at about £1.62 per patient visit or a total of £12.25 per week. In addition they estimated the costs for persons using private transport or buses (the average return journey being around 24 miles) and concluded that the approximate overall transport cost for patients attending at the hospital ante natal clinics was about £15 per week. In comparison, the estimated total cost for travel to the health centre clinic was only approximately £2 per clinic week made up of £1.19 patients' travel costs and 77p from the NHS (consultant's transport plus ambulance costs for the occasional patient transferred to the Neath hospital). These costs were based on 1971/72 prices.

Staffing of clinics and frequencies of sessions

There were some clinics where the consultant was aided by other hospital medical staff, but usually assistance was given by practice nurses, local authority nurses and midwives. Secretarial help was available in many practices. No inferences could be drawn from the information relating to session frequencies, as it was not possible to take into account variations in the overall referral rates to individual specialties, the size of the lists of the referring practitioners, and the availability of consultants regarding their total workloads.

Appointment booking systems and the organisation of medical records

Generally appointment bookings were made in the practices, and the hospital

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[1] Note, all the papers reviewed in this section are summarised in Table 1.1.

(either the records department or a secretary) notified in sufficient time to enable the relevant medical record folders to be assembled for the consultant to carry to the clinic. There were variations. New ante natal appointments for patients living close to the Cymmer Health Centre were made through Neath hospital in the usual way but the patients were asked to attend the health centre clinic (ibid). In the Wolverhampton diabetic mini-clinics experiment, medical records were held by the general practitioners rather than the hospital. If a diabetic patient was referred to the hospital clinic the medical record was sent with the patient, (Thorn and Russell 1973).

It was found necessary to employ an additional hospital car driver in order to transport hospital records, laboratory specimens, etc., to the Woodside Health Centre, (Strang 1973). This was partly a consequence of the clinics attracting many more patients than expected. It was estimated in 1972 that over one third of the outpatient referrals to the health centre would previously have been sent to departments in Glasgow other than those of the Glasgow Northern Hospital Group within whose catchment area the centre was sited. Further additional staff requirements were two part-time clerical officers for the hospital records department, a full time typist to carry out secretarial duties associated with letters to general practitioners, a radiographer and a physiotherapist. The South Western Regional Hospital Board contributed one third of the salary of a member of the staff of the Nailsea Health Centre who had responsibility for booking appointments, preparing notes and undertaking reception duties for the clinics of six consultants, (Anon 1973).

The traditional procedure of clinicians' reports of consultations being typed by hospital secretaries was followed in many of the experiments described. Exceptions occurred: in one paediatric clinic the general practitioners presented their patients to the consultant and so were able to add direct to the patients' medical records the consultants findings, (Marsh and Tompkins 1969). At the Street Health Centre, a practice secretary typed certain hospital notes and the doctors received duplicate copies; this seemed to satisfy them (Forth 1974).

Suitability of clinic accommodation and availability of diagnostic equipment

Three health centre reports (Tile Hill, Cymmer and Nailsea, see Table 1.1) indicated that clinics were affected by inadequate space, suggesting that these premises were not initially designed to cater for such activities. In contrast the Witney Health Centre built by the Nuffield Provincial Hospitals Trust, and Woodside Health Centre contained designated outpatient suites, and indeed, it was observed that the Woodside accommodation was much superior to that of the largest nearby hospital (Strang 1973).

There were few comments about diagnostic facilities not being readily available. Many practices had transportation for pathology specimens. Some consultants found it convenient to take blood samples and deliver them to the hospital pathology department. One orthopaedic surgeon commented upon the inconvenience of X-ray facilities not being immediately available but he felt that this problem could be coped with either by the general practitioner arranging for an X-ray previous to the consultation or for an X-ray appointment being coupled with a visit to the district general hospital for physiotherapy, appliance measuring and such like. In two practices portable E.C.G. machines were used.

Advantages of consultant outpatient clinics being held in general practice premises

The reports generally were very favourable although most of the comments made were impressionistic rather than based upon objective evaluation. This is understandable as the papers were usually written by participants in the schemes.

For consultants, the recurring advantage cited was a greater understanding of the problems and level of medical care in general practice. The presence of the family doctor at the consultation meant that the specialist was better able to appreciate the background (both medical and social) of the presenting patient.

The general practitioners were thought to develop expertise in the diagnosis and management of certain diseases.[1] This applied particularly in situations when the family doctor met with the consultant during the clinic session, either when presenting patients or during a refreshment break. Some commentators felt that general practitioners became more selective in referring patients and were more meticulous in their 'work ups'. For those general practitioners able to 'sit in' on consultant sessions the benefits were seen to be similar to those of a refresher course. Doctors appreciated the rapid discharge of patients back for their management.

Convenience to the patients was universally cited, familiarity with surroundings was also frequently mentioned particularly with reference to psychiatric clinics - three reports suggested that patients who would normally be very reluctant attenders at hospital outpatient departments were willing to talk through their problems in a surgery situation. Realistic scheduling and shorter waiting times within the sessions were further advantages mentioned. Gibson et al (1966) found that the team approach (of family doctor, psychiatrist and psychiatric social worker) was of considerable benefit to the patient as the therapy could be adapted to his needs, and he had the support of his own doctor between sessions.

[1] See the arguments by Malins (1968) and Todd (1972) favouring community-based diabetic clinics.

The parents of patients who had attended one paediatric clinic were asked for their views, (Marsh and Tompkins 1969). The authors were surprised that reassurance of the child by having their own family doctor present when seeing a specialist, was the advantage most frequently offered. Familiar surgery surroundings being conducive to a relaxed atmosphere was mentioned by one-third of the respondents. More significant from the stand-point of improved medical care were the spontaneous comments from parents about the advantages of having the family doctor present to aid in the interpretation of the consultant's questions and the describing of symptoms. Complementing this interaction was a willingness of the parents to accept the continued management of the patients by the family doctor.

Problems and drawbacks associated with peripheral clinics

Anxieties were expressed by clinicians in two papers about general practitioners' lack of interest in participating in such schemes either because of the pressure of other commitments, or a general unwillingness. One consultant psychiatrist felt that the biggest disappointment in his experiment was the failure to interest family doctors other than those in the original practice in the scheme; a considerable amount of education and persuasion would be required to extend the scheme. He believed that the care of individual patients was almost certainly improved by joint consultations, but while the present shortage of psychiatric time continued, it would probably be better to work for a limited period in one practice and then move on to another. This does raise a general issue about the allocation of scarce resources within specialties with manpower deficiencies.

Dr. Parry Jones, (County Medical Officer for Health for Somerset County Council in 1972) commented in response to the enquiry about health centres, (Dennis 1974),

> "In several health centres consultant sessions have been established but I am unaware that any evaluation studies have been established. They are needed.".

The reports discussed above were no more than descriptive accounts of individual peripheral clinic experiments. Some evaluative studies are reviewed in the following section.

Note: one further paper has reviewed psychiatric clinics held in two Devon health centres - Exmouth and Sidmouth, 11 and 15 miles respectively from a general hospital. Fortnightly sessions were conducted by a psychiatrist assisted in one centre by a social worker and a community psychiatric nurse. It was thought that patients were less apprehensive of visiting the smaller 'stigma free' local centre than the hospital outpatient department. See Rodger, W. (1973) Community psychiatry in the health centre: a Devon development. Practitioner, 210, 799-802.

SECTION 2

STUDIES EITHER COMPLETED OR IN PROGRESS WHICH HAVE EXAMINED ISSUES RELATING TO COMMUNITY OUTPATIENT SERVICES

Evaluative studies about the role of peripheral outpatient clinics from research departments have been scarce. The only empirical study specific to this issue published to date is that by Gruer (1972), Outpatient Services in the Scottish Border Counties sponsored by the Scottish Home and Health Department (SHHD). An earlier study (Backett et al 1966) examined outpatient facilities in hospitals in North East Scotland (the counties of Aberdeen, Kincardine, Banff and Moray plus the city of Aberdeen). Factors affecting the usage rates of peripheral clinics were presented but they were not central to the discussion. The management consultant firm, Arthur Andersen & Co., in conjunction with the Operational Research Unit of the Department of Health and Social Security (DHSS), developed a patient care event model of the outpatient sector intended as a basis for the assessment of community outpatient units. This exercise was dependent upon data provided from other studies, reports of local experiments and the views of administrators. Carstairs and Skrimshire (1968) relied upon routine outpatient attendance statistics collected for the SHHD plus data from other published and unpublished studies when they attempted to assess the catchment population necessary to support one weekly consultant session per specialty in health centres. The base data used by Mackenzie (1967) in his calculations for England were not detailed.

Bryden (1970) in an MSc thesis examined referrals from general practitioners practising in the Cumbernauld health centre. His interest was the decision making in the outpatient referral process, in an attempt to answer the question "Ought outpatient consultations to take place in a hospital complex?".[1] Some of Bryden's findings about the lack of the necessity for patients to be seen by consultants in hospital departments as opposed to a health centre clinics tallied with those of Wade and Elmes (1969) who analysed the workload of a general medical outpatient clinic in a hospital to determine how many patients could have been adequately dealt with at a health centre. More will be said of these two reports in Section 4.

In 1973 the Medical Care Research Unit at the University of Newcastle-upon-Tyne, with the financial support of the DHSS, commenced a study of outpatient activity in East Cumberland. The study which is still in progress included in its objectives; provision of information relevant to planning; assessments of the value of peripheral outpatient clinics in rural areas; and the testing of hypotheses about the effect of distance on the use of outpatient services (Glass 1972).

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[1] Another study (pilot only) by Handel (1972), looked at the logistics of consultant involvement in a health centre (Woodside).

Findings from the report Outpatient Services in the Scottish Border Counties (Gruer 1971 and 1972)

The aims of Gruer's investigation included the documentation of outpatient facilities serving the Border area, and certain aspects of the care provided over a 12 month period. The survey area consisted of the four Scottish Border Counties with a population in 1966 of just over 100,000 persons. It was served in 1969 by outpatient clinics within the Border area held at one general hospital (Peel), five general practitioner hospitals, two other clinic sites administered by the Border Hospital Board of Management, and local health authority clinics at 14 sites. Outpatients from the Border Counties were also seen in the departments of hospitals at Edinburgh the regional centre, and in towns fringing the Counties. The fieldwork comprised a prospective study of new outpatient attenders (using the H.S.10 definition[1]) over a three month period. Excluded were psychiatry, orthodontics, physiotherapy, X-ray, casualty and ante natal attenders. Hospital staff recorded data but where this was not possible information was extracted from the hospital records by the fieldworkers. Thus only routine data were collected. Where patients were referred to hospitals outside the Border Counties and Edinburgh, general practitioners making the referrals were asked to complete recording forms - the response rate was 74 per cent. As a second stage in the study, a retrospective survey was carried out on the hospital clinical records of a stratified random sample of patients from the Border Counties one year after the date of their first outpatient consultation. Summaries of the fieldwork and the data analyses are in Tables 4.1 and 4.2.

Consultants from Peel general hospital conducted all the Border clinics in the specialties of general medicine, general surgery and orthopaedic surgery. Consultants travelling from Edinburgh undertook the sessions in gynaecology, ear, nose and throat, ophthalmology, dermatology, paediatrics and diabetes, and the chest disease clinics were the responsibility of a physician from East Lothian. It was only in the orthopaedic surgery specialty that there were sufficient clinics held within the Border area to accommodate all surveyed referrals so not causing some 'new' patients to travel to Edinburgh. Local dermatology sessions could have been increased four-fold before providing sufficient outpatient scheduling for patients resident in the four counties.

The study showed that the role played by the general practitioner hospitals

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[1] The H.S.10 is the Scottish equivalent of the S.H.3 form used in England for the collection of hospital inpatient and outpatient statistics. Definitions are detailed in Section 3.

and peripheral clinics administered by the hospital board was impressive; 50 per cent of all new outpatients from the Border Counties were seen there. Gruer noted that "the general practitioners selected for referral to these clinics the conditions which required only consultant skill and not elaborate diagnostic aids." (page 78). But the type of patients referred to these clinics would to a certain extent have been predetermined by the nature of the specialties holding sessions at these sites. Some medical specialties are more dependent upon 'on the site' diagnostic equipment than surgical specialties,[1] whereas in this latter group a 'high' proportion of new outpatients are merely being 'processed' by consultants onto waiting lists for inpatient treatment.[2] Examination of the specialty mix in these peripheral hospital clinics (i.e. those not held in the Peel hospital or administered by local health authorities) showed that no more than one third of the sessions were for the specialties of general medicine, chest diseases and orthopaedic surgery which the Chesterfield data (Trout 1973) suggested were heavy users of X-ray facilities. The most frequently held sessions included gynaecology, general surgery, and ear, nose and throat, so the finding that 42 per cent of the new outpatients seen at the peripheral hospital clinics were placed on waiting list, (compared with 30 per cent of all Border new outpatients), was reasonably consistent with the figures reported by Forsyth and Logan (1968).[3]

From the retrospective survey of the hospital clinical records, it was estimated that the mean number of attendances per new outpatient for all sites over 12 months was 3.8 visits, but there were variations - patients who at their first outpatient consultation were referred to Edinburgh hospitals for follow-up had a mean number of 2.6 visits while similar patients whose follow-up attendances were at any of the Border hospital clinics, had a mean of 4.2 visits. The differing composition of the specialty mixes in the two districts seemed to account for this. Overall general medicine patients not discharged after their first attendance were found to have a mean number of visits of 3.1 annually, while the means of the other specialties (excluding orthopaedics) ranged from 1.5 to 1.8.

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[1] In the Chesterfield outpatient HAA experiment, the specialties in which 60 per cent or more of patients were X-rayed on consultant instructions were chests, general medicine and orthopaedics. Forty per cent or more of paediatrics and ear, nose and throat patients were also X-rayed but only 27 per cent of those in general surgery and 12 per cent, gynaecology. (Trout 1973). See also Forsyth and Logan's (1968) findings relating to new outpatients discharged without investigation.

[2,3] In their survey of some 80 hospitals, Forsyth and Logan (1968) found that between 30 and 45 per cent of new attenders in gynaecology, general surgery and ear, nose and throat were entered on waiting lists for admission. In the other major specialties fewer than eight per cent of new patients joined waiting lists. Reporting on the three-month workload of a surgical unit, Wilken (1975) found that about 40 per cent of new patients were placed on the waiting list.

However, in the case of orthopaedic patients the mean number of visits over 12 months was 8.1 and this seemingly high figure was attributed to the inclusion of physiotherapy in treatment programmes. As almost all orthopaedic patients appeared to have been treated by consultants from the Peel general hospital, these disproportionately long attendance patterns had a weighting effect upon the overall Border hospital clinics' mean attendance rate.[1]

Seven models of alternative arrangements of outpatient facilities for the Border Counties were designed to estimate costs; firstly, to the National Health Service (i.e. the time spent by consultants on travelling to clinics outside their base hospitals), and secondly, to the community by patients attending hospital. The fieldwork provided the base line estimates of consultants' and patients' journey distances over a 12 month period, while assumptions about methods of travel used by patients were drawn from a traffic survey carried out in the Borders by the Scottish Development Department. Loss of earnings were also calculated. Gruer acknowledged that the estimates of the community costs were likely to be underestimated, but she felt that consultants' costs could be viewed "with confidence as a good estimation of maximal figures". However the calculations only presented the 'money' costs; an assessment of 'opportunity' costs may have produced a different picture depending upon the manner in which the consultants might have otherwise utilised their travel time. So frequently it is assumed that time spent in travelling either by a consultant or a general practitioner is 'wasted'[2] and is at the cost of the 'firm'.

The models covered combinations of two sets of alternatives; permutations of existing facilities, and arrangements in which the Peel general hospital was replaced by a proposed new hospital incorporating the specialties already at the Peel hospital (general medicine, general and orthopaedic surgery) as well as four additional specialties -gynaecology, dermatology, ophthalmology and paediatrics. (Ear, nose and throat, the third largest specialty in terms of the number of new referrals during the three-month survey period, was strangely absent.)

In the first set of combinations, the model representing the current situation was the 'best buy', and one quarter of the total cost was attributed to the consultants. (The other models included a proposition that all outpatient

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[1] Twenty-two per cent of patients attending Border clinics had physiotherapy while less than one per cent of those attending in Edinburgh did so.

[2] For a discussion of the benefits (or otherwise) of transport schemes in general practice, see Bevan et al (1974).

clinics be held in Edinburgh.) But overall, the model which emerged as the 'best buy' comprised the proposed hospital, the retained general practitioner hospital clinics and the local health authority clinics but staffed by the wider range of specialists from the proposed hospital with only those patients requiring 'regional' specialties (e.g. neurology) travelling to Edinburgh.

Although each model incorporating the proposed new hospital plan was found to be more economical than the 1969 arrangement, the commentary did not point out that a population of about 100,000 might not have been sufficiently large to justify the engagement of the full-time services of teams of consultants in some of the additional specialties envisaged for the new hospital.[1] For example, Carstairs and Skrimshire (1968) estimated that in the Scottish situation the population required to support ONE WEEKLY outpatient session in paediatrics (both medical and surgical) was 34,750. Thus a full-time consultant in this specialty who was based in the new general hospital, could be obliged to undertake outpatient sessions in other hospitals/clinics so incurring travelling costs, etc.

A Patient Care Event Model of the Out-Patient Sector: A Basis for the Assessment of Community Out-Patient Units (Arthur Andersen & Co. 1972)

The purposes of the study included the determination of the likely costs and resource consequences of different approaches to the provision of outpatient services, and estimates of the sensitivity of these costs to the uncertainties in the base data/judgements. The main recommendations were:-

(a) Local outpatient sessions would not be economic in communities within predominantly urban areas of population.

(b) The provision of local outpatient units in many communities of at least 10,000 people in more rural areas would potentially result in net revenue savings for the National Health Service, despite the considerable extra cost of consultant time which would be spent in travelling to and from the community unit. "The addition of Physiotherapy facilities to these units would increase the potential for revenue savings in such communities." (page 3).

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[1] The committee of the Central Health Services Council reporting on The Functions of the District General Hospital (DHSS 1969), recommended that "District general hospitals should be planned around teams of not less than two consultants in each specialty, with all their in-patients at the one district general hospital" (page 18).

They also observed that the 1967 ratio of population per two consultants (home population England and Wales whole-time, part-time and honorary consultants) in paediatrics, was 378,000 persons, dermatology - 605,000 persons, and in ophthalmology, 289,000 persons per two consultants.

Scottish Home and Health Department estimates in 1967 of the outpatient services required by a population of 250,000 were presented by Carstairs and Howie (1972).

(c) "The provision of local units would require capital costs which for many assumptions ....., but not for all, would fail to satisfy the Treasury's recommended criteria for a 10% rate of return on capital investment - even if savings in patients' own out-of-pocket expenses were included in the revenue savings." (page 3)

The potential annual saving to the National Health Service from community outpatient units was seen to be about one per cent of the annual expenditure on the outpatient sector, the reduced use of the ambulance service forming the major part of the saving. Yet, "in general, the direct economic justification for establishing community out-patient units is weak in comparison with the system in which all out-patient services are provided only at the district general hospital, especially in view of the uncertainties surrounding the key assumptions." (page 4)

The report did recognise that there were possible medical and social advantages associated with community outpatient units which in themselves might be sufficient justification for the development of such units despite the weak economic case. There was also an acknowledgement that there may be a number of behavioural changes associated with community outpatient units for example adjusted patterns of patients' requests for outpatient services and general practitioner referral rates. Episode lengths for patients under treatment at the community site could be shorter than those for patients at the district general hospital. The team was unable to substantiate these possibilities from evidence collected independently. For example, their assumption that about 70 per cent of all outpatient attendances could be made locally at a community clinic was based on the specialty mixes operating in the Health Centres at Hythe (Hampshire) and Witney (Oxfordshire) coupled with the findings of one small study (undertaken in Northern Ireland) viewing the general medicine specialty [1], (Wade and Elmes 1969).

In assessing the manpower requirements for a programme in England of units serving communities of 10,000 persons or more within five to 10 miles of a district general hospital, the number of consultant hours lost through travelling to such outpatient units was estimated. The figure for additional whole-time equivalent consultants deemed necessary to maintain the present average was 140. The report was somewhat dismissive about significance of this estimate - it represented an overall increase in consultant posts of

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[1] A two month study showed that had it been logistically possible, 85 per cent of patients seen at a general medical outpatient clinic could have attended a health centre for their consultation (Wade and Elmes ibid).

about three per cent, though this would reach six per cent in some rural areas, and it was of a similar size to the planned annual rate of growth in consultant posts. (It was thought that if much of consultants' travel was from the community e.g. home to the clinic rather than from the district general hospital, then the estimated increase in posts may be as low as 70.) There was no reflection about the effects upon medical training provisions both undergraduate and 'in post', or the realities of consultant posts being filled with whole-time equivalent appointments.

In reaching the estimate that the provision of local sessions could represent an annual saving to the National Health Service of £1 million in revenue costs, the only consultant costs taken into account were those of time spent in travel - 'money' costs assessed at £3.67 per hour (1970 salary scale). (The 'opportunity' cost was thought to lie between £5 - £10.)

The report concluded by indicating areas for further investigation to reduce the uncertainties in their conclusions:

(a) episode lengths,
(b) unit costs of delivery of outpatient care,
(c) ambulance costs, and
(d) consultant travel.

Arthur Andersen & Co. suggested that by "establishing several 'before and after' trials in communities with identifiable and interesting patterns of requirements for out-patient care, it should be possible to obtain sound data on many behavioural aspects which may affect the success of local sessions", (page 9.5). The costs experienced by individuals in the community when attending alternative outpatient sites were not components of the patient care event model. However this aspect of outpatient care is being explored in depth by the Newcastle Medical Care Unit.

East Cumberland Outpatient Survey (Glass 1972, 1973a, 1973b)

In the East Cumberland situation, the vast majority of outpatient clinics take place at the district general hospital in Carlisle involving for some patients living in the catchment area, journeys of over 40 miles. Yet there are a number of small hospitals and health centres in the area which would seem to be suitable sites for peripheral consultant clinics. (Some orthopaedic surgery, gynaecology and psychiatry sessions were already held locally in 1972.)

> "The problem is one of estimating the benefits and costs of changes in the location of particular clinics. Some of the effects of alternative configurations of clinics will take the form of changes in the length of time during which the patient is away from his or her chosen activity. Doctors will substitute travel time for "work" or "leisure" time or vice versa. Finally, since much of the ambulance service is run by volunteers, the amount of volunteer time required by the ambulance service may vary."[1] (Glass, 1973a)

The field work for the initial phase of the study was orientated towards the utilisation of patients' 'time'. Apart from the base line data assembled from the monitoring of all appointments and attendances at outpatient clinics over one year for six selected specialties, case notes were analysed to determine how much of the treatment supplied to patients necessitated attendance that day at a district general hospital. Patients were interviewed to determine their costs and those of accompanying persons when attending the outpatient clinic. Topics covered in the schedules which applied both to the patients and accompanying persons, included occupation, length of absence from work on the day of appointment, loss of pay on the day of appointment, method of travel and journey distance, etc. Also patients were asked to express preferences about alternative clinic sites.

The assumptions underlying the design of the patient schedules were outlined in a paper by Glass (ibid). For example, in the travel time case, he assumed that the utilities of the work situation per se, and the travel process, were not significantly different. A wage figure was adopted as the best estimate of costs regarding absence from work despite reservations held by Glass about whether a large number of small reductions in random absences from work would be related to marginal product estimates - was there some sort of 'threshold' effect on the production as well as the consumption side. The problems of valuing the time of patients not in gainful employment (housewives, children, the elderly) were not resolved in the paper.

There was no intention in the Newcastle study to collect empirical data about the utilisation of consultants' time. The proposal was to assume that any extra travelling was done in the National Health Service's time - the standpoint of Gruer (1972) and Arthur Andersen & Co. (1972) in their assessments of the value of consultants' travel time.

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[1] Research into the use of ambulances in conveying patients to outpatient departments was carried out in 1970 in The London School of Hygiene and Tropical Medicine - outpatient attendances in the vicinity of Bury St. Edmunds. Also, the Architectural Association with the Operational Research Executive of the National Coal Board have analysed outpatient attendances in the vicinity of Swindon. (Arthur Andersen & Co. op cit)

The summation of the findings from Gruer's study of the Scottish Border Counties and those of the Newcastle Medical Care Research Unit's investigation in East Cumberland, will throw much light upon the costs incurred by patients in travelling from rural locations to outpatient clinics at alternative sites. Consultants' time and 'money' costs expended in travelling to clinic sites too will be better understood although the problem of estimating 'opportunity' costs is still to be resolved. However, information about the current national situation in terms of the distribution of outpatient clinics at peripheral sites according to specialties and attendance rates, which should have been a prerequisite in the development by Arthur Andersen & Co. of a model of the outpatient sector, has continued to be lacking. The following section describes an attempt to fill this gap..

SECTION 3

CONSULTANT OUTPATIENT CLINICS SITED OUTSIDE THE CONFINES OF DISTRICT GENERAL HOSPITALS: A SURVEY TO ASSESS THEIR DISTRIBUTION IN ENGLAND IN 1972

Introduction

Support for consultant outpatient sessions being held outside the confines of the district general hospital[1] (DGH) has been voiced from many quarters in the past few years: by health care commentators[2], general practitioners and consultants[3], and professional bodies[4]. Official sanction for the concept of outpatient clinics in health centres was given in the National Health Service Act, 1946 while the establishment of peripheral clinics or diagnostic centres in general practitioner hospitals was mooted in A Hospital Plan for England and Wales (NHS 1962) and reiterated in the Revision (NHS 1966). The committee of the Central Health Services Council reporting on The Functions of the District General Hospital (DHSS 1969) was more ambivalent; it suggested that the economies of peripheral day hospitals and outpatient clinics required further study. A memorandum from the Department of Health and Social Security (DHSS) in 1974 (DHSS 1974a) setting out the role and development of community hospitals, was however, positive about the integration of outpatient clinics with inpatient and day patient care for people not needing the specialised facilities of the district general hospital.

Despite the general acceptance of the concept of 'community-based' consultant outpatient clinics guidelines about the organisation and management of these schemes have not been available although the demand for such from health centre administrators was revealed by Dennis (1973). Further, the breadth of the existing provision of decentralised consultant clinics in England has not been fully documented. The British Health Centres Directory for 1973 (Brookes 1973) provided relevant details for health centres only. It was this apparent deficiency of a comprehensive assessment of the deployment of consultant services in outpatient clinics based in health centres, group practices, other local health authority premises (prior to April 1974), and general practitioner hospitals which prompted this study.[5]

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[1] i.e. outside the units which comprise a district general hospital.

[2] e.g. Draper (1967), and the Office of Health Economics (1970).

[3] e.g. Marsh and Tompkins (1969), Malins and Stuart (1971), Fry (1973), Norell (1974), and Scott et al (1975).

[4] RCP and RCGP (1972), BMA (1970 and 1974). Note that these were not policy documents.

[5] Evaluative studies of consultant outpatient clinics in the community were undertaken by Carstairs and Skrimshire (1968), Gruer (1972), Arthur Andersen & Co. (1972), and currently by the Medical Care Research Unit, University of Newcastle-upon-Tyne (Glass 1973a).

The aim of the study was to develop an overview of current practice based on existing routine records in order to see the extent to which certain key questions could be answered. It was thus intended to:-

1. estimate the number of consultant outpatient attendances at clinics decentralised from the confines of district general hospitals throughout England in 1972,

2. learn of the specialties which held sessions in such clinics in the hope of providing some elucidation of the question about the specialties best suited for decentralisation,

3. collect information about the types of premises in which decentralised clinics were held,

4. distinguish between authorities administering these consultant outpatient clinics - regional hospital boards, school health services and local health authorities, (for there may be variations in average episode lengths per patient in clinics in the same specialty but serving differing categories of patients), and

5. observe if there were any marked differences in ratios of total/new outpatients between firstly, the total outpatient attendances for England in 1972 and the decentralised attendances, secondly, types of peripheral premises and thirdly, total attendances and decentralised attendances within selected specialties. (The ratio total/new outpatients was used as a crude indicator of episode length.)

Additionally, since the data were collected from the regional hospital boards it enabled an assessment of inter-regional variations in the provision of consultant outpatient clinics at peripheral sites, and the discovery of anomalies in individual regional hospital board's collection and presentation of relevant statistics for 1972.

Method

In February 1974, a letter was sent to each of the 14 Regional Hospital Boards (RHBs) in England, requesting information about their consultant outpatient clinics held in general practitioner hospitals, health centres and other local authority premises for 1972. A number of considerations governed the decision to approach the RHBs. The routinely collected data providing such information encompassed mainly SH3 returns plus annual returns from some school health service and local health authority clinics. SH3 statistics

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[1] Forms SH3 are returned annually for each unit (hospital, home, hostel, psychiatric hospital, etc.) which is administered separately. Detailed by departments are annual numbers of patients (e.g. inpatients, outpatients, day patients), bed availability and occupancy rates, inpatient waiting lists, outpatient clinic sessions, etc.

should have been available from three sources, for prior to 1974 Hospital Management Committees (HMCs) and Boards of Governors (BGs) in England administered the collection of SH3 returns and submitted copies to the relevant RHBs and the DHSS Statistics and Research Division. (There was though no statutory requirement for this to be carried out.) A survey of HMCs was discounted as their dissolution was imminent with the Reorganisation of the National Health Service. The DHSS Statistics and Research Division was not approached as it was felt that they would probably have had difficulty in identifying the types of peripheral units in which outpatient clinics were held. After discussions with representatives of the statistics divisions of two RHBs about the feasibility of obtaining such data, it was decided to contact the 14 Boards in England, although the timing of the requests was unfortunate in view of the administrative upheaval created by the Reorganisation. However the response was satisfactory.

The year 1972 was chosen as it was the most recent one for which RHBs would have comprehensive records. (The date set by the DHSS for completed 1973 SH3 returns from HMCs/BGs was 31 January 1974, only a few days before the survey commenced.)

The letters were addressed personally to the Senior Administrative Medical Officer (SAMO), or where appropriate the acting SAMO, who passed the request to the relevant department. They were asked to supply:

> names and addresses of general practitioner hospitals, health centres and other local authority premises in their region, where consultant outpatient clinics were held in 1972,
>
> to indicate for each site, the specialties holding clinics and on whose behalf, and
>
> to provide for each specialty, the number of sessions held in 1972, the number of new outpatients and total outpatient attendances at each site in that year.

Multiple copies of an outline pro forma were supplied with an accompanying note asking that if it were more convenient to supply the data on SH3 forms or any other format, to do so. Many regions chose an alternative format (see Table 3.1).

Outpatient <u>definitions</u> applying to Form SH3 and relevant to this enquiry are:

> "Out-patients are persons attending on a non-residential basis for minor treatment, advice, consultation, etc. ....."
>
> "A "new out-patient" is one whose first attendance of a continuous series at a clinical out-patient department for the same ailment (or whose single attendance if only one is needed) falls within the year under review." (<u>Notes on Form S.H.3 for 1972</u>, DHSS 1971a).

However, a person attending different departments whether for the same or different ailments counts as a separate new outpatient in each department. A continuous series can only be terminated by discharge or death, but it can be broken by treatment as an inpatient or day case. If a patient re-attends after being discharged even for the same ailment, he is counted as a new outpatient. But a patient who attends an outpatient department for follow-up after a direct inpatient admission is counted as an old outpatient. For sessions the figures required are those of the annual number of sessions held (not merely scheduled) by or on behalf of one consultant, Senior Hospital Medical or Dental Officer, while clinics are the sites at which the sessions are undertaken.

SH3 returns have been subjected to criticism. Carstairs and Skrimshire (1968) described the outpatient terminology as being "essentially concerned with the load on the service" rather than reflecting communities' demands. They described the approaches to operational definitions adopted in some research studies. Morris et al (1974) were critical of both the descriptions for SH3 purposes of particular departments, and the policy of classifying as new patients inter-departmental transfers, in particular accident and emergency cases passed to orthopaedic surgery departments.

Response

All the regions replied. Statistics of variable comprehensiveness were submitted by 11 Regional Hospital Boards/Regional Health Authorities (RHAs), two (Birmingham RHB and Northern RHA, formerly the Newcastle RHB) supplied details for general practitioner hospitals only, while the East Anglian RHA regretted that they did not have detailed information on this matter collected routinely. Details of the response are presented in Table 3.1.

Results

The incoming regional statistics were classified in two ways:[1]

(a) by types of premises in which the clinics were held, i.e. general practitioner hospitals, health centres[2], and 'clinic premises' administered by hospital authorities, local health authorities and the school health service, and

(b) by specialty.

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[1]The coded data was processed using a computer programme, CONSTAT, developed by Mrs. Elizabeth Oxborrow at the University of Kent at Canterbury.

[2]Those qualifying under Part III, Section 21 of the National Health Service Act, 1946.

Although details relating to 'clinic premises' administered by hospital authorities (e.g. chest and venereal diseases clinics) were not requested, many RHBs included statistics for such in their returns and these were not screened out. The address of each was checked against entries in the 1972 Hospitals Year Book (Chaplin 1972). In all but a few instances these clinic addresses were different from those of local hospitals.[1] Admittedly, some of these clinics may have been in close proximity to a DGH - a possibility equally likely of health centres and the other types of 'clinic premises'. Some statistics relating to peripheral clinics undertaken by consultants based at teaching hospitals were included in the data; these have not been omitted because of problems of identification.

The analysis has done no more than indicate broad patterns, and caution must be borne in mind when interpreting the tables because of the inherent difficulties in the data as will be highlighted in the examination of the results. Since the data applied to hospital regions prior to Reorganisation, the regions have been identified throughout the analysis by their RHB titles.

1. The number of consultant outpatient attendances at clinics decentralised from the confines of district general hospitals throughout England.

In 1972 approximately six per cent of new outpatients in England, and five per cent of all attendances were recorded at outpatient clinics in peripheral units. These figures represented nearly half a million new patients and over one and a half million total attendances - old and new patients combined; converted into rates per 1,000 population 1972, they worked out at about 11 for new patients and 36 for total outpatient attendances.

2. Specialties holding decentralised clinics

Ophthalmology was markedly the most widely dispersed specialty being recorded in 329 units over 13 regions, so that in all, about nine per cent of all ophthalmology outpatient attendances in 1972 were in decentralised units. These figures of course did include school health attendances. The next most frequently found specialties were orthopaedics, child psychiatry and general surgery, the numbers of units being 179, 165 and 161 respectively, see Table 3.2. There were only 91 units accommodating consultant obstetrics clinics compared with 140 for gynaecology although the total outpatient attendance rate per 1,000 population in obstetrics in 1972 was more than double that for gynaecology. Some gynaecology returns for peripheral units incorporated obstetric patients who were not identified as such.

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[1] See footnote 1 page 3.6

However since the obstetric data included local health authority sessions undertaken by clinical medical officers and midwives it was not possible to fully assess the extent of ante natal care profferred in decentralised clinics.

Diseases of the chest had the largest number of outpatient attendances at peripheral sites - 402,895 comprising almost one-third of the total chest attendances in England in 1972. This was not an unexpected finding in view of the antecedents of chest clinics[1]. Decentralised child psychiatry attendances amounted to half of the total attendances in this specialty, while the venereal diseases figures recorded at 19 peripheral units formed almost one-tenth of all such attendances for that year. (Some peripheral clinics in this specialty were known to have been omitted from the RHBs' returns.)

3. Types of premises in which decentralised clinics were held

(a) General practitioner hospitals It was not considered feasible to furnish the RHBs with a precise definition of a general practitioner hospital, because of the ambiguities surrounding the term[2]. It was left to the individual boards to provide their own interpretation of the term and there was comment from only one about the definition applied. Returns from the South East Metropolitan RHB included only those hospitals where the number of occupied bed days in general practitioner specialties (medical, maternity or dental) was more than 50 per cent of occupied bed days for the whole hospital in 1972. (A few non-general practitioner hospitals were identified in the RHBs' returns; these were screened out as were outpatient attendances classified on SH3 forms as General Practitioner Maternity or General Practitioner Medical.)

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[1] Under the National Insurance Act of 1912 local authorities building tuberculosis dispensaries were able to claim four-fifths of the costs (Abel-Smith 1964). By 1948 many of these dispensaries had developed into chest clinics dealing with a wide range of broncho-pulmonary diseases but were usually geographically and administratively separate from general hospitals. Thus at the end of 1963 there were 175 chest clinics in England and Wales not in the curtilage of hospitals and administered separately by Hospital Management Committees (MOH 1968).

[2] Robinson (1973) drew attention to the problem.

"A precise definition of a "cottage" hospital (general practitioner hospital) is not easy: the relevant elements usually appear to be size (almost always falling into the 1-50 beds category); existence before the "appointed day" (5th July, 1948); a separate structure and administration; the acceptance of acute admissions not requiring isolation facilities; the intended absence of a high proportion of long-stay cases; contact with visiting consultant staff who are not based primarily at the hospital; absence of resident junior medical staff; and the right of some (if not all) local general practitioners to admit, treat and discharge their own cases, this right relating to a majority of the occupied bed days in each year." (page 12)

Two hundred and thirteen general practitioner hospitals in 13 regions were identified as accommodating consultant outpatient clinics (Tables 3.3 and 3.7), the average number of specialties per hospital was five. (The means for most of the individual hospital regions ranged between five and six.) However, 20 general practitioner hospitals each housed 10 or more specialties.

General surgery was the specialty most often found in general practitioner hospitals - 155 in all, and the average frequency of the sessions was once weekly. This scheduling frequency was matched by many of the specialties sited in the hospitals, see Table 3.3. The imbalance between gynaecology and obstetrics was even more marked within these units; 63 per cent accommodated gynaecology while obstetrics was held in only 27 per cent. The other specialties found in nearly half or more of such hospitals were general medicine (120 units) and orthopaedics (105 units).

(b) Health centres Only 44 health centres[1] in 11 regions appeared in the RHB returns to be sites of consultant outpatient clinics (Tables 3.3, 3.4 and 3.8) and yet by the end of 1972 there were in all 364 health centres in England (DHSS 1974b). It is probable that the data from the hospital boards were under-representative of firstly, the total number of health centres attended by consultants, and secondly, the full range of specialties offered. There seemed to be two main reasons for this situation.

(i) The DHSS did not request the submission of individual SH3 returns from decentralised premises in which consultant outpatient sessions were held. The 1972 SH3 Notes (DHSS 1971a) stated that an HMC or BG need not make separate returns for clinics which were under the control of a single hospital. So in such cases one combined return should have been made. If a peripheral clinic was sited in a neighbouring hospital group then the administrative responsibility for the return lay with the HMC/BG controlling that hospital group. There was no specific reference in the Notes to peripheral clinics sited in local health authority administered premises, e.g. health centres. Thus in some instances workload data for peripheral clinics were incorporated in the returns of the hospital departments to which the consultants undertaking the sessions were attached. This meant that the RHBs were unable to identify the statistics relevant to these decentralised clinic premises.

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[1] Included was the Nuffield Health Centre at Witney in Oxfordshire, financed by the Nuffield Provincial Hospitals Trust, whose statistics were obtained separately, (Pleydell 1972) and a premises at Maltby in Yorkshire which the Trent RHA classified as a health centre (a general practitioner had his surgery in the building), but was not recognised as a Section 21 unit in the DHSS list (DHSS 1974b).

(ii) Problems were encountered in classifying health centres in the submitted returns because RHBs tended to describe units by their administrative titles, School Ophthalmic Clinic, Orthopaedic Clinic, etc., and in the majority of cases the only address given was the town. Occasionally specialties held in the same building were listed as being in separate premises. A further complication in the categorising arose from local authority premises being described by the nomenclature of 'health centre'[1].

A validation procedure[2] identified six health centres not described as such in the returns or accompanying directories, while 33 units described as health centres were found to be in premises which did not accommodate general practitioner surgeries. Some health centres sited in the grounds of general practitioner or acute hospitals, housed certain consultant sessions which were previously held in the adjacent hospitals. In two such cases, the returns submitted by the relevant RHBs attributed the sessions to the hospitals.

It had been hoped that the health centre data supplied by the regions would complement the inventory in the British Health Centres Directory (Brookes 1973). Table 3.4 lists health centres identified from the returns of 11 RHBs plus the specialties in which consultant sessions were held. Also listed for each centre are comparative details from the Directory as regards services and administering bodies be they local authorities (LAs) or RHBs. There are discrepancies in the table. Either specialties appeared in the regions' data which were not in the Directory, or more often, there were additional specialties listed in the Directory. Personal communication occasionally revealed extra specialties in health centres in 1972 which were not apparent in either source. Further, 17 health centres providing RHB services in 1972 and sited within regions who submitted supposedly comprehensive peripheral outpatient data, were listed in the Directory (and in the table) but were unidentifiable in the regional returns.

The variations between the two sources are probably for the most part attributable to the differing methods of collecting the base data. The general problems in the regional hospital boards' data are amplified above. The information for the Directory was provided by the medical officers of health for the

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[1]This was possible since Part III, Section 21 of the National Health Service Act, 1946, enabled the term 'health centre' to be applied to premises serving a breadth of purposes, see page 3.15.

[2]This involved checking all non-hospital entries against three inventories (Brookes 1973, Trent RHA 1974, and DHSS 1974b), followed where necessary by telephone calls to individual premises.

local health authorities of England, Wales and Northern Ireland, and was that attaining on 31st March, 1972. Data about the Scottish health centres was gathered from the Scottish Home and Health Department plus other agencies. The medical officers were sent a list of health centres in their administrative areas (compiled from an earlier directory,Curwen and Brookes, 1971) and they were requested to check and amend the entries, but often this task was delegated to other staff, (Brookes 1974). They were instructed that where consultants undertook sessions in health centres, the relevant specialties administered by RHBs be listed separately from those of the school health service. The published Directory identified for each health centre the hospital board specialties (RHB) but in the other category, LA, there was no distinction between school sessions undertaken by consultants and sessions staffed by non-consultants such as psychologists engaged in child guidance.

(c) 'Clinic premises' Included in the category of 'clinic premises'[1] were chest clinics, special treatment clinics (venereal diseases), presumed to be administered by hospital boards, plus local health authority clinics (primarily obstetrics), and school health clinics - child psychiatry, orthopaedics, ophthalmology, and ear, nose and throat. Analysis according to specialty only seemed relevant as the composition of this category was so diffuse regarding origins of patient referrals, and age of patients (Table 3.3). In all 57 per cent of attendances at peripheral sessions were to 'clinic premises'.

In terms of total numbers of units, the ophthalmology specialty predominated being found in 236 'clinic premises'. Most of these clinics and those of child psychiatry, the second most frequent specialty so sited (144 'clinic premises'), would have been administered by local education authorities. (Overall, there were 498 child guidance clinics in England and Wales in 1972 (DES 1974), but what proportion of these was staffed by consultant psychiatrists is not known.)

Chest diseases and venereal diseases, although concentrated in far fewer of these units (63 and 14 respectively) had intensive session scheduling; the mean per clinic being seven sessions per week for chests and nine in venereal diseases (a consequence perhaps of the open access policy regarding patient self referrals in this specialty).

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[1] i.e. buildings which did not accommodate general practitioners' surgeries or inpatient facilities.

4. Authorities administering consultant outpatient clinics

It was hoped that the survey might show the proportion of consultant outpatient clinics outside district general hospitals which were held on behalf of local health and education authorities. These would have been staffed by consultants under arrangements with regional hospital boards.

The medical manpower inputs to local government medical services were surveyed by Warren and Cooper (1967). In April 1967 983 specialists employed by regional hospital boards in England were working on a sessional or part-time basis for local authorities. Ophthalmologists working for the school health service, chest physicians and psychiatrists (child guidance) comprised two-thirds of these appointments. By 1972, local education authorities in England employed under arrangement with hospital authorities 251 part-time and 19 full-time psychiatrists (DES 1974).

There was no requirement for notification to the RHBs by school medical officers of SH3 statistics or equivalent from consultant clinics under their jurisdiction. School medical statistics were submitted to the Department of Education and Science (DES). Likewise local health authority clinic returns need only have been supplied to the DHSS. This situation then probably explains the poor response by the regional hospital boards to the request for information about the administration of the community-based outpatient clinics. Only two regions, Oxford and Liverpool, indicated the sponsorship of their clinics.

5. Ratios of total/new outpatients as indicators of episode length[1]

The overall ratio for 13 hospital regions of total/new patients at peripheral consultant outpatient sessions in 1972 was 3.4 compared with 4.2 for all outpatients in England in the same year. It represented almost one less attendance in each peripheral episode and the characteristic of shorter episode lengths was evident in some measure in all 13 regions (Table 3.5). The ratios for general practitioner hospitals, health centres and 'clinic premises' for the combined regions was also lower than that for all outpatients in England, the general practitioner hospitals having the lowest average total/new ratio of 3.0, see Table 3.3.

Within individual specialties the same pattern emerged. Only child psychiatry and adult psychiatry were exceptions - Table 3.2. These findings must though be treated with some caution. Account could not be taken of variability in case mixes at the differing sites. Screening by either general practitioners

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[1]These are ratios of attendances within a 12 month period. Many episodes could have commenced prior to 1972 and others finished after December 31, 1972.

or consultants may have meant that urgent or more complicated cases with longer episode lengths were directed to the fully equipped general hospital, while referrals for advice only, and patients needing less frequent follow-up were channelled to the decentralised clinics. This may well be the practice in general surgery and general medicine, as the ratios for total/new outpatients in these two specialties were lower at all types of peripheral sites than for England as a whole. Many of the decentralised sessions in ophthalmology and orthopaedics were held on behalf of the school health service and this factor may have had a weighting effect in favour of shorter overall episode lengths if, relatively short outpatient episodes were a characteristic of school children (or chronic cases were channelled into the outpatient departments of acute hospitals) - see page 3.18.

The two specialties, child psychiatry and adult psychiatry, with slightly longer average episode lengths for peripheral sessions as compared with the national attendances, were typified by relatively extended episode patterns. The finding for child psychiatry was noteworthy since more than half of the total attendances in 1972 were at decentralised clinics.

6. Inter-regional variations

There was a wide variation in the overall numbers per region[1] of premises accommodating decentralised consultant outpatient clinics (that is amongst the 11 regions who submitted reasonably comprehensive data), from 122 units in Sheffield to 31 units for Leeds, (Table 3.5). General practitioner hospitals with consultant clinics were noticeably more numerous in the South Western region (61 hospitals with a mean number of specialties of 5.5)[2]; for most other regions the number of such units ranged between 12 and 21 (Table 3.6). As regards health centres identifiable in the returns, there was a very low level of provision in all regions except Sheffield with 16 centres housing consultant outpatient clinics (Table 3.7). This region also contained the largest number of 'clinic premises' with similar services (90), but was closely followed by North West Metropolitan and North East Metropolitan containing 81 and 78 'clinic premises' respectively, as can be seen in Table 3.8.

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[1] The boundaries of the regional hospital areas for England prior to April 1, 1974, were detailed in Health and Personal Social Services Statistics for England 1974. (DHSS 1974d)

[2] A reflection no doubt of a historical proliferation of cottage hospitals to meet the needs of a geographically dispersed population served by few major centres. (The hectare/population ratio in 1971 for the counties of Cornwall and the Isles of Scilly, and Devon of 0.93 and 0.75 were considerably in excess of the ratio for England and Wales, 0.31, OPCS 1972, 1973a, 1974a.)

To overcome the problem of differentials in the population distribution between regions, attendance rates per 1,000 1972 population were calculated, see Table 3.9. The South Western RHB had the highest rate per 1,000 population of new patients at peripheral outpatient sessions (25.7), followed by the Wessex RHB (20.3), and North East Metropolitan RHB (17.6). In terms of total attendances at peripheral units, the Wessex RHB appeared to exceed the South Western RHB in its provision per 1,000 population (71.4 and 70.2 respectively) but the statistics from the latter region did not incorporate child psychiatry which could have made a difference since in the overall 1972 figures, attendances in this specialty comprised seven per cent of the total peripheral attendances. A related calculation of units per 1,000 1972 population produced a similar ordering of the regions; North East Metropolitan, South Western and Wessex averaged one peripheral unit per 34 - 36,000 persons followed by Sheffield (38,000), and the remaining three metropolitan regions (42 - 50,000).

Generally, the regional variations in average peripheral episode lengths (that is the ratios of total/new outpatients for decentralised sessions, Table 3.5), did not seem to be marked. Among regions with reasonably comprehensive data, the lowest ratio applied to South Western but the absence of child psychiatry (which was characterised by relatively extended episode patterns) in the statistics for that region, plus a predominance of general practitioner hospital clinics which had the lowest overall total/new outpatient ratio, may have been the explanation. In contrast, in the returns of the two regions with the highest ratios, Oxford and North West Metropolitan, this specialty, i.e. child psychiatry accounted for 25 per cent and 13 per cent respectively of the total attendances compared with the mean for all the regions of seven per cent.

7. Anomalies in the regional statistics

Many of the anomalies in the regional hospital boards' presentation of outpatient statistics relating to decentralised clinics have already been cited, and these are summarised in Table 3.10.

It would appear that many of the Regional Health Authorities (RHAs) in 1974 were aware of the problems in accounting for peripheral outpatient premises. In November 1973, a NHS Reorganisation Circular, HRC(73)38, (DHSS 1973a) requested that the shadow RHAs in consultation with Area Health Authorities (AHAs) and Joint Liaison Committees as appropriate, identify all hospitals, day hospitals and HMC/BG clinics for which separate returns for accounting, statistical or any other purposes would be completed after 1 January, 1974. (This was not an administrative guideline[1], merely a listing of institutions.)

[1]The relevant circular here was HRC(73)27 (DHSS 1973b).

These institutions were to be classified into Broad type codes - 0 or 1 (hospitals), 2 (day hospitals), 3 (former HMC/BG clinics), and for codes 0 or 1 further two-digit numbers indicating detailed description, e.g. acute, maternity, were to be allocated. However, the RHAs were to bear in mind that "wherever possible hospital premises and HMC/BG clinics which are administered as an entity should be given one number only", (HRC(73)38) - a reminder of the convention applied in the completion of SH3 returns. (Codes to identify former local health authority clinics, school health service clinics, health centres, etc. existed but allocation re inclusion in these lists was optional for the regions. However, digits identifying general practitioner hospitals were absent.)

The consolidated lists subsequently compiled by the DHSS Statistics and Research Division highlighted the compilation difficulties experienced by some RHAs. Enclosures and corrigendas became necessary to supplement the original listings from some regions if only to take account of new or redesignated units. Moreover, interpretation of the categories, notably code 3 HMC/BG clinics varied (DHSS 1974c). The Trent RHA in their Directory (Trent RHA 1974) described Broad type code 3 as "former HMC/BG clinics-consultant services"; that is, clinics in which consultant outpatient sessions were held (prior to Reorganisation) be they on behalf of the regional hospital board, local health authority or school health service. In the DHSS consolidated lists this convention seemed to have been followed by many regions, but the entries for Yorkshire and North East Thames RHAs included many more HMC/BG clinics than were indicated to our study as having consultant sessions in 1972, some of the additional entries being school health clinics and special schools. Thus the difficulties experienced in the South Western region were probably typical for most other regions:

> "Where sessions are carried out by consultants in health centres or other Local Authority premises we would normally expect to receive an SH3 return .... Some such sessions have obtained for a number of years and it is not altogether clear on whose behalf they are carried out. In attempting to meet the requirements of Circular HRC(73)38 we are continuing to try to clarify the situation."
> (N.A. Dent 1974, Personal communication).

Summary of results

The purpose of the study, to gain an overview from existing routine records of the current situation in the decentralisation of consultant outpatient clinics from district general hospitals, was achieved. At least between five and six per cent of the new patients and total outpatient attendances in England in 1972 were seen at peripheral clinics. Nearly three-fifths of those

attendances were to 'clinic premises' administered by hospital authorities, local health authorities and the school health service, and most of the remainder were at sessions held in general practitioner hospitals. Even allowing for the incompleteness of the data, wide variations were evident in the inter-regional provision of accommodation for decentralised clinics - the South Western region's total encompassed 29 per cent of the general practitioner hospitals, while one-third of the relatively few health centres with consultant outpatient clinics identified in the returns were in the Sheffield region. Comparisons between the inventory in the British Health Centres Directory and the health centres list extracted from the RHB returns merely highlighted inconsistencies between the two sources.

The endeavour to distinguish between authorities administering the consultant outpatient clinicswas thwarted because of the lack of identification provided by the regional hospital boards, and this influenced the interpretation of the data relating to specialties. Ophthalmology was sited in more than 300 decentralised units but it could only be assumed that the great majority of attendances were made by school children because four-fifths of the clinics were sited in premises other than general practitioner hospitals and were usually labelled 'school eye' clinics. Of those specialties found in general practitioner hospitals (and therefore were more likely to be catering for family doctor referred patients), general surgery clinics were held in 73 per cent of these hospitals, gynaecology clinics in 63 per cent and general medicine clinics in 56 per cent. The crude indicator of episode length (i.e. ratio of total/new outpatient attendances) suggested that decentralised outpatient clinic episodes in all three types of premises and in all specialties excluding child and adult psychiatry, were on average shorter than the overall ratios for England in 1972. However, account could not be taken of variabilities in case mixes within specialties at differing clinic sites. What then are some of the implications of these findings?

Discussion

The general concept of health centres in which are gathered the health services of districts, with the medical staffing by general practitioners, and consultants and specialists visiting, was mooted in 1920 by The Consultative Council on Medical and Allied Services (the Dawson report, MOH 1920)[1]. Twenty-two years later a Medical Planning Commission of the British Medical Association reporting on a number of issues including group medicine and health centres,

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[1]These were the primary health centres referred to in the report.

considered that the services available in a 'standard form' of health centre might include the attendance of some specialists (Medical Planning Commission 1942). The Commission was more specific about the needs of the practitioner serving a sparsely populated rural area:

> "The rural practitioner ... needs a consultation centre: for example, an arrangement by which consultants in different branches of medicine would come to the area periodically to hold sessions to see patients presented by the practitioners." (BMJ, June 20 1942, page 750).

The provision of health centres was seen by this body as an official part of a regional authority's comprehensive medical service, the building being provided or approved by that authority.

The National Health Service Act, 1946, embodied this principle of health centres provided by local health authorities in which a range of facilities be made available including the services of specialists or other services provided for outpatients[1]. However, the momentum in the development of health centres in England was slow to build up - 17 were opened between 1949 and 1963, 166 between 1964 and 1970, while during the years of 1971, 1972 and 1973, the new units numbered 83, 94 and 104 respectively (DHSS 1974b). Even tardier was the proliferation of health centres incorporating consultant outpatient clinics for the provision of such was only found in the survey data in about 12 per cent of 364 centres in England at the end of 1972.

In many of the health centres where consultant clinics were undertaken on behalf of regional hospital boards prior to April 1974, the RHBs would have negotiated for accommodation when the centres were designed and this they subsequently rented from the local health authorities. Regional board policies differed with regard to health centre involvement (see Table 3.4) but the reasons have not been documented. It is known, however, that some experiments of consultant clinics in health centres lacking supporting diagnostic facilities have been viewed favourably by participating hospital clinicians (as detailed in Table 1.1). With Reorganisation and the transfer

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[1]Part III Section 21 in the National Health Service Act, 1946 directed that:
"It shall be the duty of every local health authority to provide, equip, and maintain to the satisfaction of the Minister premises, which shall be called "health centres", at which facilities shall be available for all or any of the following purposes:-

(a) for the provision of general medical services ... by medical practitioners;
(b) for the provision of general dental services ... by dental practitioners;
(c) for the provision of pharmaceutical services ... by registered pharmacists;
(d) ... services which the local health authority ... provide;
(e) for the provision of the services of specialists or other services provided for out-patients under Part II of this Act; ..."
(National Health Service Act, 1946).

of health centre planning and administration from the local government health authorities to the NHS, coordination in the design of future centres to accommodate almost all the services envisaged in the 1946 National Health Service Act, plus any diagnostic equipment seen to be necessary, should be much more feasible. (The Scottish Home and Health Department was in 1974 considering the inclusion of x-ray departments in all health centres serving a population of over 30,000, Barber et al 1974.) An additional consideration is that out-patient departments are becoming overcrowded in some district general hospitals. Where expansion prospects are dimmed because of planning cutbacks, health authorities might well be forced to seek alternative accommodation in premises such as health centres, clinics previously under the control of local health authorities and general practitioner hospitals.

The memorandum on community hospitals (DHSS 1974a) called for outpatient facilities to be provided in community hospitals.

> "At present most out-patient work is done at the district general hospital. While expensive equipment and supporting facilities should not be provided at community hospitals, it would be valuable for consultants to hold appropriate out-patient clinics there and suitable facilities should be provided. This will be more convenient for the patients and will also provide useful opportunities for case-conferences and other contacts between consultants, general practitioners and staff in other professions concerned in primary health care and hospital work." (page 8)

The responsibility for planning these units was attributed to the District Management Teams and Area Health Authorities in consultation with the Joint Consultative Committees. The document recognised that not all community hospitals would have the same functions[1], and that they would vary in size and location. Some local hospitals were considered to be adaptable but many existing hospitals were seen to be unsuitable because of siting or other reasons (unspecified) and it was essential that these should be closed so that the resources they used could be redeployed.

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[1] The services and facilities considered appropriate to community hospitals in the memorandum, ranged widely: certain general medical and surgical services for general practitioner cases, preconvalescent transfers and outpatients, continuous on-call medical cover including the treatment of minor injury cases, dental care for inpatients and outpatients, geriatric facilities for inpatients post assessment at the DGH, services for elderly patients with dementia, ante natal and post natal facilities, selected services for the physically and mentally handicapped and rehabilitation.

In guiding health authorities in the planning of community hospital services particularly with regard to the retention of existing hospital services the memorandum advised that they "should consider carefully the implications for capital and revenue expenditure and the efficient use of manpower". There was no reference to the 'needs' of the community as a variable. The regional hospital boards' data showed that in 1972 more than half of the approximately 400 general practitioner hospitals scattered throughout England were offering consultant outpatient services as well as inpatient facilities to their supporting communities. (Many of the general practitioner hospitals lacking clinics in 1972 were maternity units rather than acute hospitals.) There was of course, an uneven distribution of such units with outpatient facilities. The Liverpool RHB had only one while in the South Western region the number was 61. The average number of specialties to be found in these units was five - the individual means for 10 of the regions ranged between five and six. If in the completion of a national network of community and district general hospitals, many existing hospitals are closed, then will some communities be deprived of peripheral outpatient facilities that are at present meeting local 'needs'?

Which specialties then seem appropriate for decentralisation to peripheral clinics? The DHSS memorandum on community hospitals (DHSS 1974a) did not offer guidance as to which of the 'major'specialties in terms of total attendances (apart from ante natal and post natal clinics), would be most suited for community hospital accommodation. (Reference was made though to geriatrics, mental handicap,mental illness and dentistry.) The Sub-committee (chaired by Harvard Davis) reporting to the Standing Medical Advisory Committee on the organisation of group practice (DHSS 1971b), and Norell (1973) considered the specialties most suitable for decentralisation were general medicine, dermatology, psychiatry, paediatrics, obstetrics and gynaecology, and some aspects of geriatrics, although the criteria on which their judgements were based were unspecified. Fry (1973) also felt that there was a strong case for getting paediatricians, psychiatrists, obstetricians, gynaecologists and general medicine physicians into the community.

The specialties most commonly found in the general practitioner hospitals were general surgery, gynaecology and general medicine, (155, 134 and 120 units respectively), followed by orthopaedics and ear, nose and throat. Yet general surgery was not included in the lists of the authors cited above. These hospital general surgery clinics averaged one session weekly with mean sessional attendances of 7.4 new patients and 19 total attenders. In health centres, apart from ophthalmology and child psychiatry there were no preponderant specialties.

In the overall 1972 peripheral returns ophthalmology was the specialty found in by far the greatest number of individual units, indeed almost double those of the next commonest specialty, orthopaedics. Yet neither ophthalmology nor orthopaedics were recommended by any of the commentators cited above. Predominant in the 1972 ophthalmology statistics for peripheral sessions were returns from school health clinics and this probably accounts for the seeming oversight regarding the potentiality of this specialty for decentralisation, and it might also apply for orthopaedics.

It may well be argued that the school eye peripheral clinics are somehow different from hospital based clinics in that less sophisticated equipment is utilised, children with complications are transferred to hospital clinics, and generally, less severe disorders are treated in this medical area. Such views are not supported by some administrators of school health services (Lindon et al 1975); they feel that consultants can expect to be provided with an adequate range of equipment, and that relatively few children are asked to present at hospital clinics after initial assessment by the consultant at a peripheral site. Further, it is considered that children (who will probably have been already twice screened before referral, by the school health nurse and by the school medical officer or general practitioner) attending peripheral clinics receive a 'high' standard of medical care. They will almost always be seen by the consultant assisted only by a nurse whereas in the hospital, delegation of the case to a junior clinician is quite likely especially for follow-up attendances[1]. In addition, six monthly check-ups are more rigorously encouraged by school health clinic staff.

An evaluative study of the school eye clinics in the Northampton area did though cast some doubt upon whether the local resources were being put to the most efficient use (Ingram 1973). Over a period of one year 45 per cent of 327 new child patients seen in the school clinics were found to have squint and/or refractive errors requiring priority attention, 26 per cent

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[1] There were 320 part-time and five full-time ophthalmic specialists staffing the school health service in England in 1972, but the proportion who were not consultants was unstated (DES 1974). This was thought to be small (Lindon et al 1975).

did not have an ocular defect[1], while 29 per cent were diagnosed as having uncomplicated myopia. It was this latter group which it was felt could be adequately treated by ophthalmic opticians or ophthalmic medical practitioners so not requiring the attention of a consultant ophthalmologist[2].

The difficulties experienced in obtaining comprehensive peripheral clinic statistics from the 14 regional hospital boards in England, coupled with the problems of interpretation served to highlight generally the complexities prior to 1974 of amassing on a regional or national basis workload statistics spanning the breadth of the health care system (e.g. consultant services provided in hospitals, local health authorities and the school health service). The potential value of medical information systems as a tool in the planning of optimum health care is widely acknowledged - see for example Benjamin (1971), Bodenham and Wellman (1972), and Alderson (1973a and 1974). Hospital Activity Analysis (HAA) is an integral part of the National Health Service information system although many problems in its development remain to be solved particularly if it is to encompass both inpatient and outpatient workloads in the future. There are current research programmes developing outpatient monitoring systems. The Sheffield RHB (later Trent RHA) in conjunction with the DHSS commenced routine recording of outpatient HAA in the Chesterfield group of hospitals in 1970 (see Trout 1973, and Trout and Martindale 1974) and the project continues (Smith 1974). Trials were designed in at least two other hospital regions, notably the South East Thames and South West Thames RHAs (Kempner 1974). The Medical Information Unit of the Wessex RHA has been designing and testing a national outpatient form as part of a health information development (Alderson 1973b).

[1, 2] Gruer (1972) in her study of outpatient facilities in the Scottish Border Counties, found that for local authority consultant clinics the category 'nothing abnormal discovered' was very high (24.3 per cent) compared with a range of 3.6 to 9.3 per cent in the hospital clinics.

In reviewing the role of local authority clinics in these counties Gruer felt that because individual sessions were not over-booked, and because they were conveniently situated for patients, many cases which did not really require consultant care were referred, and many cases which could well be discharged retained. However, it was not thought advisable to withdraw some services from that district and her conclusion was widely applicable:

> "a reappraisal of the specialist services for children within the context of such services for the whole community might result in a more effective use of resources, at the same time retaining or improving accessibility to those in need." (page 29).

These schemes will inevitably take time to be suitable for widespread application, but in the meantime can administrators and researchers expect fully comprehensive outpatient statistics based on SH3 returns to be available at Area or Regional level? The DHSS took steps towards standardising the classification of health authority premises when it instructed the shadow regional health authorities to compile and submit lists identifying health institutions for which separate returns for accounting, statistical or any other purposes would be completed. But the policy relating to the compilation of SH3 returns has remained unchanged (although Area Health Authorities, Area Health Authorities (Teaching) and Boards of Governors now have the responsibility for submitting them to the DHSS and RHAs). There is still no need for separate returns to be made for clinics which are under the control of a single hospital. Further, figures for clinics which were previously administered by local health authorities are not to be included, (DHSS 1973d). Yet an understanding of the differentials in the behaviour of clinicians and patients at alternative sites is a prerequisite for rational planning of outpatient services and analyses of workload statistics would seem to be an obvious starting point.

Conclusions

The inherent assumption throughout the discussion of the survey has been that the decentralisation of consultant outpatient clinics away from hospital complexes ought to be encouraged by the DHSS. However the case for such a policy really has not yet been proved by evaluative studies. The advantages are usually viewed by commentators, as being positive to the patients especially those resident in rural areas. Gruer (1972) constructed models of the estimated costs to both patients and the NHS (consultants' travel time) of alternatives in clinic siting in the Scottish Border Counties. She deduced that the most economical model was one which incorporated a planned local general hospital coupled with peripheral clinics staffed by consultants from this hospital, (see Section 2 for a brief critique of this study). The Medical Care Research Unit at Newcastle-upon-Tyne went further and collected data about costs both financial and timewise from individual patients travelling up to 40 miles in round journeys to a DGH in East Cumberland (Glass 1973b). The results from this study are not yet published. There are a number of small descriptive reviews of consultant clinic experiments in health centre and group practices in which convenience to patients has been cited as an advantage (see Table 1.1). But no study to date has attempted to estimate the 'opportunity' costs of consultants' involvement in peripheral clinics.

One very important question still to be answered is to what extent are the case loads in established decentralised clinics different from those of the hospital based clinics in the same specialty? There were consistent regional and specialty trends of episode lengths in peripheral clinics for all types of premises (as indicated in the ratios of total/new outpatients) being on average shorter than national episode lengths in the 1972 survey data. A variety a possible explanations can be proffered. It may be that lengths of episodes are related to the degree of autonomy within the medical teams undertaking the clinics - house officers in hospitals being less inclined towards discharging patients than consultants who tend to conduct peripheral clinics single-handed. Again, a referring general practitioner or consultant may screen patients directing the 'less ill' to the peripheral sites. Patients requiring infrequent follow-up may be directed to their 'local' clinic. The extent to which consultants need backing up facilities particularly X-ray and pathology has not really been probed although the Newcastle study did record the types of examinations ordered for each person surveyed with the intention of identifying the frequency that tests were ordered which could not be undertaken during the same attendance at the hospital for the outpatient appointment. Wade and Elmes (1969) finding that 85 per cent of patients seen in a general medical outpatient clinic could have been treated equally well at sessions held in a health centre, applied to only one specialty over a two month recording period.

Changes may occur in the referring/discharge behaviour of general practitioners and consultants as a consequence of resiting clinic sessions in close proximity to the family doctors' surgeries. The educational benefits to both the general practitioner and the consultant were stressed in a number of papers detailed in Table 1.1. The long term effects could be a reduction in both the number of referrals made and the average episode lengths. On the other hand, some general practitioners knowing that their patients were going to be less inconvenienced travelwise, might make increasing demands upon consultants' services. The patients too may modify their expectations about specialist care and become more demanding of referral. It was suggested by Gibson (1966) and Brook (1967) that an advantage of holding psychiatric outpatient sessions in general practitioners' surgeries was that the 'familiarity' of the setting plus the convenience encouraged the attendance of patients who would otherwise have been reluctant to present at a hospital department.

The survey of the 1972 regional hospital board statistics has provided an overview of the distribution of consultant outpatient clinics sited outside the confines of district general hospitals. A marked regional and specialty imbalance was found. However, the study has not shed light upon the questions raised above. For this purpose, well designed micro-studies of experimental schemes are needed. But a general understanding of the outpatient sector is a prerequisite to any evaluative assessment of peripheral clinics. The literature review in the following section will it is hoped offer some elucidation.

SECTION 4

THE INTERFACE BETWEEN 'PRIMARY' MEDICAL CARE AND HOSPITAL OUTPATIENT CARE - A REVIEW OF BRITISH LITERATURE

Cognisance of the general issues surrounding the siting of outpatient clinics will be fully realised only after all the elements of the outpatient 'system' are considered. But what is really known about the interface between 'primary' (community-based) and 'secondary' (hospital-based) care in the British context? It is in the outpatient sector that ambulatory patients make their initial contact with the providers of 'secondary' care. The linkages between this sector and the 'primary' agencies include the referral and discharge of patients, the back and forth flow of patient records, and lately, the movement of specialists from the hospital to undertake sessions in decentralised outpatient clinics. Thus there is a centripetal movement of patients from the periphery to the centre, and the centrifugal transfer of firstly, patients discharged to the community either with treatment completed, or for continued management in day hospitals, community hospitals and by 'primary' medical teams, and secondly, some skilled personnel.

There are three participants in the outpatient consultation process, the patient, the referral agent (usually a general practitioner via a written communication), and the consultant or his deputy. This section reviews the literature referring to the interrelated parts, the patient, the general practitioner and the consultant, in the hope of teasing out the factors controlling the centripetal and centrifugal movement of patients through the community/hospital interface. For, without comprehension of the 'roles' of the components in the outpatient system, can studies evaluating the costs and benefits of alternative clinic sites be successfully mounted?

1. The Patient

Within the National Health Service patients can only present at outpatient departments for specialist advice after being referred initially by a medical practitioner or certain other health/welfare agencies. (There is open access to venereal diseases clinics and accident and emergency departments.) "The process of referral hinges on the formal organisation of the service modified by an informal medical and community network." (Spencer 1971).

Little is known of patient strategies in the referral process. The Stimson and Webb (1975) study about the consultation process in general practice threw no light on this facet of the patient/doctor interaction. Cartwright (1964, 1967) in two patient surveys assembled views about general

practitioners' referral decisions in relation to respondents' illnesses, and direct access to specialists. In the 1964 study attitudes towards doctors' referral decisions were reported via anecdotes from which Cartwright concluded that there was a need for another way in which patients could obtain a second opinion. However, the later study reported that of persons asked how they would feel if they did not have a family doctor but could go straight to the appropriate specialist, 79 per cent unequivocally preferred to have a general practitioner and the main reason given was the need for some preliminary diagnosis. The majority of the 13 per cent choosing to see specialists felt that specialists were better qualified and had more knowledge or better equipment.

Relatively few referrals seemed to Chamberlain (1966) to be in direct compliance with patients' wishes. From an analysis of referral letters to clinicians in three hospital groups, i.e. a south coast group, London non-teaching and London teaching, Chamberlain determined that no more than eight per cent of referrals to the first two hospital groups were suggested by patients or relatives, while less than three per cent of the referrals to the teaching hospital were similarly instigated.

Patient/consultant interactions likewise have been little observed and reported in Britain. Bloor (no date) analysed about 500 interactions between 11 ear, nose and throat specialists and the parents of child-patients in Scottish outpatient clinics - these clinics were seen as a round of routine[1] activities. There were clinical routines - the interpretation of signs and symptoms, the setting up of investigatory procedures, and the clinic organisation. Further routines (strategies) were operable to ensure the parents' acceptance of the surgeons' decisions regarding the necessity or otherwise of surgery. The parents did though have some potential influence over the outcome in terms of their presentation of the patient's history, and their answers to questions asked during the examinations of patients (but no account was taken by Bloor of the contents of the general practitioners' letters). Like Stimson and Webb (op cit) Bloor too observed the maintenance of autonomy by the clinicians; the position of the patient's chair, the mannerisms employed in guiding patients/parents out of the consultation, etc. So in all, these specialists were seen to create "a world populated by familiar complaints to which familiar investigatory procedures can be applied to yield up familiar findings which imply familiar forms of therapeutic intervention", (page 2). Although in the ear, nose and throat clinics the unexpected occasionally

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[1] The notion of routines was applied by Fletcher (1974) to the performance of the family doctor in the consultation process. The entire consultation was seen as a routine within which sub-routines could be employed - e.g. familiarisation, a diagnosis, therapy including prescriptions, and the possibility of issuing a sick note.

disrupted the interaction, over time these too became a routine so that truly novel situations where the specialist found his responses to be problematic became rarer.[1]

Who are the outpatient attenders?

(a) Overall attendances rates

The General Household Survey (GHS) conducted by the Office of Population Censuses and Surveys (OPCS), collected information in 1972 from over 34,000 informants in just under 12,000 households in Great Britain about usage of casualty or outpatient departments of hospitals apart from ante-natal or post-natal clinics (OPCS 1973). The question asked was,

> "During the months of ....., ... and ....., did you (or any of your children under 15) attend as a patient, the casualty or out-patient department of a hospital (apart from hospital ante or post-natal clinics)?".

Ten per cent of informants said that they had attended one or more times in a three-month reference period - it represented an average of 1.0 attendances per person per year. It was thought that this attendance rate was lower than might have been expected (although the rate calculated from the Department of Health and Social Security's 1971 statistics for England and Wales was 0.9, DHSS 1974d). Comparisons though were difficult for a number of reasons, notably the DHSS policy of recording each departmental visit as a separate visit, plus the impossibility of calculating from the GHS data the number of multi-attendances.

The incomparability of their findings with national workload statistics recorded via S.H.3 returns (see Section 3) bothered the OPCS. Reasons offered included the long reference period on memory for informants, and more critically, the definition.

> "The out-patient department and the casualty department of a hospital have very precise meanings in offical terminology. For example, the former means a place where specialist advice and care is given to ambulatory patients who are seen by appointment, usually following referral from general practitioners. To the general public the out-patient department may mean any one of a number of different departments they go to, having entered a main door of a hospital bearing a sign "out-patients"." (OPCS 1973, page 324).

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[1] See however the claim of Emerson (1970) that the reality of the gynaecological situation could never be routinised but would always remain precarious; and she felt that the gynaecological examination should not be dismissed as an anomaly but as an extreme example of the phenomenon.

[2] In the 1972 GHS, again some 10 per cent of informants in England and Wales claimed that they had attended the casualty or outpatient department of a hospital (excluding ante- or post-natal clinics) one or more times during three months. The General Household Survey 1972, OPCS 1975, HMSO.

In 1972 a pilot study was undertaken to try to separate out in the minds of the informants, consultative outpatients attendances from casualty or emergency attendances and visits to ancillary departments such as physiotherapy. The study revealed "quite extensive inability on the part of informants as a whole, to identify in official terminology the proceedings in which they had taken part when they went to a hospital, other than as an in-patient." (OPCS ibid)

Cartwright too (1967), although from a very much smaller population sample found that her 1964 data suggested a lower annual average rate of attendances at outpatient departments including casualty than indicated by the Ministry of Health estimates of 0.9 attendances per person. Three quarters of her sample had not attended in the 12 months under question.

On the other hand Palmer et al (1969) and Clarke and Bennett (1971) reporting on the Lambeth population survey, commented that when sample results were checked against hospital records the general tendency was for more hospital experience to be reported than recorded. But this may have been a characteristic unique to an inner London community - validation showed that the hospital experience of men was better reported than that of women especially elderly women, while that of social classes I and II was better reported than that of other classes.

(b) Social characteristics

The age and sex distribution of outpatients were recorded in a number of studies[1] (see Table 4.2) but only in a few reports were the age groupings of new attenders related to the total population of the catchment areas, i.e. Scott and Gilmore (1966), Backett et al (1966), Forsyth and Logan (1968) and Gruer (1972). In all of these studies the representation of the elderly (persons over 65 years of age) in the outpatient new referrals, was relatively proportional to their representation in the total catchment population.

It bothered the authors of the three studies published in the 1960s referred to above, that the elderly were under-represented in the outpatient population; this seeming anomaly being heightened by comparisons made with the age distribution of general practitioners' consultations, and inpatient rates of bed occupancy and discharges. Forsyth and Logan offered two possible explanations; the deprivation of the inter war period may have lowered the expectation of persons over 65 years of age in their approach to medical services, and the less willingness of the elderly to exert pressure upon

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[1] Definitions and fieldwork for these studies are detailed in Table 4.1. The morbidity study of Exeter 1966-67, also detailed social characteristics of outpatient attenders (Ashford and Pearson 1970).

general practitioners to refer them for specialist opinion until the condition became so acute that the first contact with the hospital was inpatient admittance or a domiciliary consultation. However Gruer (op cit) took to task the specious assumptions in this argument. She suggested that new outpatient referrals could not be compared with all general practitioner consultations. "Either new outpatient referrals should be compared with new general practitioner consultations or all outpatient consultations compared with all general practitioner consultations. Similarly new outpatient consultations appear comparable with discharges and deaths from inpatient care, and all outpatient consultations with occupied bed-days of inpatient care." (page 72).

Gruer demonstrated that the age group 65 years and over comprised about 15 per cent of the Border Counties population in 1966. In 1969 they formed fewer than 20 per cent of the total new referrals to outpatients, but 30 per cent of all outpatient consultations excluding physiotherapy, and when physiotherapy was included, the figure was 40 per cent of all consultations.

Unfortunately, even Gruer may have based her argument on a somewhat false premise. Both she and Forsyth and Logan when comparing outpatient attenders (new and total) with users of other medical services, grouped together the over 65s. Doubt on the validity of such a grouping is shown in the General Household Survey's finding (OPCS 1973) that persons aged 65 - 74 in England and Wales had far higher rates per 1,000 population as attending outpatients in a three month reference period (103.6 males and 125.6 females, the largest of any age/sex group) than persons aged 75 years and over, the mean for the two sexes being 96.1. This was consistent with the findings in the morbidity statistics from general practice (OPCS 1974). In the referrals to outpatient departments by general practitioners, males and females aged 75 years and over had lower rates per 1,000 population than those aged 65 - 74 years, but these were offset by far higher inpatient admission rates for the older age group.

Data about marital status were presented in only three of the comprehensive outpatient studies summarised in Table 4.2. Forsyth and Logan (1968) concluded again from new referrals only, that "In terms of marital status outpatients 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." (page 37). But doubt on the applicability of such a conclusion to all outpatient attendances was once

more cast by the General Household Survey , for the rates of attendances per 1,000 persons over a three month reference period werehighest for the widowed/divorced/separated in each of the age groups presented, (OPCS op cit).

The social class composition (particularly classes I, II and V) of new patients attending a south coast hospital group and a London non-teaching group were seen by Chamberlain (1966) to reflect the constitution of the population in each area (although no evidence of this was offered). In comparison, an analysis of new referrals to a London teaching hospital (Guy's) suggested that these outpatients were not selected randomly from the general population (Butterfield and Wadsworth 1966).

(c) Distances between outpatient departments and patients' residences

The majority of outpatient studies recorded the address of outpatient attenders (see Table 4.2), usually with the expressed intention of defining catchment areas which could be used as a basis for the calculation of referral rates, e.g. Montgomery's study of St. Thomas' Hospital (1968), and Chamberlain et al (1966) re Guy's Hospital. Backett et al (1966) and Gruer (1972) were however surveying the outpatient facilities serving wide geographical areas (the city of Aberdeen and four counties, and the Scottish Border counties), and the influences of peripheral clinic sites in the referral decisions was discussed by them. Distance was seen to be only one factor affecting the referral pattern in North-East Scotland for there were differences in the proportions of referrals sent to Aberdeen between groups which were approximately the same distance away. Specialty availability, waiting times for appointments and consultant preferences were also presumed to be influences on the choice of site.

Gruer (ibid) defined a rather more patient orientated approach to the problems; she was concerned that patients resident some distance from outpatient clinics were disadvantaged in terms of the amount of 'care' they could 'consume'. She hypothesised that

> "If distance from a clinic is a deterrent to referral to that clinic, one would expect to find an inverse relationship between the ratio of the observed referral rate from each county to the expected referral rate to the same specialty and the ratio of the observed proportion who travelled more than the specified distance to the expected proportion who travelled that distance." (page 52).

Using ratios for five specialties (in which the total number of referrals was 30 or more), an inverse relationship was found to exist - when the distance selected was 15 miles, the correlation coefficient was -0.78. Distance was found not to have an effect upon the status of the doctor who saw

the patient at the first consultation, neither on the level of diagnosis reached nor the outcome for patients in need of advice only or management of a condition. But there was a trend that with increasing distance an increasing proportion of patients presented with acute conditions requiring immediate inpatient admission rather than being put onto a waiting list, or further investigation. (Distance too may have acted as a deterrent to the general practitioner in ordering diagnostic investigations for such patients.)

If this rather tenuous claim could be substantiated, i.e. that patients resident some distance from outpatient departments are less likely to be referred, and when referral does occur are presenting with clinically more acute conditions, (and Gruer does point to the much higher crude referral rate found in the Edinburgh catchment area, 15.2 per 100 population, by Scott and Gilmore (1966) compared with the Border Counties estimate of 8.7 per 100), then it could have significant implications for policies regarding decentralised outpatient clinics.

(d) 'Time' and the patient

Is it possible that the organisation of consultant sessions in health centres and group practices may hasten the processing of individuals' perceived needs for some form of medical help or advice into demands on the health care system? They may decide to attend the general practitioner much earlier within any period of 'psycho-biological' disfunction because they appreciate the convenience of referral to specialist supervision (either in the 'time' sense or ease of location and/or familiarity of setting). This may be viewed by the profession as loading the consultants with unnecessary case loads of 'trivia', but alternatively, patients, and therefore the community, could be making significant savings in terms of days not lost from work, family stability, etc. There have been oblique hints to patients' responsiveness to their own illness in at least three reports of psychiatric outpatient clinics held in health centres - it has been commented that patients have shown a willingness to meet with the consultant in a familiar setting whereas they would probably have baulked at attending an outpatient department, see Gibson et al (1966), Brook (1967) and Condon et al (1973). (Admittedly there is a suggestion now that spontaneous recoveries are made by some patients waiting to see psychiatrists, but such occurrences may be a reflection of the indiscriminate referral patterns of certain general practitioners.)

Although there seems to be a variable time gap between individuals' perception of a disease threat and their seeking medical attention, once they have entered the health care system their expectations regarding the speed of the delivery of care may be more uniform. In a small study based on a group practice with direct access to X-ray and pathology departments in two London hospitals, it was shown that the onus was on the patient either to deliver his specimen to the laboratory or make his own appointment with the X-ray department. The length of time between the dating of the referral letter handed to the patient by the practitioner, and the date of receiving the results was measured; almost one-third of the X-ray results and one-quarter of the pathology tests were available within three days, 80 per cent of both types of results were returned within the week, and virtually all within three weeks. (Heafford and Heafford 1972). Thus patients' motivations to hasten investigatory outcomes appeared to be high.

Patients' anxieties about the 'speed' at which they entered the secondary care system were revealed in a 'medical audit' of the referrals to hospital agencies by 18 Leicester general practitioners (Fraser et al 1974). Over an 11-12 week period 694 NHS registered patients were referred for specialist opinions in outpatient departments (excluding obstetrics and casualty) of whom 139 (20 per cent) opted for a private consultation. Of these, 120 chose to attend privately at the time when the decision was first made to refer them, and 19 requested a private consultation after receiving the NHS hospital appointment date[1]. Reasons given by the patients for their choice were, a desire to by pass the outpatient waiting list (46 per cent), to avoid waiting in outpatient departments (18 per cent) and to enable consultant choice (also 18 per cent of reasons). Significantly almost half of those preferring private appointments were categorised as social classes I and II. However, no more than six per cent of the total referred population belonged to a health insurance scheme.

If these experiences cited above do truely reflect certain individuals' desire to accelerate the delivery of care to themselves, then untold are the frustrations experienced by patients, who, having been examined by a consultant, are told to see their general practitioner in a week or so to receive a prescription for medication as advised in the consultant's letter.

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[1]The survey showed that for 40 per cent of the NHS referrals the waiting time for a routine outpatient appointment was between 6-16 weeks, amongst the private sector patients only 5 per cent experienced such a long delay.

Excessive time expenditures have been recognised in three areas of the outpatient event: firstly, the waiting period before an appointment date, secondly, within the clinic itself, and thirdly the travelling to the clinic site.

(i) The waiting period before an appointment date and its effects

The 1964 Ministry of Health circular on Management Problems in Out-Patient Departments, (HM (64) 102), was intended to encourage Hospital Management Committees (HMCs) to examine and, where necessary, to improve the service offered by their outpatient departments. Two standards were suggested; a waiting time for an appointment not to exceed two weeks, and reduced waiting time within outpatient departments. Specific suggestions not requiring any major expenditure were included in the circular. Stewart and Sleeman (1967) analysed the responses of a random sample of HMCs in England and Wales to these requests. They sought answers to the questions of whether the circular was necessary, was treated conscientiously, and made any difference. Of a sample of 30 HMCs with large outpatient departments, none could meet the standard of two weeks wait for a clinic appointment excluding urgent requests. One third of the HMCs had made no attempt in the five years prior to 1966 to check the workings of the appointments system and few of the others reviewed it regularly. It was found that 11 HMCs had a positive approach to the circular so making a thorough review of the situation. Nine did almost nothing. But was the standard of a two week appointment waiting time realistic? Stewart and Sleeman never questioned this supposition.

Investigations of data relating to appointment waiting times formed part of many of the studies outlined in Table 4.2. In particular, Backett et al (1966) generalised that

> "The principal determinant of waiting-times for appointments must, of course, be the frequency of clinics and the case load." (page 106).

But it can be argued that case loads are an effect as well as a cause of waiting time interval - doctors adjust their referral rates in accordance with fluctuations, especially seasonal, in the waiting list delays. (Most hospital outpatient departments now circulate local general practitioners with specialty waiting time information.) An example of family doctors sending patients to a more distant hospital in which the consultant of their choice held clinics, rather than to him at the nearby hospital with a longer appointment date waiting time, was cited by Forsyth and Logan (1968).

The dual waiting periods - the total time lapse between the referral and the receipt of the hospital letter with instructions on the management of the condition including prescribing and work resumption, concerned Carmichael et al (1963); it was their subjective impression that

> "Often the decision to refer a patient who is already off work is delayed in the hope that he will recover sufficiently to return without a second opinion being sought." (page 737).

These authors also attempted to 'cost' the interval between referral and the implementation of the specialist's service.

The 'costs' to consumers and the NHS of waiting lists especially for inpatient admission[1] are being probed by health economists[2]. The adage that waiting lists serve a useful purpose because some complaints cure themselves in the mean time (see for example Backett et al, op cit, page 101), has been seen as a 'benefit' to the NHS, but it should also be regarded in the outpatient sector as a 'cost' to the consumer. Clinic sessions normally comprise a mix of new and return patients, the new patients being apportioned as much as 20 to 30 minutes of the clinician's time in some specialties such as general medicine. In psychiatry, the appointment time scheduled for a new patient may be up to one hour. The defaulting of a new patient because of a spontaneous recovery, (and so it could be argued was possibly an inappropriate referral), has the effect of depriving at least one other individual of a consultation. Further, although the clinician may prefer not to waste his time viewing 'well' patients, at least he is spared the administration involved in pursuing defaulters. (And he may choose to 'educate' the referral agent in the handling of such cases to obviate future referrals.)

Long waiting times, death and inpatient admission are the reasons most frequently identified for non-attendance at outpatient clinics by new and return patients. Gruer (1972) did not find distance between home and Border clinic sitesa significant variable amongst the Border Counties self-discharged patients (see also Hoenig and Ragg 1966). In the Guy's Hospital study 11 per cent of patients failed to keep their appointments and it was observed by the authors (Butterfield and Wadsworth 1966) that this figure was very

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[1] Cocking (1974) raised doubts about the standard methods of determining waiting list sizes for inpatient admission. For example, waiting lists compiled from SH3 returns are of patients who have not been offered or given a date for admission. Thus patients with allocated dates for 'cold' surgery are excluded. On the other hand, many names are no longer valid because of death, removal, etc.

[2] For example, the Medical Care Research Unit, University of Newcastle-upon-Tyne, have been estimating 'costs' to patients for alternative forms of surgical treatment for hernias and haemorroids. The Institute of Social and Economic Research at the University of York has interests in hospital waiting lists, see Culyer and Cullis (1975).

similar to the Nuffield Provincial Hospitals Trust's (1965) findings for 474 clinics of 12.7 per cent. However, they failed to point out that the Guy's result applied to new patients only. Backett et al (1966) conducted a separate sample survey of one hospital within their North-East Scotland study, to identify the performance of patients marked on the computer clinic lists as 'DNA'. Of the total number of unkept appointments, 44 per cent definitely kept later appointments, 34 per cent definitely never attended as a result of the initial referral, and 13 per cent could not be traced. Thus they surmised that the true estimate of referrals to this hospital was 95 per cent attenders and five per cent non attenders[1].

Psychiatry has been identified in more than one study as the specialty with the largest number of patients who fail to complete the course of treatment - see Trout (1973), and Bryden (1970). So, bothered by the high defaulting rate (almost one-fifth) of new psychiatry patients with appointments at the Manchester Royal Infirmary, Hoenig and Ragg (1966) tried to see how much the appointment system contributed to the absenteeism. They found that lengths of waiting time particularly when more than four weeks, had an adverse effect, but distance was not a factor. A close relationship between specialist and referring agent, preferably another specialist, seemed to improve attendance rates. Their final assertion added further weight to the case for experimenting with peripheral outpatient mental illness clinics; "Even if administrative adjustments are made ..., it is not likely that this will reduce non-attendance to the level of that found in non-psychiatric clinics" (page 100).

(ii) The period between the scheduled appointment and the actual time of consultation. Operational research studies in this area have been numerous.[2] The general conclusions seem to be that appointment systems operate at maximum efficiency if the consultant arrives on time; block bookings do not occur except at the start of clinics when two or three patients can be scheduled for the same appointment time, so minimising the consultant's free time should there be defaulters; 'new' patients, who absorb on average two or three minutes more of the consultant's time to be interspersed with return patients; and lastly, patients arrive on time. Frequent references are made to this behavioural characteristic of patients arriving in outpatients departments early for appointments, but none of the studies have attempted to probe the reasons.

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[1] Eastwood in Edinburgh interviewed outpatient defaulters as part of a study investigating the use of hospital departments by general practitioners. (Personal communication 1973.)

[2] See for example, Oxford Regional Hospital Board (1962) and (no date), Nuffield Provincial Hospitals Trust (1965), and Barber and Abbott (1972).

Many patients will, of course, be dependent upon the scheduling of public transport or ambulance/hospital car services. However, early attenders are commonplace in general practitioners' surgeries - a study of a three-man partnership by Cunningham et al (1975) showed that over a duration of 127 surgeries per doctor about half of the patients arrived early for their appointments and the average number of minutes early was 10 approximately. Bevan and Draper (1967) in short surveys of 11 practices observed that 34 per cent of patients arrived more than five minutes prior to their appointments.

Finally, the questions must be asked, what are the patients' expectations of the care they receive from the specialist, and are they really distressed by the 'inhumane' conditions of many outpatient departments, (see Porritt 1962, and Forsyth and Logan 1968)? The findings of Carstairs (1970) in Scotland suggest a widespread indifference. Scott and Gilmore (1966) integrated patient interviews into their study on outpatient services in the Edinburgh hospitals. They received numerous complaints about lack of privacy in the consultation. Half of all the patients interviewed knew the name of the clinician who examined them, but only one-fifth knew what his status was and it seemed of little importance to those who did not know. Most of the patients knew the diagnosis of the condition for which they were referred, having been told this either by their general practitioner or hospital clinician, but a number would have welcomed more information from the hospital doctors.

2. The General Practitioner

> "He acts as the essential intermediary in the transmission of specialised skills to the individual. Without this function of the personal doctor the hospital service can be used wastefully, even damagingly to the patient. This involves assessment of patients' requirements and selection of the appropriate consultant and department. The family doctor must interpret the patient, his problem and circumstances to the consultant, explain the need for hospital service and its possibilities to the patient and ensure the necessary communication with all concerned including the relatives." (page 9, MOH 1963)

This was one of three aspects of the work of the family doctor spelt out by the sub-committee chaired by Annis Gillie, of the Standard Medical Advisory Committee. This role of general practitioners is unique to Britain; Stevens (1966) details the evolution of the present referral system.

General practitioners' referral patterns to hospital departments are widely divergent.[1] The study Morbidity Statistics from General Practice, (OPCS 1974), presented referral rates per 1,000 population (on practice

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[1] The following discussion on referral behaviour lacks specific references to research concentrating upon psychiatric referral patterns: see for example, Rawnsley and Loudon (1962), Shepherd et al (1966), Sainsbury (1969), Hopkins and Cooper (1969), Kaeser and Cooper (1971), Mezey and Kellett (1971), Fahy (1974), Gardiner et al (1974a and 1974b) and Robertson (1974).

registers); the overall rate for 115 principals in England and Wales to outpatient departments in 12 months 1970/71 was 86.0. However, there were marked standard regional variations and within regions, fluctuating urban/rural rates- the highest regional rate, East Anglia rural only (four principals), was almost double the national figure, (160.7), the lowest rate was for the combined 14 principals in West Midlands, (67.2).

In field work carried out almost 10 years previously, Forsyth and Logan (1968) observed for 369 general practitioners gross variations in outpatient referral rates per individual doctor. Most general practitioners referred between 40 and 80 patients per 1,000 practice list, but some referred over 200 and others less than 20.

Yet the mean rates of referral in the two studies are at variance with each other, the 1960s figure being considerably lower than the 1970s. The explanation may rest solely upon behavioural changes in general practitioners over the decade, plus increased open access to diagnostic and remedial hospital departments. But a partial explanation probably lies in the methodology of the two surveys. Firstly, the participants in the OPCS survey were self-selected general practitioners with strong motivations towards research, whereas the Forsyth and Logan enquiry was restricted to general practitioners practising within defined catchment areas of the hospitals under review. Secondly, the morbidity study participants recorded individually all referrals made not only to outpatient departments but also to inpatient and investigatory departments plus local authority agencies. Thus in theory, the total results should have reflected a 100 per cent coverage of referrals to departments in any hospital, not just local hospitals. In comparison, Forsyth and Logan extracted information about referred patients from hospital records, and so if general practitioners within a hospital catchment area had referred patients to other hospitals, evidence was not available. Therefore, there could have been under-recording of the total number of referred patients. Thirdly, the OPCS rates per 1,000 population were calculated against age/sex registers for each participating doctor/practice. The earlier study was forced to rely upon information supplied by executive councils about list sizes. As it is now widely recognised that list estimates from central authorities can vary as much as 10 per cent from the 'actual' practice populations, because of death, removal of patients either from the district or preferred choice of doctor, etc. (Munro and Ratoff 1974), this could have the effect of inflating age/sex rates quite considerably. Lastly, the definitions of referred patients may have been inconsistent between the two studies.

I have deliberately laboured the observable reasons for incomparability between these two national surveys. It has been the disregard of researchers for the need for uniformity in methodology including definitions, which has virtually nullified the contributions, particularly of micro-studies, to the body of knowledge encompassing this facet the delivery of health care.

Problems in the collection and reportage of referral rates

Carstairs and Skrimshire (1968) produced an admirable review of published sources and unpublished data on the use of outpatient services. They were attempting to produce indices for the planning of outpatient care in health centres. And in doing so they summarised those studies available to date, indicating where there were differences in definitions, in coverage and in the adequacy of the population base. They presented a useful table and appendix reviewing sources and indicating variations in definitions, etc., but did not offer guidance on the methods and definitions in micro-studies which would be most useful to planners.

The Royal College of General Practitioners made no more than a perfunctory examination of this issue in the third edition of the handbook Present state and future needs of general practice (RCGP 1973a). They produced a table listing sources of publications, sizes of recording bases (i.e. number of participating doctors), and crude referral rates per 100 population. Apart from an observation that there were wide discrepancies in the results from individual studies, partly because of variations in definitions and ways of measurement, the College did not attempt to spell out to the readers most of whom, presumably they hoped, would be general practitioners with research interests, guidelines on standardisation of definitions and reliable research techniques. Instead it was said that there was a "need for further studies to discover what these differences mean and why they occur", (page 36).[1]

In Table 4.3 a comprehensive collection of published papers presenting referral rates has been analysed with the intention not of observing any comparability in the rates, but of identifying reasons relating to definitions and methods which partially explain why the rates are so varied. It is not so much a replication of the work of Carstairs and Skrimshire, as an extension of it. The table has been organised into three parts; sources relating to individual practices, sources relating to multiple practices in which general

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[1] The Research Unit of the RCGP did produce a general practice glossary (RCGP 1973b) but the definitions relating to referral data were scanty.

practitioners carried out the recording, and sources relating to data collected in outpatient departments. Thus Table 4.3 illuminates certain of the following problem areas.

(a) Recording agencies

Information about referrals to outpatients can be collected at two sites; at the place of referral normally the general practitioner's surgery, usually by the doctor himself at the time of referral, i.e. in the consultation process, and in the outpatient department, often by extracting information from case notes at the conclusion of a clinic. Validation of the reliability of the referrers' recordings can be undertaken in the outpatient department. These two data sources provide referral rates relating to differing population bases. General practitioners' recordings will be applicable only to the patients on their practice lists, whereas the hospital based data will, when summed together, relate to the population of the catchment area. Thus in the hospital data there will be referrals of new patients from other primary agencies such as local authority doctors and school medical officers, etc., and it is reasonable to expect that the rates produced will be in excess of the rates for general practitioners alone. The significance of the data source seemed to elude some commentators who compared their own results with dissimilar studies - the Oxford Regional Hospital Board (1963) compared the rate for the Reading County Borough with those reported by Brotherston and Chave (1956), and Fry (1959), both of whom were reporting upon individual practices. Scott and Gilmore (1966) likewise mixed referral rates from outpatient department and general practice studies. The R C G P (1973a) review did indicate in its summary table the size of the data base, although with some inaccurate reportage (the term practices instead of doctors was applied in some instances) and no obvious distinction between types of recording agents.

Reliability of the recording agents appears to be a 'bug-bear' no matter how well motivated the agents towards the research. In their study of the Frimley area, Clarke and Bennett (1971) had the cooperation of the general practitioners to record on special cards, details of each referral for immediate hospital admission, outpatient attendance, or consultant domiciliary visit. Referrals to casualty, physiotherapy and occupational therapy services were also detailed. Recording lasted for a period of 13 weeks. To establish the completeness of the recordings, all new outpatient attendances and inpatient admissions within the Farnham Group of Hospitals during one month of the survey period were identified and checked. Only three-quarters of outpatient referrals and half the immediate inpatient admissions were recorded.[1] Thus

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[1] This validation period did coincide with a Hong Kong 'flu epidemic, (Clarke and Mulholland 1973).

the recalculated outpatient referral rate for the area rose from 9.6 per 100 population to 12.8. In the practice reported by Morrell et al (1971), three general practitioners recorded all consultations over a 12 month period. Whenever a hospital referral was made the doctor was required to complete a second form. Validation showed that in 13 per cent of consultations at which a patient was referred to hospital, the doctors had failed to raise the hospital referral card. In the closely monitored general practice morbidity survey, (OPCS 1974) a sample of 100 patient records from the computer register of each practice was compared against the clinical notes held in the practice. The deficiency rate of surgery consultations on the computerised record was 3.4 per cent, but the overall omission rate for referrals was 11.9 per cent, and it was more marked for outpatient (14·6 per cent) than for inpatient referrals.

In validating statistics collected from outpatient records, most research teams have drawn comparisons with routinely collected S.H.3 or H.S.10 returns, and have usually concluded that comparability was not feasible because of variations in the definitions of new patients between the two data recording teams, and even inter-departmental interpretations in the routine recordings. See for example the Oxford Regional Hospital Board's (1963) study of Reading Hospitals, who felt that "it would seem that the 'true' new patients may be about half that shown in the national returns"; also Scott and Gilmore (1966) and Gruer (1972).

None of the outpatient-based studies referred to in Table 4.3 gave evidence of collecting statistics about non-attending newly referred patients, and yet if the breadth of referrals from the community are to be appreciated these non-attenders should be incorporated. (There is of course, the problem of identifying such patients if they subsequently attended a clinic). The results from a small survey of newly referred non-attenders by Backett et al (1966) suggested that the percentage of all referrals who do not attend (even at a later date) was around five per cent although the range of specialties in the sample was not stated and the exclusion of psychiatry would have weighted the result.

(b) Definitions

Few reported studies have spelt out in detail the range of hospital-based facilities available to the general practitioner; full or partial pathology and x-ray procedures, E.C.G. machines, G.P. general and maternity beds, and physiotherapy. Yet the availability of access is a variable which can

greatly influence the size of doctors' referral rates. Open access for most diagnostic investigations is now widespread throughout England and Wales (Butler et al 1971 and Irvine and Jefferys 1971), a trend which 'took off' in the 1960s.[1]

Some studies published about fieldwork undertaken in the 1950s gave referral rates to outpatients in the vicinity of 20 or more per 100 population, see Table 4.3. The highest rate 25.3 applied to Hopkins' practice in London, a single-handed practitioner with an N.H.S. list size of averaging 1,355. He did not have open access to diagnostic facilities, and examinations of his referral pattern showed that of a total of 1,029 outpatient referrals in three years, 382 were for investigation only - pathology and x-ray. If these diagnostic referrals are excluded, then his readjusted referral rate was about 16 per 100 average list size. Again, Brotherston and Chave (1956) reporting on a practice in a post-war L.C.C. housing estate, indicated that they had some open access to laboratories, but x-ray facilities were not mentioned. However, the report showed that the referral rate for diagnostic investigation was relatively low, approximately 1.5 per 100, so suggesting that their overall referral rate to outpatient departments may have included a significant proportion of patients requiring unavailable investigations only.

In some studies, notably Gruer (1972) referrals to orthopaedic departments were found to be relatively high because general practitioners did not have direct access to physiotherapy departments. The inclusion of routine maternity referrals can also inflate referral rates - Morrell (1971) indicated that more than 13 per cent of all referrals to outpatient departments in his practice during 12 months in 1967-8 were obstetric cases.

Referral rates can be calculated according to either the total number of individual patients referred to outpatient departments or the total number of referrals, i.e. episodes sent. Rates derived from this latter base-line will usually be in excess of patient-based rates, as some patients are likely to be referred more than once in a survey period. The variation over 12 months may be 1.0 per 100 population - see Morrell et al (1971) in Table 4.3.

The population base used in the calculation of referral rates, can inflate or deflate the results. Most researchers have used the average practice list size usually prepared by the Executive Council (now the Family Practitioner Committee), as their population base. But as it was pointed out earlier,

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[1] The situation in the early 1960s was reviewed by Macaulay (1962) and Levitt (1964).

there are reasons for anxiety caused especially by migration and deaths, about the accuracy of these lists. The Newcastle practice reported by Walker (1973), the Lambeth practice (Morrell et al 1971), plus the national morbidity study (OPCS 1974), all used age/sex registers in the presentation of results.

Another unacknowledged pitfall in the use of administrative practice lists (and even age/sex registers) as a base-line for individual doctor referral rates is created by the sharing of partners' patients, particularly by principals in group practice. Thus there may be a considerable gap between the nominal list size for a principal held by the Family Practitioner Committee and the number of patients who consider the principal to be their 'doctor'.

Often, authors e.g. Fry (1969) and Williams (1970), have included domiciliary consultations in the outpatient referral statistics. Fortunately, these usually constitute a very small proportion of the total number of consultant contacts.

Occasionally papers have included statements giving the percentage of total diagnoses recorded in a survey period which were referred to hospital (e.g.Scott et al 1960). If the recording of multiple diagnoses has been permitted for each consultation as in the national morbidity study (OPCS 1974) then the total number of diagnoses will probably exceed the total number of consultations in a survey by about seven per cent (OPCS ibid), thus making rates of referral calculated against diagnoses incomparable with those based on consultations unless adjustments are made.[1] Sometimes referral rates per total consultations have been presented; these can be related to direct consultations only (Wright 1968 and Williams 1970) or direct and indirect consultations combined (Morrell et al 1971). As indirect contacts can comprise up to 11 per cent of a year's workload (Morrell et al 1970), a comparison of referral rates calculated against such base-lines is misleading if account is not taken of the definitions applied - a point seemingly overlooked by Morrell and his colleagues in their 1971 paper.

Outpatient studies are bedevilled by the definition of 'new referrals'. Scott and Gilmore, and Gruer adopted the definition used in the completion of H.S.10/S.H.3 returns (see Table 4.1), whereas the Oxford Regional Hospital Board and Forsyth and Logan redefined the definition to exclude inter specialty transfers. The Edinburgh referral rate of 11.8 did not include referrals from one department to another within the hospital (Scott and Gilmore 1966 p.12).

(c) Ambiguities in the reportage of results

Difficulties in interpreting the results have occurred with some papers

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[1] The data reported by Scott et al (1960) enabled the calculation of two referral rates: 20.8 per 100 practice population based on diagnoses referred (cited by Carstairs and Skrimshire 1968, and RCGP 1973a), or 16.2 re referred consultations only.

because the explanatory information regarding definitions, research methods and data bases, have been omitted. Two interesting examples are the papers by Fry (1957 and 1959) and Morrell (1971 and et al 1971). The rate of 3.8 referrals per 100 practice population to outpatient departments for the South East London practice of which Fry (1959) is a principal has often been cited by other authors as being comparatively low. This rate was calculated on the workload for the 12 months of 1957. However, Fry published a paper two years previously which gave an outpatient referral rate of 7.8, being the mean of referrals for a five-year period ending 1956. To offset this decline in the use of outpatient services, his inpatient admissions rose from 0.7 for the period 1952-6, to 3.7 per 100 patients at risk in 1957 - a relatively very high figure compared with other published inpatient referral rates. Fry in his later paper gave no hint as to why this referral pattern should have altered so markedly in such a short space of time.[1]

A further example of ambiguity appeared in the two papers giving referral figures for a Lambeth practice, the principals of which had recorded all direct and indirect consultations plus additional data on referred patients for 12 months, 1967-8. The paper with joint authorship, Morrell et al (1971), stated, "During the year, 3,455 patients consulted the practice on 21,098 occasions. Of these, 489 (11 per cent) were referred to the outpatient department on 529 occasions, giving an overall referral rate of 11.9 per cent", (page 79). Yet in the paper published by Morrell only (1971), reporting again on results from the 1967-8 fieldwork, the outpatient referral figure was 451, e.g. "The disease groups which contributed most to the 451 patients referred to the outpatient department were .....", (page 456). Morrell gave no explanation in this paper as to the discrepancy in results from identical fieldwork (the total number of patient attendances in the two papers were almost exactly the same). It was only after searching through the paper published jointly, that an explanation was found. The three participating principals were responsible for completing two forms whenever a referral decision was taken. The first form related to routine consultation data and the second to the referral decision. In only 451 instances were both forms completed.[2]

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[1] Fry's more recent papers (1971 and 1972) showing his referral trends over 21 years do offer a possible explanation; the mean total hospital referral rates for the period 1952-6 masked a range in the annual referral rates; the early 1950s being higher than the mid-1950s. The papers do not clarify the variations between the outpatient and inpatient rates though.

[2] Even the bar graph indicating the referral rates of the 369 doctors surveyed by Forsyth and Logan (1968) is misleading - it represents nearly 400 participants.

The presentation of referral statistics can fail to impress the reader of their significance. Williams (1970), reporting on the survey undertaken by 68 general practitioners in the Welsh Faculty of the RCGP gave the number of outpatient referrals as a percentage of the total consultations. While doing so he was making comparisons with the results from an earlier study of members of the South-west England Faculty, (Wright 1968). The percentage rates were very similar, 3.5 for South Wales and 3.2 for South-west England. (This did include some small inconsistencies in definitions.) What Williams failed to point out was that the rate of consultations per patient at risk in South Wales was considerably higher than in the English study, thus giving an overall referral rate per 100 population in the former area as being almost half as big again as the rate for the latter area, (see Table 4.3).

The above discussion of the problems of collecting and presenting referral data has in no part contributed to explanations as to why there should be such variety in the use of outpatient facilities by general practitioners and communities. Backett et al (1966) and Scott and Gilmore (1966) were unable to establish any correlation between referral rates and available arbitrary indices such as size and type of practice, and year of qualification. Forsyth and Logan (1968) included clinical assistantships, practice list sizes, urban/rural environment and open access to diagnostic facilities; their only positive result was a marked tendency for general practitioners in partnerships and group practices to use direct access and outpatient facilities more often than those in solo practice. And to be added is Backett et al's deduction that the more doctors refer patients to 'open access' diagnostic departments, the greater their use of the outpatient facilities.[1,2] A relationship seemed

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[1] In an in-depth analysis using multiple regressions of the referral data amassed in the North-East Scotland study reported by Backett et al (1966), Sumner and Kilpatrick (no date) found that city practices referred more than urban and rural practices of similar size, except for small practices. The influence of distance from clinics on doctors' referral patterns was also discussed by Gruer (1972).

[2] This view was supported by Forbes (1966) analysing the use of services provided by an East Kent hospital, and Rose and Abel-Smith (1972) reporting on the results of a survey in one county in 1966. However, the argument was discounted because either no relationship was seen to exist or it was inverse, by Forsyth and Logan (1960) in the Barrow and Furness study, and again by these authors (1965) as regards Reading and Bolton; also by Darmady (1964) for the Portsmouth area and Levitt (1964).

Although the fieldwork for all these studies was carried out more than eight years ago, it may well be that local usage patterns are influenced by policies regarding specimen 'pick-up' services and the delivery of results with accompanying interpretation. The waiting period for appointments for certain tests may also act as a deterrent.

evident between the percentages of general practitioners' lists referred annually and the weekly rates of items of service per list size, of 23 participating doctors in the survey reported Starey (1961); in other words, the more items of service per practice population performed by a general practitioner the greater the likelihood of referral. But there were some exceptions.

Even when many external factors such as environment, social class composition, access to hospital facilities and to a lesser extent the age and sex structure of the practice population are uniform within a single group practice, wide variability in the referral behaviour of the principals is still observable, see Evans and McBride (1968), Morrell et al (1971), Walker (1973) and Sumner and Kilpatrick (no date). Age of the principals seems so far to be the only emerging explanatory variable, the older doctors (and to a certain extent the very young) showing lower referral tendencies. Sumner and Kilpatrick suggested that longitudinal studies of referral patterns in multi-doctor practices were needed to clarify if referral rates were associated with particular phases in the evolution of practices.

Reasons for referral to hospital outpatient departments

Various studies have attempted to identify the reasons for general practitioners' referral actions. The assessments have been based on the contents of referral letters or special recordings made by doctors at the time of referral.[1] A general practitioner's decision to refer a patient to the specialist in an outpatient department can be rationalised on the following accounts.

(a) Where a general practitioner does not have open access to hospital-based diagnostic facilities, or remedial departments, e.g. physiotherapy, he will be forced to use the specialist as a referral agent.

(b) A patient may have a demand for a minor surgical procedure which can only be carried out within the hospital confines, again by a specialist (possibly on a day surgery basis).

(c) The general practitioner may suspect or even be confident that the patient requires inpatient admission, usually for surgery, and if it is for a non-urgent matter the patient will have to be screened by the specialist in an outpatient clinic before being placed on the inpatient waiting list.

(d) The general practitioner may have doubts about the diagnosis and/or treatment of a disorder (the management of which may be within or outside his capabilities).

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[1] A tabulation of the results from a range of studies was not attempted because of the difficulties of comparing the behaviour of groups of general practitioners either areally or through time, the lack of sufficient base-line information relating to access to diagnostic facilities and remedial departments, the availability of general practitioner inpatient beds or day surgery, plus the amalgamation of referrals to specialties offering widely differing services. See however analyses in Hopkins (1956), Fry (1959), Starey (1961), Oxford Regional Hospital Board (1963), Chamberlain (1966), Gruer (1972) and Fraser et al (1974).

(e) Referral may be fulfilling the expectations of the patient or reassuring the patient, his family or doctor. Alternatively, there may be instances where the general practitioner just wants to 'off-load' a difficult case.

Each of the broadly defined referral accounts are now examined.

(a) Access to diagnostic facilities

Direct access to some diagnostic facilities is now available to almost all general practitioners as evidenced by two national surveys undertaken in 1969, (Irvine and Jefferys 1971, and Butler et al 1971). The former study undertaken on behalf of the British Medical Association (BMA) Planning Unit Working Party on Primary Medical Care, concluded that the Royal College of General Practitioners and BMA who had fought hard to secure open access to diagnostic laboratories, x-ray and physiotherapy departments could feel that the situation had improved but nevertheless progress was uneven, and this was applicable to both the range of facilities available and the regional distribution. (Only just over half of the 776 principals surveyed had access to contrast media x-ray, and no more than one-quarter could refer patients direct to physiotherapy.)

A question more relevant to this discussion is who uses these diagnostic facilities and for what purposes - open access should not presuppose usage, indeed it emerged in the 1963 Edinburgh survey that some general practitioners did not realise that direct access was available to them (Scott and Gilmore 1966). Ignorance of facilities could not have been revealed in the 1969 national surveys cited above, for the information about access was provided by the doctors themselves. Forsyth and Logan (1968) found that five per cent of the 369 doctors participating in their 1962 fieldwork made no use at all of direct access pathology or radiology, and 60 per cent used chest x-rays for less than 30 patients in a 12 month period.[1] Another survey of general practitioners in England and Wales in 1966, asked 813 respondents to indicate from a range of 19 diagnostic procedures firstly, those to which they had direct access, and secondly, those which they had used in the previous two weeks. From the data it appeared that most doctors who had access to diagnostic facilities used them, (Mechanic 1968 and 1970). (In a subsequent paper, Mechanic (1972) contrasted the relatively light use of diagnostic facilities by British doctors with the more regular use by American doctors as reported in similar studies.)

It seems that about one-third of all diagnostic tests ordered by family

[1] The mean referral rate for investigations per 1,000 population (England and Wales) in the national morbidity study (OPCS 1974) was 110.1. The wide regional urban/rural variations was though the consequence of the atypical investigatory patterns of individual doctors. Two Aberdeen studies amply demonstrate the wide variability in general practitioner/practice referral patterns for radiological investigations (Mair et al 1974) and pathology (Porter and Brodie 1972).

doctors will produce abnormal results. In the four most frequently requested tests by 18 Leicestershire general practitioners over nearly 12 weeks in 1970 (haematology, bacteriology, x-ray and chemical pathology), the range of abnormal results was between 30 and 40 per cent, (Patterson et al 1974). A partnership in south-east Lancashire had an overall percentage of 38.3 abnormal results for investigations undertaken in 1969 (Lloyd 1973). For radiology only, 34 per cent of 11,360 direct referrals by general practitioners in the Aberdeen area in 1973 were abnormal (Mair et al 1974) - see also Wallace et al (1973).[1]

There have been very few evaluative studies of the use made by individual general practitioners of such facilities in relation to outpatient referrals. Fry (1971) and Marsh (1973) claimed that through the use of excellent diagnostic facilities (and supporting teams of para medical staff) they had greatly reduced the number of referrals made to outpatient departments. However, a group of five general practitioners attached as clinical assistants to the Western General Hospital, Edinburgh, over a five-year period, thought that one of the benefits from the scheme was the acquisition of a more discerning usage of laboratory and radiological facilities, (MacLeod 1973).

The Leicestershire general practitioners were required to answer a hypothetical question in respect of patients who were investigated - "If Laboratory and Technical services had not been available, in this case would you have made a referral to outpatients?" The paper by Patterson et al (1974) indicated that the question was posed when a test was ordered, but on the actual recording form this was the final question being part of a block relating to the "G.P's Final Diagnosis", based on the investigatory reports (Fraser 1974). If such an assessment was made retrospectively, then the findings were of little consequence. Much more illuminating were the outcome decisions based on the results of the the tests; eight per cent of the diagnostic group and one per cent of the screening group were referred to hospital. For two-thirds of the patients undergoing diagnostic tests, the results enabled the continuation of the present management. (Fifteen per cent of positive x-ray findings became referrals to outpatients in the 13 month recordings of a health centre x-ray unit, Howie 1974.)

In many hospital diagnostic departments the load created by general practitioners is now between 20 and 30 per cent of the total throughput. Green (1973) in an exhaustive review of the literature relating to general practitioners and open access pathology services, claimed that the case for open access reducing the load on hospital facilities was by no means proven. He cited the results and arguments from a number of studies suggesting that open access actually reduced the load on hospital beds and outpatient clinics, but then based his counter argument upon the views by Forbes (1966), Backett et al (1966), and Rose and Abel-Smith (1972) all of whom observed a positive relationship between

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[1] X-ray units in health centres have been described by Howie (1974) and Barber et al (1974): in the former experiment at Springwell House Health Centre, Edinburgh, the mean positive findings over 13 months were 51.8 per cent of results while in the latter study, (Woodside Health Centre), one-third of a year's examinations were positive.

use of direct access pathology and outpatient referrals[1]. What he failed to emphasise when he summed up that the correlation approach used by some researchers could not be used to prove a casual relationship between use of open access and outpatient referrals, was that these studies were examining a static situation. In developing an argument in favour of open access to the general practitioner, it matters not that high outpatient referrers are also heavy users of diagnostic services; the fundamental question is what would be their referral rates to outpatient departments if these investigatory facilities were not available.

The views of consultants on the issue of general practitioner access to diagnostic facilities were collected in surveys by Forsyth and Logan (1968), Long (1973) and Long and Atkins (1974). In the national study, 164 consultants and SHMOs completed postal questionnaires. Direct access of general practitioners to haematology and bacteriology services received the support of virtually all respondents, but only two-thirds were favourable to similar access to biochemistry. Again, almost all consultants favoured direct access for chest and most other straight x-rays, but the case for access to contrast media x-rays was not supported by more than three-fifths of replies. Only one-third of the general medicine consultants approved of general practitioners having access to ECG machines: direct access to physiotherapy was vetoed by overwhelming majorities within the orthopaedic and general surgery specialties (Forsyth and Logan op cit). A similar consensus view against open access to physiotherapy was expressed by more than half of 79 consultants interviewed in the North East Metropolitan hospital board region. However, in response to the same question, three-quarters of 93 general practitioners questioned supported direct access to physiotherapy, (Long op cit).

(b) Referral for treatment[2] requiring inpatient admission

The inpatient admission procedure for non-urgent cases, requires outpatient inspection by the surgeon or another member of his 'firm', before the patient is entered onto a waiting list. The question has been raised of whether general practitioners could place patients with a firm diagnosis directly onto the waiting list, see Oxford Regional Hospital Board 1963, Starey 1961, Backett et al 1966. It is argued that such a system would eliminate the need for some patients to experience two waiting lists, and reduce the outpatient

[1] Refer to footnote, page 4.20.

[2] Treatment here implies surgical routines which traditionally have been performed in hospital settings, and since 1948, usually by surgeons. (There is some general practitioner surgery in general practitioner hospitals and clinics.)

load. This outpatient reduction perhaps would not be as great as assumed since the average length of consultation time per patient in surgical clinics can be less than five minutes. A published argued case defending the existing system is not known. In conversations consultants justify the system firstly because it enables them to screen the patient's condition, both medically and socially, and secondly, it allows the patient some choice - he may choose not to undergo the operation at all, he may prefer to be operated upon by a different surgeon or even elect to be treated as a private patient.

The pertinent question is to what extent is the general practitioner's referral behaviour, when faced with a patient requiring surgical repair, etc. modified by the admission procedure? Is he really influenced in the choice of consultant, hospital or even the advisability of seeking specialist care within the NHS, by the dual waiting periods as suggested by Carmichael et al (1963)? In the earlier section on The Patient, there was mention of the Leicestershire study which gave evidence of patients' choice to seek private medical care, plus the general hypothesis that general practitioners adjust their referral patterns in accordance with shifts in waiting list times particularly for inpatient admission, but reportage of individual doctors' behaviour has been very rare.

(c) Referral for surgical procedures which can be performed on a day surgery basis

An increasing proportion of surgical routines are now executed on a day surgery basis.[1] The first year in which national statistics were made available was 1972 and the rate of day case attendances per 1,000 population in England for that year was 8.6. For non-psychiatric specialties only, the rate was 7.5 (DHSS 1973c). In 1973, a Memorandum on the Arrangements for the Care of Persons Attending Hospital for Surgical Procedures as Day Patients was circulated (NHS 1973). This was the offshoot of a survey undertaken in 1969 showing the wide variety and extent of work already being done in this way. A follow-up sample survey of surgical waiting lists showed that a substantial proportion of those on waiting lists in general surgery, gynaecology and urology were suffering from conditions which could permit selection for treatment on a day basis. For discussions of successful day surgery schemes, see for example Farquharson (1955), Williams (1969) Ruckley et al (1971, 1973), Wagman and Bamford (1971), Craig (1970), Lord (1969), Stephens and Dudley (1961) - most of the authors being hospital clinicians.

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[1] Day surgery is not to be confused with outpatient treatment; the day patients have usually first been screened in outpatient clinics. Day cases are defined by the DHSS as "persons attending as non-resident patients for investigation, therapeutic tests, operative procedure, or other treatment, and who require some form of preparation, period of recovery, or both, involving the provision of accommodation and services." (DHSS 1973b page 2).

The responsibilities of general practitioners and community nursing teams in the pre-selection of patients and post-operative care, were highlighted by Dean and Wilkinson (1969) and Ruckley et al (op cit). "For the scheme to work it is most important that there should be mutual trust and understanding between the surgeon and the general practitioner. If the latter does not feel that he can co-operate it is better that day case operations be avoided", (Dean and Wilkinson op cit page 176). One aspect of day surgery to which attention has not really been drawn is the frequency of non-operation on cases rejected 'on the day' because of their unsuitability (on medical grounds) to receive a general anaesthetic. This was touched upon by Stephens and Dudley (op cit) while Ogg (1972) described how it became necessary to devise a new form for outpatient procedures re patients' behaviour, to clarify legal responsibilities. "Many experienced anaesthetists will agree that a few of their day surgery cases pay little attention to the pre-operative instructions issued", (Ogg ibid page 575). The driving of vehicles within the 24-hour post-operative period causes great anxiety and the practice was felt by Ogg to be common.

(d) Referrals where the diagnosis and/or the treatment of the disorder is in doubt

The most frequently cited reason for referral is the need for advice about symptoms, signs, diagnoses, possibly accompanied by a request for guidance over the management of the condition.[1] From an examination of a sample of 4,610 general practitioners' letters, Backett et al (1966) estimated the level of diagnosis at referral in six specialties. The inter-specialty variability emphasised the inadvisability of generalisations about referral behaviour without due attention to specialty mix. In four specialties, surgery, ear, nose and throat, orthopaedics and dermatology, almost three-quarters or more of the referral letters either stated a known diagnosis or suggested a suspected diagnosis, but in medicine and gynaecology the proportion of letters offering this information was about half. They were much more likely to have symptoms and/or history only given, and more than one-tenth of all medicine referral letters contained no diagnostic information.

The family doctor can in most situations, choose to investigate the patient in an endeavour to determine or confirm the diagnosis before referral. Results from the Chesterfield outpatient HAA study (Trout 1973) and surveys from two non-teaching hospitals (Chamberlain 1966) suggest that the frequency of reported general practitioner initiated diagnostic investigation in referral letters is very low. Fewer than five per cent of letters examined

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[1] See footnote 1, page 4.21.

by Chamberlain gave such information; for Chesterfield, in no specialty (apart from chest diseases) were more than four per cent of patients presenting with x-ray results. (For chests the proportion was 18 per cent.) The pathology department was no more frequently used. However, the proportion of referral letters containing investigatory details from the eight Newcastle practitioners was much higher - 39 per cent, but the participants in the study may well have been strongly motivated, (Walker 1973).

A factor which could influence the family doctor's decision to seek advice about the management of a condition, is the anticipated behaviour of the consultant in the delegation of responsibility between hospital (outpatient) and community care. The general practitioner will be responding to past experiences and may in some instances specify in the referral letter that he wishes to resume management. There are three 'care' alternatives; total management within the hospital department, dual management between consultant and general practitioner, and community management by the family doctor alone after an initial consultation with the specialist. (Note, this is in reference to one specific clinical condition. The patient may of course consult with his own doctor for other conditions while remaining under consultant supervision for the primary diagnosis. There may also be occasions where a patient is supervised by more than one specialty.)

Discontent about the duration and necessity of outpatient episodes has been reported in general practitioner surveys, e.g. Scott and Gilmore (1966), Chamberlain (1966), Cartwright (1964) and Long (1973). Consultants too, are concerned by the apparent necessity to retain certain chronic conditions for surveillance, (see Thorn and Russell, 1973 who developed a scheme of diabetic mini clinics in the community).

Intent upon assessing the level of 'dual care' in their practices, 59 general practitioners recorded over a three-month period (1964/5) every patient attending their surgery who was under the care of a hospital (or other clinic) during that time, (Cammock and Lee 1966). More than three and a half thousand patients, 2.3 per cent of the total population at risk, were under the care of some hospital as well as attending their general practitioner; 62 per cent of referrals for a second opinion were jointly managed presumably for the same diagnosis. There was little fluctuation around this proportion when practices were divided according to partnership size and rural/urban location. (Much more valuable would have been tables showing the range of proportions for individual general practitioners.) The patients whose management was totally

supervised by hospital departments were attending in the more highly specialised specialties such as thoracic surgery, endocrinology, radiotherapy, etc. The diseases most likely to be managed jointly and which the family doctors wished to treat themselves were diabetes, anaemias, hypertensive disease, respiratory disease, peptic ulcer, arthritis and rheumatism. Items of service most usually performed for these patients by the family doctors were the issuing of sickness certificates and prescriptions. Interestingly, the participants felt that given the necessary facilities, they would have preferred to regain sole management of about 15 per cent of the patients referred to hospital.

When referring a patient, the family doctor may not only be uncertain of the diagnosis of the conditions, but also be unsure of the specialty best able to diagnose and treat the patient. Inter-specialty transfers apart from those from accident and emergency departments can comprise about five per cent of 'new' referrals. (This figure also excludes transfers to para-medical departments.)

However, internal transfers to general medicine and paediatrics are likely to amount to 10 per cent all new outpatients and the percentage is higher in psychiatry, (Forsyth and Logan 1968, Chamberlain 1966, Trout 1973, etc.).

General practitioners hold divergent views as to the degree of autonomy consultants should have regarding inter-specialty transfers. In a survey of 77 general practitioners in two London boroughs (Acheson et al 1962) all but 10 of the 73 respondents felt that once a patient had been referred to the outpatient department they did not want to be involved in any further decisions about treatment or cross-referrals to other specialists within the hospital. In the Edinburgh situation, Scott and Gilmore (1966) found that about one-third of the doctors interviewed believed they held the ultimate responsibility for the patient, for example, the choice of a second consultant when a patient was referred from one outpatient department to another, should be theirs. Of course for some clinical conditions, speedy transfers between departments is essential and the conventional communication method, the letter, could disadvantage the patient's welfare; the frequency that telephones are used in such circumstances is not known. In a report on a pilot study of communications between family and hospital doctors in a district general hospital (Bevan et al 1973), nearly half of the general practitioners indicated that they were not merely informed about inter-specialty transfers but consulted about such decisions.

(e) Referral to reassure the patient or his family

Patient initiated referrals were found in three studies to comprise fewer than eight per cent of the total referral decisions, see Chamberlain (1966),

Starey (1961) and Fraser et al (1974). However, there is virtually no knowledge about general practitioners' behaviour towards patients who attempt to initiate the referral process (apart from occasional 'request for abortion' studies).

Many factors that impinge upon the referral decision so triggering the centripetal movement of the patient towards the hospital sector, have been introduced in this sub-section. Mention has not been made of the informal relationships between family doctors and individual consultants which may have a marked effect upon referral (and discharge) behaviour. Balint (1964) discussed the hypothesis of the "perpetuation of the teacher-pupil relationship" between specialist and generalist. Spencer (1971) developed models of the referral process taking account of the indirect interaction between a consultant and a general practitioner. Coles and Bridger (1969) added in the patient to form a 'three-person group' technique which they felt could result in many more cases being seen in the outpatient clinic, and greater satisfaction would be achieved in general practice.

The stimuli to the consultant (or deputy) to initiate the centrifugal movement of patients back to the community are now identified where possible.

3. The Consultant

> "A consultant is a doctor, appointed in open competition by a statutory hospital authority to permanent staff status in the hospital service after completing training in a specialty and, in future, being included in the appropriate vocational register; by reason of his training and qualifications he undertakes full responsibility for the clinical care of his patients without supervision in professional matters by any other person; and his personal qualities and other abilities are pertinent to the particular post."
> The Responsibilities of the Consultant Grade, (DHSS 1969c page 6).

The perception of this working party (chaired by Sir George Godber) of the clinical autonomy of specialists left unresolved the question of the hospital consultant's relationship with general practitioners who also claim clinical autonomy with regard to patient management, see for example the Standing Medical Advisory Committee report, The Field of Work of the Family Doctor (MOH 1963) which considered that he "must have continuing responsibility for the medical needs of each individual in his care", (page 9). This view was reiterated in the RCGP (1972) manual on The Future General Practitioner. Nevertheless,

the definition propounded the concept of hospital consultants wielding authority in the outward or centrifugal movement of patients from hospital to community. So once more it is pertinent to ask, what is known about discharge behaviour with reference to the outpatient sector, and the answer is that there is an even smaller body of knowledge about consultant behaviour than has been assembled with respect to general practitioners. Published information relating to outpatient activities has been gleaned from hospital workload analyses, clinical notes and discharge letters, plus occasional surveys of consultants' attitudes to outpatient clinics which have been superficial in reportage if not in fieldwork. Refer to Tables 4.1 and 4.2 for an outline of data available from various outpatient studies.

(a) Workload analyses

The specialty mixes of new outpatients from a range of surveys (and presented in Table 4.4) serve to emphasise not so much the variability of results between surveys, but the effect that unstandardised definitions can have upon such data.[1] For example the percentage distribution will be greatly influenced by the range of departments included in each study - the omission of obstetrics which comprises nationally about 9 per cent of new patients, can have a weighting effect on other specialties. Likewise the exclusion from orthopaedic surgery data of internal transfers made by accident and emergency departments may explain the wide range in the percentage distribution of patients between studies. (In the DHSS annual statistics orthopaedic surgery has the largest proportion of new outpatients in England, about 15 per cent in 1973 - column 9, Table 4.4). The adoption of differing definitions of new patients will also have an effect upon the overall distribution, although just how significant this can be is not really known.

(b) Clinical actions and outcomes

(i) Status of clinicians seeing new patients There seems to be a rather high probability that new patients attending provincial hospital outpatient departments will be seen by a consultant, (Table 4.5), and peripheral clinic attenders both new and return may be even more certain of their attention, (Gruer 1972). All the studies which gave the proportion of patients seen by

[1] Certain papers reporting general practitioners' referrals to outpatient departments have presented diagnostic breakdowns; diagnoses only, Scott et al (1960), Bloor (1962) and Walker (1973); diagnostic groups, Morrell (1971) and Morrell et al (1971); hospital departments, Fry (1959), Carmichael et al (1963), Starey (1961), Crawford (1954), Hopkins (1956), Evans and McBride (1968) and Walker (1973). Priest (1962) itemised diagnoses confirmed in a general medicine department while all of the studies which collected comprehensive data from outpatient departments listed selected diagnoses/diagnostic groups.

the consultant to whom the referral letter was addressed were reporting on metropolitan situations; in Edinburgh 75 per cent of new attenders saw the consultant specified, the figure was 10 per cent lower for a London teaching hospital. A survey of 77 general practitioners in two London boroughs, (Acheson et al 1962), showed that only one-third of the respondents nominated the consultant they wished the patient to see in the outpatient department and these were mainly users of regional hospital board hospitals. However, uncertainty in the fulfilling of requests by named consultant was not one of the three commonest reasons for deciding against nominating a consultant. (The three reasons were the belief that all consultants were equally capable of treating any disease within their specialty, the inability to name consultants, and the longer delay created for patients wanting appointments with named consultants.)

In many outpatient departments clinicians in training posts see increasing proportions of subsequent attendances, (Forsyth and Logan 1968, Trout 1973, Scott and Gilmore 1966). Thus the view held by some general practitioners (Cartwright 1964, and substantiated by Gruer op cit, and Chamberlain 1966) that disposal is significantly related to the status of the doctor may mean that some patients are held unnecessarily under review. Likewise it may offer a partial explanation for self discharging by return patients which can comprise between six and nine per cent of all patients under observation (Oxford Regional Hospital Board 1963, Trout op cit and Gruer op cit).

(ii) Diagnostic investigations Anxieties sometimes expressed about the wasteful duplication by consultants of diagnostic tests already carried out on patients by their general practitioners have not been substantiated nor really discounted in the literature. Only the Chesterfield study presented evidence, (Trout 1973). Less than two per cent of all new patients seen in all departments over a six-month period were x-rayed both before and after the medical consultation, and the percentage receiving dual pathology investigation was no higher. (It was noted earlier, pg. 4.26 that the proportion of newly referred patients with general practitioner initiated test results available seems to be small.) Of course, it is possible that the nature of the tests differs slightly, but equally likely, the consultant requiring information on treatment progress, duplicates tests. Probably a more necessary area for review is the duplication of tests for inpatients, particularly for those admitted primarily for investigation (Forsyth and Logan 1968, and Loudon 1970).

Considerable concern was expressed by Forsyth and Logan (1968) about the proportion of outpatients discharged after one consultation who had received neither x-ray nor pathological investigation under the supervision of the consultant. In paediatrics and orthopaedics it was over one half, and in general medicine, 38 per cent.[1] Even many reattending patients in paediatrics, surgery and orthopaedics still lacked investigation. They were highly critical of discharge decisions for certain diagnoses (psycho-neuroses, peptic ulcers, heart disease and menstrual disorders) taken without recourse to routine investigations. Studies which detailed diagnostic investigations ordered in outpatient departments are identified in Table 4.2.

(iii) Use of para-medical facilities Also of interest is the use made by clinicians of para-medical facilities, e.g. dietetics, appliances, physiotherapy. Once more, the small Chesterfield study offered some illumination. The physiotherapy department was used almost exclusively by orthopaedic referrals (15 per cent of all new outpatients in this specialty). The heaviest user of the pharmacy department was general medicine, 15 per cent of the new outpatients under surveillance being referred with prescriptions. (Note too, that the paediatric specialty although much smaller in terms of total new outpatients, prescribed directly from the hospital pharmacy for one-third of its new attenders. Convenience to the patient could have accounted for this.)

(iv) Outcome of first attendance The outcomes of patients at their first attendance as a new referral recorded in seven studies (Table 4.6) show that despite variations between definitions used in the individual reports, there is a degree of consistency in the relative importance of differing alternatives. The largest category in all but the Scottish Border Counties was 'proceed as an outpatient'. However, between 20 and 30 per cent of all newly referred patients were either sent back to the referral agent or discharged without any reference. In their national study Forsyth and Logan (1968) pursued outcome of first visit at specialty level. Between 35 and 45 per cent of gynaecology and general surgery patients were put on to waiting lists and the same applied to 30 per cent of ear, nose and throat attenders, but for each of the other major specialties including orthopaedics the percentage was less than 10 per cent. About three-quarters of orthopaedic[2] and psychiatry referrals were retained as outpatients. The specialties most likely to discharge patients back to the community were ophthalmology, dermatology and chests (about 40 per cent of new patients);

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[1] Backett et al (1966) too demonstrated considerable variability between six specialties but in a lower order of magnitude. Walker (1973) observed that the proportions of patients discharged without investigations or treatment to the eight Newcastle doctors varied from nil for cardiology to 26 per cent for dermatology.

[2] The proportion of these orthopaedic patients needing physiotherapy treatment only was not indicated in the results.

for medicine, paediatrics and ear, nose and throat, the proportion was around one-third. Backett et al (1966) and Walker (1973) also produced specialty breakdowns of outcome at first attendance. The order of the specialties was similar to the breakdown cited above, but there were variations in the proportions.

To what extent is the consultant's disposal decision influenced not just by the contents of the accompanying referral letter, but his perceived assessment of the referral agent constructed from previous communications such as referral letters, telephone conversations, discussions about patients on the ward, plus any professional and social contacts? The general practitioner's referral letter may even adversely affect the diagnostic decision of the consultant. Backett et al (1966) found that where the patient referral note gave a confidently defined diagnosis there was a greater likelihood in the first outpatient visit for the consultant to make a 'positive' action either to refer the patient back to general practitioner care or proceed towards inpatient care. Only 42 per cent of defined diagnoses in the 20 largest categories remained in outpatient care, compared to 59 per cent of ill-defined diagnoses as indicated by the general practitioner. Could there be occasions when the consultant makes an adverse decision based on a misjudged referral diagnosis?

(v) Outcomes at the conclusion of defined survey periods The outcomes of patients at the end of defined periods of time have been presented in a number of reports - refer to Table 4.2. It would seem that about one-tenth of new patients can expect to be under the supervision of a hospital department 12 months after initial referral. There is, of course, inter-specialty variation.

(vi) Outpatient surveillance and computerised monitoring The prolonged management of certain common gynaecological disorders and chest cases such as bronchitics and asthmatics concerned Forsyth and Logan (1968). Their findings in the general medicine specialty substantiated disappointments expressed by general practitioners about transferring to hospital departments patients whose clinical conditions they understand and indeed they would prefer to manage. Diabetes, rheumatoid arthritis, thyroid disease, hypertension, epilepsy and blood disease were diagnoses singled out by the authors.

> "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." (Forsyth and Logan 1968, page 61).

In an endeavour to transfer the routine management of patients to the family doctor yet continuing to oversee progress, some clinicians have been experimenting with computerised monitoring programmes, (Crooks 1968, and Beilin et al 1973). Such schemes rely on joint participation between consultant, general practitioner, and patient.

(vii) Choice of clinic site for new and return outpatients Doubt has been cast upon the necessity for many new and review patients to be seen in hospital departments, by two small studies. Wade and Elmes (1969), concluded that 85 per cent of all patients seen in a general medical outpatient clinic over a two-month period could have been adequately dealt with by consultants in health centre clinics. Bryden's (1970) findings complemented those cited above - four-fifths of outpatients registered with doctors practising from the Cumbernauld Health Centre could have been cared for in health centre consultant clinics.

(c) Communications between family and hospital doctors

The referral letter is the pivot in the transfer of the patient from community-based to hospital ambulatory care. The discharge letter is not such a crucial component in the centrifugal movement of the patient back to the community. Indeed, it has been shown that as many as 40 per cent of all discharges from some hospital departments have not been notified to the general practitioners. Formal communication by letter between doctors, is one facet in the referral/discharge process on which much attention had been focused. In an early paper, Report on Communications and Relationships between General Practitioners and Hospital Medical Staff, (Shaw 1963), the cumulative experience of a small group of family and hospital doctors was reported and certain general suggestions made, including, "The consultant and general practitioner to decide between them who is to have "overall care" while the patient is attending hospital." (page 30). Since the early 1960s, studies have looked into the contents of medical letters, for example de Alarcon et al 1960, de Alarcon and Hodson 1964, McMullen and Barr 1964, Chamberlain 1966, Gormez 1967, Forsyth and Logan 1968, Bryden 1970, and Williams and Wallace 1974. Refer also to Table 4.2.

Analyses undertaken in these studies have ranged from counting the number of words in letters on the assumption that length reflects quantity if not quality of information, to assessments of the quality of the information provided against check lists of the items most desired in referral letters agreed to by concensus amongst consultants. Two studies elicited the views of family and hospital doctors by surveys, the first a postal survey (Bevan et al 1973) and

second using interviews (Long 1973 and Long and Atkins 1974). Dissatisfaction was found amongst general practitioners about certain areas of communication particularly the timing of the notification of the discharge of inpatient Consultants in the North East Metropolitan Regional Hospital Board study complained of insufficient detail in referral letters, (Long ibid).

A full discussion of the literature surrounding communication methods was not deemed necessary because of the exhaustive treatment in the studies cited earlier. It sufficies to repeat an observation from the pilot study of communications in the Canterbury area, (Bevan et al op cit).

> "In general, the survey appeared to confirm other studies particularly in respect of complaints by general practitioners about certain areas of communication. That these findings have been reported over a number of years without change suggests that the problem at the present time is not one of eliciting further detailed or more geographically widespread information but of implementation of measures to correct the already well known lacunae in the communication system and of monitoring such experiments as are devised to improve communications." (page 36)

If the content of a referral letter does in fact influence the outcome for the patient (a proposition which must be explored) then experiments with referral pro forma must be carried out. Long recommended that the referral letter should have a standardised format and be used through out the North West Metropolitan hospital board region, yet Bevan et al found that general practitioners were not unanimous in their preference for this type of referral note: sympathies towards the traditional letter were expressed. And is there any certainty that the consultants disposal decision will be modified when presented with additional data not routinely applied? In one pilot study where consultants were supplied with information of a social nature about inpatients, no adjustments were observed in their discharge decisions (Barker 1974).

This discussion of consultant outpatient performance has been almost entirely descriptive of the workload. It has not been possible to identify any factors which may have a causal effect upon discharge decisions of ambulatory patients. As a group, consultants are an enigma. In a survey of consultant opinions relating to outpatient activities, outpatient work seemed to enjoy little status in the eyes of most consultants. (These were the views of 164 respondents; the fieldwork was undertaken as part of the comprehensive study reported by Forsyth and Logan, 1968.)

The pressure of work in the outpatient department severely conditioned these attitudes, but abuse of outpatient services was not ascribed as a significant reason for this situation. Forsyth and Logan found it questionable how far a more widespread provision of junior hospital staff to assist in outpatients would in fact ease the pressure on the departments. The vast majority of referrals are seen by consultants, a convention few would want to change.

Surely the time is now ripe for an in depth investigation into the management of outpatient clinics to see where rationalisation of scarce manpower resources can be effected. A team of clinicians and administrators at Northwick Park Hospital have designed management documents for consultants which display "visually the extent to which a consultant is keeping pace with demands on his services in out-patients and in the wards, together with the resources he is using in the process" (Mason et al 1974 page 46). But these avoid any behavioural examination of his performance, and not until there is a fuller comprehension of these aspects can rationalisation of resources not only those of the hospital service but in the community be effected.

EPILOGUE

This interim report was compiled from published and unpublished sources, including a survey of regional hospital boards, in order to acquire some feeling for the general factors influencing the delivery of health care in the outpatient sector. Without such an overview it was felt that the most relevant questions regarding the location of consultations between ambulatory patients and specialists could not be discerned. Having concluded what these questions are it is the intention to pursue them in the main field study.

Historically there has been a considerable amount of support for the idea of outpatient sessions being held in health centres, and as early as 1920 Lord Dawson of Penn envisaged primary health centres in which consultations between general practitioners and specialists over patients could be conducted. The principle of health centres accommodating specialist outpatient facilities was embodied in the 1946 National Health Service Act but progress in the realisation of this policy was slow. By 1972 only 12 per cent of the 364 health centres established in England appear to have housed outpatient clinics and many of these sessions were held on behalf of the school health service.

The incorporation of outpatient facilities in general practitioner hospitals was proposed in the hospital plans of the 1960s, and further supported in the 1974 memorandum on community hospitals prepared by the Department of Health and Social Security. In this area it does seem that the provision of such services is already widespread (but with marked regional imbalance) for sessions were recorded in more than half of the approximately 400 general practitioner hospitals of England in 1972. (More frequent still were the consultant outpatient sessions held in other types of 'clinic premises' on behalf of regional hospital boards, local health and school health authorities.)

Despite the apparent backing in recent years for decentralised consultant outpatient sessions from professional bodies arguing from the standpoint of patients' convenience and the mutual education of general practitioners and specialists, evaluative studies of experiments in peripheral premises have been rare. Reports that are available have offered impressionistic appraisals usually favourable. The benefits cited have included convenience to patients,

plus the reassurance of their being seen in a familiar setting. In some instances there have been suggestions that episode lengths are shorter in the peripheral clinics than for patients attending the hospital outpatient departments (this was one finding in the 1972 regional hospital boards' returns for peripheral clinics). However little has been learnt from these studies of peripheral sites about for example the case selection, the dependency of individual specialties on supporting diagnostic equipment and remedial facilities, and the effectiveness of mutual education between the family doctors and specialists. The two major field studies to date (in the Scottish Border Counties and East Cumberland) merely attempted to estimate costs to patients and consultants of attending alternative clinic sites. Crucial questions about possible modifications in the referral/discharge process between consultants and general practitioners involved in such schemes were not investigated.

Many gaps in our knowledge of the overall purpose and functioning of the outpatient sector are evident from the review of the literature. A number of studies in the 1960s provided valuable workload analyses of outpatient departments, emphasising in particular inter-specialty variations, and accounts by general practitioners of their referral rates to outpatient departments highlighted the variability in referral patterns. But a greater understanding of the three participants in the outpatient consultation process is now needed as a prerequisite to the formulation of recommendations about the siting of sessions. Too little is known of the manipulative powers of patients who themselves perceive a need for specialist advice. Too little is known about the reasons for the wide range in the general practitioners' referral patterns - what are the influences which impinge on their decisions to refer (or not refer)? An appreciation of the dependency of consultants and their deputies on diagnostic and remedial facilites is long overdue. Even more essential is a deeper understanding of how consultants within specialties select patients either for continued review or discharge. It is hoped to explore some of these issues in a subsequent report.

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Table 1.1 - Summary of reports Detailing Consultant Outpatient Clinic Experiments in Health Centres and General Practice Surgery Premises

Practice/scheme and source	Selection of specialties: Comments	Selection of specialties: Type and sessions per mnth	Clinic staffing in the practice premises	Appointments booking and medical records systems	Cited advantages and disadvantages of the schemes		
Petworth group practice, Sussex 4 GPs, 6,000 pats. (Bell 1961 and 1975)	New surgery premises opened in 1960. Scheme still operating	med (1) ophth (4)	Consultant with pats. presented by GPs	GPs booked pats. and notified a hospital sec; Consultants carried records to clinics	Pats.- 15 mile journey saved; benefited from drs.' joint interest in case; shorter 'episode lengths'; tea-break chats may have reduced need for other referrals	GPs - better able to present cases; more able to keep abreast of medical advances; follow-up pats. not lost sight of in hosp. system	Consultants - new insights into pats.' background and problems of general practice Hosp. - less congestion, pressure on junior clncns; transport savings
Winchester group practice, Wessex 5 GPs (Gibson et al 1966)	'Honorary' scheme started in 1964	psych (4)	3 consultants and a psychiatric soc. worker plus GPs presenting cases	Surgery sec. booked pats. and attended related correspond Consultants carried records	Pats. - early diagnosis and therapy adapted to needs; familiar setting, no waiting; support of GP between sessions	GPs/consultants - could confer over physical aspects of cases; patients less able to play off one dr. against the other; early treatment reduced demands from chronic patients	
2 London practices, 2 GPs (Brook 1967)	Scheme arose from seminars on psychological problems in general practice 6 month pilot in 1965	psych (2)	Specialist and GP in consultation about patients and problems	Afternoon schedule was at the discretion of the individual GP	Pats. - most favoured informality, joint cosultations, and not having to attend hosp.	GPs - joint consultations over individual patients	Consultant - identification with some of the problems facing GPs; reassessment of the nature of minor psychological problems in general practice
Stockton-on-Tees group practice, Durham 5 GPs 15,000 pats. (Marsh & Tompkins 1969)	Scheme proposed by consultant with overseas experience of such 1967/68 ceased when consultant emigrated	paed. (6 weeks)	Consultant with pats. presented by GPs	GPs' sec. booked in pats. and liaised with a hosp.sec. re medical records	Pats. - invited comments included:- convenience of surgery re access with small children, familiar surroundings, better appointment systems; GPs' reassurance to the children and help to the parents in the interpretation of questions and description of symptoms; parents greater confidence in GPs' ability to manage cases	GPs - more intensive 'work up' (incldg. investigations) of patients for presentation, and dual care eliminated; sessions offered benefits similar to short paediatric refresher courses; reduced paper work as no letters needed, diagnoses,etc. entered on GP record cards	Consultant - insights into the working of a group practice centre; joint discussions aided diagnoses formulation; reduced outpatient workload
Witney Health Centre Oxfordshire 7 GPs plus nearby practices, about 30,000 pats. (Morgan 1970)	Health centre, built by Nuffield Provincial Hosps. Trust, has suite of rooms for out-patient sessions. Also physiotherapy gym, small pathology lab., small X-ray department	psych(8) ophth(4) med (2) surg(2) chests(2) ortho(2) phys.med(2) neur(1) gynae(1) ger assess(1)	Clncns.assisted by part-time nurse, and GPs often presented patients	Sessions administered by a receptionist	Pats. - journey of 12 miles or more to Oxford saved, shorter waiting time; familiar surroundings	GPs - better prepared (incldg. investigations) referrals; opportunities to discuss non-referred patients' problems; improved lines of communication to hospital service	Consultants - discussion of problems with GPs and often ancillary staff (health visitors, district nurses enabled earlier patient discharges

Table 4.1 cont...

Practice/scheme and source	Selection of specialties: Comments	Type and sessions per mnth	Clinic staffing in the practice premises	Appointments booking and medical records systems	Cited advantages and disadvantages of the schemes		
Coleshill group practice Warwicks. 4 GPs, 9,500 pats. (Malins & Stuart 1971)	Initiative from the practice - a desire for jnt.consultns. re diabetic pats. (Similar experiments were set up in two other practices)	diabetic clinic (annually)	From the hosp., 2 conslts., senr.registrar, nursing sister, sec.and techn; From the practice, 4 GPs, nurse and 2 secs. .	Results were charted on both hosp.and practice records	Pats. - 12 miles to hospital; familiar setting; personal and social circumstances were fully taken into account	GPs - developed new expertise in the care of the disease (appreciated by the patients)	Conslts. - background to disease discussed more leisurely; some team members learnt that competent medicine was practised outside hospitals
Cymmer Health Centre, Glamorgan 2 GPs, 4,500 pats. (Welsh Hospital Board 1972)	Small survey highlighted the dependence upon ambulances by pats. travelling 12 miles to the Neath Hosp. After a 3 month trial(1972) scheme was fully implmtd.	obstet (2)	Conslt. assisted by 2 loc.authy. midwives	New bookings made through general hosp. Conslt.takes clinic sheet and records to HC (20-24 pats. per clinic.)Blood samples taken and delivered by conslt. to hospital.	Pats. - travel time and costs reduced (estimated total travel savings of £1.73 per clinic); appointment time keeping poor, but reduced defaulting rate		Conslt. - benefited from direct contacts with midwives who knew the pats. well; more space re examinations and clerical help would have enabled larger clinics; travel costs 53p per clinic week Ambulance service - saving of approximately £12 per week (1972)
Woodside HC,Glasgow 8 practs.,21 GPs approx 40,000 pats. plus pats.from other practs. (Strang 1973, and Harper et al 1972) See also Robertson (1973), Birkett (1973) and Handel (1972).	Agreement between Western RHB, SHHD, and HC comm.of Management for clinics to be organised by Glasgow Northern Hosp.Group, phased over 1971/1972 with gynae as pilot. Note that in 1968 the Western RHB helped set up clinics in 8 specialties at the Kilsyth HC (Blair et al 1970)	surg(4) gynae(4) med(3) ENT(3) psych(3) derm(2) obstet(2) vas.surg diab.(1) paed (1) ger (1)	Usually a conslt. plus 2 local authy. nurses	Member of HC clerical staff made bookings 2 days before clinic's hosp.records dept. prepared necessary records from pats. lists	Pats. - reduced travel distance, familiar surroundings	GPs - joint consultations/ discussions possible yet "Because of their other commitments, there is less contact with the Practitioners than we would wish." (Harper et al 1972 p.283)	Conslts.-better accommodation in HC than in hospital outpatient department Hosp.authys. - a lower patient defaulting rate at at HC; necessity to augment hosp. clerical staff and transport, and employ radiogr. and physiotherapist; need to provide consultative cover in hospitals schemes were set up widely in HCs; junior medical staff would need HC clinic training
Wolverhampton 14 practs. 36 GPs, 104,514 pats. (Thorn & Russell 1973, and Thorn 1971)	Scheme started in 1970, developed from 2 monthly discussion group GPs hold own practice mini-clinics monthly	diabetic mini-clinics (annually)	Conslt.with other hosp. staff and GPs	Not applicable - mini-clinic records were held in each GPs surgery and accompanied any pats.referred to the hosp.clinics Note: All newly diagnosed pats.were seen at least once at the hosp.clinic	Pats. - continuity of care from same clinician; closer management of disease, e.g. most mini-clinic pats. had more blood sugar tests annually than hosp.clinic pats; more comfort, less waiting; consultation and prescription from the same source may have meant fewer defaulters	GPs - increased competence in management of diabetic pats; maintained complete clinical charge of the patient; practice nurses helped in educating pats.	Conslt. - growth of hosp. clinic retarded

Table 1 cont

Practice/scheme and source	Selection of specialties: Comments	Type and sessions per mth	Clinic staffing in the practice premises	Appointments booking and medical records systems	Cited advantages and disadvantages of the schemes		
Nailsea HC, Somerset 2 groups, 8 GPs, 19,500 pats. (Anon 1973)	HC house committee approached county medical officer and individual consults.	child psych(4)	consult.and hosp. soc.worker	A HC staff member made clinic appointment bookings, prepared notes and took reception duties Also she made hosp. bookings for resulting admissions and treatments, and typed letters for one consult. RHB paid 1/3rd of her salary	Pats. 10 mile journey saved; familiar surroundings; shorter waiting time for HC clinic appntmt. date; psychiatric pats. felt less labelled	GPs "generally ... a tremendous help ..." Health centre accommodation problems as op. clinics were not planned for	Consltrs."seem to enjoy coming ... and hold their clinics with perhaps a more informal relaxed atmosphere ....."
		gynae/ ante-natal (2)	consult., a GP and 2 nurses				
		psych(2)	consult. plus discussions with GPs				
		surg (1)	consult.,nurse resulting minor ops.done by GP				
		med (1)	consult.,nurse				
		ger (1)	consult.				
Tile Hill HC, Coventry 9 GPs, 14,000 pats. (Condon et al 1973)	Lack of op.accommodation at DGH plus consults. wish to experiment with a HC clinic	ortho (n.k.)	consult., hosp.doc., 2 nurses and sec.	n.k.	Pats.(ortho) ambulances were little used and a better appointments system; Pats.(psych) "willingness of usually reluctant pats. to see a psychiatrist" (pats. were then often willing to have hospital treatment).	GPs (psych.clinic) joint consultations improved case of individual pats. but there was a failure to interest other GPs in such a scheme. "A considerable amount of education and persuasion would therefore be required to extend the scheme."	Consltrs.(ortho) X-rays not on hand could be overcome by GPs making prior arrangements; recommended expansion of such clinics; clinic to be extended when more space available Consultant (psych) learnt of methods and problems of general practice "While the present shortage of psychiatric time continues, it may be better to work for a limited period in the practice and then move on to another."
		psych(1)	consult.	n.k.			
Street HC, Somerset. 4 GPs 9,500 pats. (Forth 1974)	Street & Glastonbury HCs recorded for 4 months all referrals and hosp. follow-ups. Majority were in these specialties. (Scheme implemented in both HCs in 1972)	ortho(2)	consult.and hosp. physiotherapist, plus HC nurse and sec.	GPs booked pats. into local sessions, notified hospital records and the consult. carried records. Hosp.notes were typed in HC and GPs received duplicates	Pats. saved journey of 12-22 miles.	GPs able to consult over difficult cases and start treatments before referring.	Ambulance services considerable mileage saved.
		surg(2)	consult.and hosp. sec.				
Cumbernauld HC, nr. Glasgow. 13 GPs, 40,000 pop.approx. (Scott et al 1975)	Results incl. clinical details from 2 years experience. (Clinics held in 7 other specialties, see Bryden 1970)	urol(6)	consult.weekly sen.registrar fortnightly	Pats.records commenced at first attendance, transferred to hosp. for results then returned to HC	Pats. greatly reduced travelling - high level of employment in district especially women part-time	GPs communication with hosp.drs. easier	Consltrs. registrars taken in turn to HC; time spent away from hosp. a disadvantage; some problems re medical records and specimen transp; can give 1st class pat.care and excellently placed for clinical research

Table 3.1 Responses of Regional Hospital Boards to requests for statistics relating to consultant outpatient clinics held in general practitioner hospitals, health centres, and other local authority premises

Regional Hospital Board	Date of first reminder letter	Date data dispatched	Breadth of data submitted		Comments re data submitted
			General practitioner hospitals	Health centres and 'clinic premises'	
N.E.Metropolitan (N.E.Thames)	-	13 Feb.74	Yes	Yes	Approach made to Board prior to 18 Feb. 74
S.E.Metropolitan (S.E.Thames)	-	22 Feb.74	Yes	Yes	1972 bound volumes
Sheffield (Trent)	-	5 Mar.74	Yes	Yes	1972 bound volumes
Birmingham (West Midlands)	-	6 Mar.74	Yes	No	Survey pro forma used; no details were held of health centres or local authority premises
Manchester (North Western)	-	11 Mar.74	Yes	Yes	Data on Board's own pro forma
Liverpool (Mersey)	-	13 Mar.74	Yes	Yes	Survey pro forma used; some non-g.p. hospitals included
South Western (South Western)	-	15 Mar.74	Yes	Yes	1972 bound volumes
N.W.Metropolitan (N.W.Thames)	-	28 Mar.74	Yes	Yes	Data on Board's own pro forma
S.W.Metropolitan (S.W.Thames)	-	29 Mar.74	Yes	Yes	Survey pro forma used
Newcastle (Northern)	-	3 Apr.74	Yes	No	Survey pro forma used
Oxford (Oxford)	22 Apr.74	15 May 74	Yes	Yes	Survey pro forma used
East Anglian (East Anglian)	4 June 74	17 June 74	No	No	Only information held by RHA were copies of SH3 returns
Wessex (Wessex)	4 June 74	5 Aug 74	Yes	Yes	Copies of hospital records, SH3 forms, etc.
Leeds (Yorkshire)	22 Apr.74	18 Oct.74	Yes	Yes	Copies of hospital records, SH3 forms, etc.

Note: The original letters to the Regional Hospital Boards were dated 18 February, 1974.

Names in ( ) are those of the relevant Regional Health Authorities

Table 3.2 Specialties in which Peripheral Consultant Outpatient Clinics were held, and Total Outpatient Statistics for England, for 1972

Specialty	Peripheral outpatient clinic statistics for 13 Regional Hospital Boards, 1972				Total outpatient statistics for England, 1972		Peripheral total attendances as % of total attendances for England
	Total no. of units in which clinics were sited	Total no. of new patients	Total no. of attendances	Ratio of total/new out-patients	Ratio of total/new out-patients	Total out-patient attendances per 1,000 1972 population	
Ophthalmology	329	66,174	239,657	3.6	4.6	59.4	8.7
Orthopaedics	179	48,839	160,612	3.3	4.0	97.2	3.6
Child psychiatry[1]	165	16,360	115,868	7.1	6.6	4.8	52.5
General surgery	161	57,676	147,500	2.6	3.5	73.3	4.3
Ear, nose & throat[2]	143	29,107	70,256	2.4	3.2	43.1	3.5
Gynaecology[3]	140	25,772	58,436	2.3	2.8	32.4	3.9
General medicine	132	19,611	66,766	3.4	6.2	69.2	2.1
Diseases of the chest	114	108,578	402,895	3.7	4.2	28.7	30.3
Obstetrics[4]	91	35,410	113,627	3.2	4.7	74.0	3.3
Adult psychiatry	81	7,046	56,404	8.0	7.7	29.4	4.1
Paediatrics	60	3,723	15,108	4.1	5.2	19.9	1.6
Physical medicine	56	12,457	35,431	2.8	3.7	12.7	5.9
Dermatology	42	9,344	27,741	3.0	3.7	32.8	1.8
Venereal diseases	19	30,653	97,801	3.2	3.4	22.1	9.6
Geriatrics	19	430	2,306	5.4	5.7	3.6	1.2
Radiotherapy	18	7,629	25,578	3.4	7.7	15.3	3.6
Urology	12	641	1,746	2.7	4.1	6.8	0.6
Neurology	10	885	2,651	3.0	3.8	6.6	1.0
Pathology/Cytology[5]	9	4,881	7,458	1.5	-	-	-
Dental surgery	6	618	1,092	1.8	3.5	39.9	0.1
Orthodontics	5	751	5,418	7.2	7.4	8.7	1.2
Rheumatology	5	207	984	4.8	6.3	4.0	0.5
Other[6]	13	780	4,846	-	-	-	-
Total	1,809[7]	487,572	1,660,181	3.4	4.2	718.0	5.0

[1] includes 1 unit treating adolescent and adult psychiatric patients
[2] includes some urology
[3] includes 1 audiology clinic
[4] includes 8 units treating some obstetric patients
[5] includes 1 haemotology unit
[6] includes mental handicap (4 units), adolescent psychology (1 unit), diabetes (1 unit), cardiology (1 unit), thoracic (2 units), special care babies (2 units), and chemotherapy (1 unit).
[7] excludes 14 specialty clinics for which statistics were not available

Source: Data supplied by Regional Hospital Boards/Regional Health Authorities, and Health and Personal Social Services Statistics for England and Wales 1973 and 1974.

Table 3.3 Types of Units, Distributions of Clinic Sessions and Total Attendances, and Ratios of Total /New Outpatients for Selected Specialties

Selected Specialties	Total no. of units in which consultant out-patient clinics were held in 1972			Total no. of clinic sessions			% of total attendances at peripheral units			Ratio of total/new outpatients		
	G.P. hospitals	Health centres	'Clinic premises'	G.P. hospitals	Health centres	'Clinic premises'	G.P. hospitals	Health centres	'Clinic premises'	G.P. hospitals	Health centres	'Clinic premises'
Diseases of the chest	50	1	63	1,976	35	22,215	6.3	0.2	93.5	4.2	9.9	3.7
Ophthalmology	63	30	236	2,855	1,172	13,210	21.2	6.9	71.9	3.9	4.5	3.5
Orthopaedics	105	6	68	4,434	112	2,009	66.3	1.5	32.2	3.1	2.5	3.9
General surgery	155	4	2	7,515	140	111	96.1	1.6	2.3	2.6	2.2	2.7
Child psychiatry	5	15	144	181	2,217	32,480	0.7	5.3	94.0	3.7	6.1	7.1
Obstetrics	57	2	32	3,652	23	2,127	59.7	0.4	40.0	2.9	3.3	3.8
Venereal diseases	5	-	14	208	-	6,340	2.2	-	97.8	3.1	-	3.2
Ear, nose and throat	88	4	50	2,799	135	1,731	68.3	2.7	29.0	2.3	2.8	2.6
General medicine	120	4	8	4,824	153	931	84.7	2.3	12.9	3.5	4.2	2.6
Gynaecology	134	4	2	3,818	81	92	95.0	3.1	1.9	2.3	2.2	2.2
Adult psychiatry	70	2	9	3,553	104	4,994	71.6	1.6	26.8	7.4	4.3	11.0
Physical medicine	48	3	5	2,197	123	217	75.5	6.0	18.4	2.6	2.7	4.7
Total for all specialties	213	44	548	42,113	4,528	89,486	40.9	2.4	56.7	3.0	3.8	3.8

Note: G.P. hospitals data apply to 13 regions, the health centres and 'clinic premises' data to 11 regions.
Source: Data supplied by Regional Hospital Boards/Regional Health Authorities.

Table 3.4 Health Centres in England which Accommodated Consultant Outpatient Clinics in 1972: Comparative Data drawn from the Returns Submitted by the Regional Hospital Boards/Regional Health Authorities and the British Health Centres Directory

Note Information about specialties enclosed in ( ) was obtained from alternative sources.

Sources

British Health Centres Directory 1973 (Brookes 1973) columns 1,5 and 6

Returns submitted from the Regional Hospital Boards/ Regional Health Authorities columns 2,3 and 4

Department of Health and Social Security. Health Centres. Summary (as at 31 March 1974). (DHSS 1974b)

Report to the Joint Management Committee of the Nuffield Health Centre, Witney, on the functioning of the Health Centre during the period 1st April, 1971 - 31st March, 1972. (Pleydell 1972)

Sheppard, E. (1973) Health Visitor in a Health Centre. Practice Team, No. 26, 2-4.

Personal communications

Abbreviations

audio	audiology	ophth	ophthalmology
chest	chest diseases	ortho	orthopaedics
ch guid	child guidance	paed	paediatrics
ch psych	child psychiatry	psych	adult psychiatry
dental	school dental	physio	physiotherapy
derm	dermatology	phys med	physical medicine
E.N.T.	ear, nose and throat	radioth	radiotherapy
gen med	general medicine	speech	speech therapy
gen surg	general surgery	thermo	thermography
ger	geriatrics	urol	urology
gynae	gynaecology	VD	venereal diseases
obst	obstetrics		

Table 3.4

Name and address of health centre	Regional Hospital Boards' returns for decentralised consultant outpatient sessions in 1972		British Health Centres Directory 1973 Services listed as at 31 March 1972	
	RHB name of clinic/premises	Specialties	LA	RHB
LEEDS REGIONAL HOSPITAL BOARD				
Welbeck Street, Castleford	Castleford Health Centre, Welbeck Street	paed	dental speech ophth	-
SHEFFIELD REGIONAL HOSPITAL BOARD				
Laithes Lane, Athersley, Barnsley	Child Guidance Centre, Athersley Estate	ch psych	dental physio	-
Health Centre, Main Street, Shirebrook	Shirebrook Ophthalmic Clinic	ophth	dental ophth	-
Health Centre Gosber Road, Eckington	Eckington Ophthalmic Clinic	ophth	dental speech ophth	-
Birley Moor Health Centre, East Glade Crescent, Sheffield	Birley Health Centre	ophth ch psych	-	-
The Park, Woodlands, Doncaster	Woodlands Child Guidance Clinic	ch psych	ch guid ophth	-
Manor House Road, Horncastle	Lindsay C.C. Clinic Horncastle	ophth	dental speech physio	physio ophth
Gordon Field, Market Rasen	Children's Ophthalmic Clinic, Market Rasen	ophth	dental physio	ophth physio
New Street, Huthwaite. Sutton-in-Ashfield	School Clinic, New Street, Sutton-in-Ashfield	ophth	-	-
St. John Street, Mansfield	School Clinic, St. John's St., Mansfield	ophth	dental speech physio ophth psych	-
High Street, Arnold, Nottingham	School Ophthalmic Clinic, Arnold	ophth	dental speech physio ophth	-
Walters Road, Maltby	Child Welfare Centre, Maltby	ophth ch psych	not listed	not liste
Adwick Road, Mexborough	Child Welfare Centre, Mexborough	ophth	dental ophth	-
Mill Road, Ecclesfield	Child Guidance Clinic, Ecclesfield	ch psych	dental speech ch guid ophth psych	-
Rock House, Charnwood St. Swinton	Child Guidance Clinic, Swinton	ch psych	ch guid	-
Newgate Street, Worksop	Ophthalmic School Clinic, Workshop	ophth	dental speech physio ophth psych	
Johnson Street, Stocksbridge	Ophthalmic Clinic, Stocksbridge	ophth	dental speech	-
MANCHESTER REGIONAL HOSPITAL BOARD				
Montague Health Centre, Blackburn	E.N.T. (School) Clinic, Montague Health Centre	E.N.T.	dental speech ch guid physio ophth psych	E.N.T. obst
Deansgate Health Centre, Bolton	Deansgate Health Centre	ch psych	dental speech ch guid physio	obst
Larkhill Health Centre Mount Pleasant	not listed	-	dental speech ch guid ophth psych	E.N.T. obst psych V.D.

For notes, sources and abbreviations, refer to title page of Table 3.4.

[1] This premises was classified as a health centre by the Trent RHA.

Table 3.4 cont.

Name and address of health centre	Regional Hospital Boards' returns for decentralised consultant outpatient sessions in 1972		British Health Centres Directory 1973 Services listed as at 31 March 1972	
	RHB name of clinic/premises	Specialties	LA	RHB
OXFORD REGIONAL HOSPITAL BOARD				
London Road, Daventry In grounds of Daventry hospital	not listed	-	-	psych
(High Street, Burton Latimer)[1]		-	-	(psych)[1]
Coxwell Road, Faringdon, Berks	School Eye, Ante Natal, Faringdon Health Centre	ophth obst	dental ch guid	gynae ophth
Kidlington	School Eye, Kidlington Health Centre	ophth	dental	-
Nuffield Health Centre, Witney Note: financed by the Nuffield Provincial Hospitals Trust	not listed	gen med chest neurol phys med ger gen surg ortho ophth psych gynae thermo school ophth	not applicable	not applicable
SOUTH WESTERN REGIONAL HOSPITAL BOARD				
Calne, Wiltshire	not listed	-	dental ortho	E.N.T. psych
Wincanton Health Centre, Somerset	Wincanton Health Centre	ophth	dental	-
Clevedon, Somerset	not listed	-	-	ophth
Nailsea, Somerset	Nailsea Health Clinic/ Centre	gen med gen surg ger gynae obst	dental	gen med gen surg ger gynae obst
Street, Somerset	not listed	(gen surg)	ch guid	ortho
Eastland Road, Thornbury, Gloucestershire	Thornbury Health Clinic	psych (mental handicap)	dental speech ch guid ophth	ger
21, West Walk, Yate, Gloucestershire	Yate Health Centre	ortho ophth	dental speech ch guid ophth	psych
Hugh Town, The Isles of Scilly Part of St. Mary's Hosp.	not listed	-	dental	ortho
Okehampton In grounds of Okehampton District hospital	not listed	-	dental speech	ortho
Southmead Health Centre, Bristol	not listed	(gen med) (psych) (ger)	dental speech ophth	-
William Budd Health Centre, Bristol	not listed	-	dental speech physio ch guid	obst
Charlotte Keel Health Centre, Bristol	not listed	-	dental speech	obst
Barrows Road, Cheddar	not listed	-	-	ortho
Park Road, Frome (adj. to Frome Victoria Hospital)	Frome Clinic	ophth	dental speech ch guid	ophth ortho
Wells Road, Glastonbury	Glastonbury Clinic	ophth (gen surg)	dental speech ch guid	ophth ortho
WESSEX REGIONAL HOSPITAL BOARD				
Consort Road, Cowes	not listed	-	dental speech	psych
North Allington, Bridport,	Child Guidance Clinic, The Health Centre, North Allington, Bridport	ch psych	dental speech ch guid	-
Andover Health Centre, Charlton Road, Andover (in grounds of Andover War Memorial Hospital)	Child Guidance Clinic, Health Centre, Charlton Road, Andover	ch psych	dental speech ch guid audio	-

[1] This health centre was listed in the Directory as housing an RHB psychiatry clinic, but an inquiry showed the situation to be otherwise.

For notes, sources and abbreviations, refer to title page of Table 3.4.

Table 3.4 cont.

Name and address of health centre	Regional Hospital Boards' returns for decentralised consultant outpatient sessions in 1972		British Health Centres Directory 1973 Services listed as at 31 March 1972	
	RHB name of clinic/premises	Specialties	LA	RHB
Hythe Medical Centre, Beaulieu Road, Dibden Purlieu (in grounds of Hythe Hospital)	Hythe Hospital, and Child Guidance Clinic, Hythe Medical Centre, Hythe	ch psych gen med paed derm phys med ger gen surg E.N.T. ortho ophth gynae	dental speech ch guid	chest gen med gen surg gynae psych derm ophth paed ortho phys med
NORTH EAST METROPOLITAN REGIONAL HOSPITAL BOARD				
High Street, Hoddesdon	Child Guidance Clinic, Hoddesdon	ch psych	dental speech ch guid	-
Hurst Road, Walthamstow	Hurst Road Health Centre E.17.	E.N.T. ortho ophth paed	dental speech ch guid physio	E.N.T. ophth ortho
Gooshays Drive, Harold Hill, Romford	Harold Hill Health Centre	ophth	dental speech ophth ortho	-
Buntingford, Hertfordshire	Buntingford School Ophthalmic	ophth	dental speech	ophth
John Scott Health Centre, Hackney	John Scott Health Centre	ophth ch psych	dental speech ch guid physio ophth E.N.T.	-
Aveley Health Centre, Darenth Lane, South Ockendon	Aveley Health Centre, South Ockendon	ophth	dental	-
High Road, Laindon	Laindon Health Centre	ophth	dental speech ophth	-
Gifford Cross Road, Corringham	Corringham Health Centre	ophth	-	-

For notes, sources and abbreviations, refer to title page of Table 3.4.

Name and address of health centre	Regional Hospital Boards' returns for decentralised consultant outpatient sessions in 1972		British Health Centres Directory 1973 Services listed as at 31 March 1972	
	RHB name of clinic/premises	Specialties	LA	RHB
NORTH WEST METROPOLITAN REGIONAL HOSPITAL BOARD				
Finsbury Health Centre, Pine Street, Clerkenwell EC1	Finsbury Health Centre Pine Street, Clerkenwell	phys med	dental physio	-
River Place Health Centre, Essex Road, London N1	School Eye Clinic, River Place, N1 and Canonbury Child Guidance Unit, River Place Health Centre, N1	ophth ch psych	dental ch guid	-
92, Bath Road, Hounslow	Orthopaedic and Ophthalmic Clinics, 92, Bath Road, Hounslow, and Child Guidance Clinic, Bath Road, Hounslow	ortho ophth ch psych	dental speech physio	ortho ophth psych
Maswell Park Health Centre, Hounslow	not listed	-	dental speech physio	ophth ortho psych
Albany Road, Brentford	Orthopaedic and Ophthalmic Clinics, Albany Road, Brentford	ortho ophth	dental speech physio	obst ophth ortho
SOUTH EAST METROPOLITAN REGIONAL HOSPITAL BOARD				
Maison Dieu Road, Dover	not listed	-	(psych)	dental speech ch guid
SOUTH WEST METROPOLITAN REGIONAL HOSPITAL BOARD				
Rodney Road, Walton-on-Thames (in grounds of Walton-on-Thames Hospital)	Walton, Hersham and Oatlands Hospital, Walton-on-Thames	gen med paed gen surg E.N.T. radioth urol gynae	speech ophth	gen med gen surg gynae E.N.T. paed psych
Fitzalan Road, Littlehampton, adj. to Littlehampton and District Hospital	not listed	-	dental speech ophth	phys med
Parkway, New Addington, Croydon	not listed	-	dental speech ch guid physio	diabetic

Table 3.5 Regional Hospital Boards' statistics relating to peripheral premises in which consultant outpatient clinics were held in 1972

Regional Hospital Board	Total number of units in which peripheral consultant outpatient clinics were held in 1972	Total number of specialties which held consultant outpatient clinics in peripheral units	Total number of consultant outpatient clinics held in peripheral units	Total number of new patients at peripheral consultant sessions	Total number of all outpatients at peripheral consultant sessions	Ratio of total/new outpatients at peripheral consultant sessions
Newcastle	4[1]	10[1]	436[1]	3,183[1]	7,549[1]	2.4[1]
Leeds	31[2]	104[2]	4,294[2]	16,445[2]	59,561[2]	3.6[2]
Sheffield	122	233	15,421[2]	68,462	250,864	3.7
Liverpool	34	52	6,361	29,770	98,365	3.3
Manchester	78	90	8,074	41,253	123,194	3.0
Birmingham	15[1]	73[1]	2,564[1]	13,459[1]	46,272[1]	3.4[1]
Oxford	33[2]	91[2]	5,724[2]	10,098[2]	40,869[2]	4.0[2]
South Western	90[4]	372[4]	13,959[4]	82,619[4]	225,320[4]	2.7[4]
Wessex	57	160	12,101[2]	41,893	147,567	3.5
East Anglian	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
N.E.Metropolitan	99	199	18,273	59,636	210,091	3.5
N.W.Metropolitan	98	174	25,502	46,369	192,240	4.1
S.E.Metropolitan	79	146	13,369	48,516	166,452	3.4
S.W.Metropolitan	65	119	10,049	25,869	91,837	3.6
Total 13 Regional Hospital Boards	805	1,823	136,127	487,572	1,660,181	3.4

[1] general practitioner hospitals only

[2] excludes some clinics and attendances

[3] excludes child psychiatry clinics

n.a. not available

Source: see Table 3.3

Table 3.6 Statistics relating to General Practitioner Hospitals in which consultant outpatient clinics were held in 1972

Regional Hospital Board	Total number of general practitioner hospitals in which consultant outpatient clinics were held	Total number of specialties which held consultant outpatient clinics in general practitioner hospitals	Total number of consultant outpatient clinic sessions held in general practitioner hospitals	Total number of new patients at consultant outpatient sessions in general practitioner hospitals	Total number of all outpatients at consultant outpatient sessions in general practitioner hospitals
Newcastle	4	10	436	3,183	7,549
Leeds	13	77	3,672	14,890	56,207
Sheffield	16	92	3,906	23,907	70,636
Liverpool	1	3	103	598	1,896
Manchester	15	15	796	6,484	11,732
Birmingham	15	73	2,564	13,459	46,272
Oxford	12	58	1,738	7,157	24,184
South Western	61	334	10,936	60,918	173,987
Wessex	21	112	4,777	24,710	80,528
East Anglian	n.a.	n.a.	n.a.	n.a.	n.a.
N.E.Metropolitan	13	83	4,031	22,239	69,843
N.W.Metropolitan	13	60	2,523	14,489	34,443
S.E.Metropolitan	16	82	4,119	24,896	71,805
S.W.Metropolitan	13	58	2,512	10,794	29,728
Total 13 Regional Hospital Boards	213	1,057	42,113	227,724	678,810

n.a. not available

Source: see Table 3.3

Table 3.7 Statistics relating to Health Centres in which consultant outpatient clinics were held in 1972

Regional Hospital Board	Total number of health centres in which consultant outpatient clinics were held in 1972	Total number of specialties which held consultant outpatient clinics in health centres in 1972	Total number of consultant outpatient clinic sessions held in health centres	Total number of new patients at consultant outpatient sessions in health centres	Total number of all outpatients at consultant outpatient sessions in health centres
Newcastle	n.a.	n.a.	n.a.	n.a.	n.a.
Leeds	1	1	2	17	19
Sheffield	16	18	870	1,688	7,850
Liverpool	-	-	-	-	-
Manchester	2	2	146	233	804
Birmingham	n.a.	n.a.	n.a.	n.a.	n.a.
Oxford	3[1]	15[1]	395[1]	1,749[1]	5,632[1]
South Western	6	11	164	545	1,685
Wessex	3	13	563	2,201	6,960
East Anglian	n.a.	n.a.	n.a.	n.a.	n.a.
N.E.Metropolitan	8	12	1,303	1,603	8,537
N.W.Metropolitan	4	8	843	1,206	4,667
S.E.Metropolitan	-	-	-	-	-
S.W.Metropolitan	1	7	242	1,298	3,486
Total 11 Regional Hospital Boards	44	87	4,528	10,540	39,640

[1] Includes Nuffield Health Centre, Witney

n.a. not available

Source: See Table 3.3

Table 3.8 Statistics relating to 'Clinic Premises' in which consultant outpatient clinics were held in 1972

Regional Hospital Board	Total number of 'clinics premises' in which consultant outpatient sessions were held in 1972	Total number of specialties which held consultant outpatient sessions in 'clinics premises' in 1972	Total number of consultant outpatient sessions held in 'clinics premises'	Total number of new patients at consultant outpatient sessions held in 'clinics premises'	Total number of all outpatients at consultant outpatient sessions in 'clinics premises'
Newcastle	n.a.	n.a.	n.a.	n.a.	n.a.
Leeds	17	26	620	1,538	3,335
Sheffield	90	123	10,645	42,867	172,378
Liverpool	33	49	6,258	29,172	96,469
Manchester	61	73	7,132	34,536	110,658
Birmingham	n.a.	n.a.	n.a.	n.a.	n.a.
Oxford	18	18	3,591	1,192	11,053
South Western	23	27	2,859	21,156	49,648
Wessex	33	35	6,761	14,982	60,079
East Anglian	n.a.	n.a.	n.a.	n.a.	n.a.
N.E.Metropolitan	78	104	12,939	35,794	131,711
N.W.Metropolitan	81	106	22,136	30,674	153,130
S.E.Metropolitan	63	64	9,250	23,620	94,647
S.W.Metropolitan	51	54	7,295	13,777	58,623
Total 11 Regional Hospital Boards	548	679	89,486	249,308	941,731

Note. 'Clinic premises' are peripheral sites excluding general practitioner hospitals and health centres

n.a. not available

Source: see Table 3.3

Table 3.9 Attendance Figures and Rates per 1,000 Population for All Outpatients, and for Peripheral Units by Hospital Region

Regional Hospital Board	Home population 1972 '000	Total new outpatients for Hospital Region 1972		Total outpatient attendances for Hospital Region 1972		New outpatients at peripheral clinics 1972		Total outpatient attendances at peripheral clinics 1972	
		'000	per 1,000 population	'000	per 1,000 population	Total	per 1,000 population	Total	per 1,000 population
Newcastle	3,045	480	157.1	2,009	659.7	3,183[1]	1.0[1]	7,549[1]	2.5[1]
Leeds	3,240	469	144.8	2,103	648.9	16,445	5.1	59,361	18.4
Sheffield	4,674	668	143.0	2,898	620.0	68,462	14.6	250,864	53.7
Liverpool	2,217	415	187.2	1,712	772.1	29,770	13.4	98,365	44.4
Manchester	4,582	753	164.3	3,102	676.9	41,253	9.0	123,194	26.9
Birmingham	5,148	770	149.6	3,346	649.8	13,459[1]	2.6[1]	46,272[1]	9.0[1]
Oxford	2,031	324	159.7	1,231	605.9	10,098	5.0	40,869	20.1
South Western	3,209	480	149.7	1,778	554.0	82,619	25.7	225,320	70.2
Wessex	2,067	295	142.6	1,210	585.5	41,893	20.3	147,567	71.4
East Anglian	1,790	241	134.8	949	530.2	n.a.	n.a.	n.a.	n.a.
N.E.Metropolitan	3,386	651	192.2	2,767	817.1	59,636	17.6	210,091	62.0
N.W. Metropolitan	4,129	1,041	252.0	4,502	1,090.4	46,369	11.2	192,240	46.6
S.E. Metropolitan	3,547	653	184.1	2,804	790.5	48,516	13.7	166,452	46.9
S.W. Metropolitan	3,235	686	212.2	2,835	876.4	25,869	8.0	91,837	28.4
England	46,297	7,927	171.2	33,243	719.4	487,572[2]	10.5[2]	1,660,181[2]	35.9[2]

Source: see Table 3.2

1 Statistics available for general practitioner hospitals only.

2 Total 13 Regional Hospital Boards.

n.a. not available

Table 3.10 Anomalies found[1] in the Data from Regional Hospital Boards

Regional Hospital Board	Statistics for premises other than general practitioner hospitals not available	School health clinics and/or local health authy.clinics occurring in the same premises but listed separately	School health or LA clinics described by RHB only by their official title and town were found to be held in a health centre[1]	RHB described premises as health centres, but were found[1] to be 'clinic premises' only[2]	Returns included data relating to 'clinic premises' administered by hospital authorities	RHB returns did not attribute clinic sessions to known peripheral sites e.g. health centres[3]
Newcastle	*	n.a.	n.a.	n.a.	n.a.	n.a.
Leeds						
Sheffield		*	*		*	
Liverpool				*	*	
Manchester				*	*	*
Birmingham	*	n.a.	n.a.	n.a.	n.a.	n.a.
Oxford				*		*
South Western	4		*		*	*
Wessex		*		*	*	*
East Anglian	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
N.E.Metropolitan				*	*	
N.W.Metropolitan		*	*	*	*	*
S.E.Metropolitan				*	*	*
S.W.Metropolitan					*	*

Key

* Anomaly found in RHB's returns

n.a. No RHB returns available

1 The validation process included checking entries against directories and personal communication with certain RHBs, health centres and 'clinic premises'.

2 Premises housing general practitioner surgeries were classified as health centres, those without as 'clinic premises'.

3 Health centres with RHB clinics identified either in the British Health Centres Directory or by personal communication.

4 Returns excluded child psychiatry.

Table 4.1 The Definitions and Fieldwork Details of Studies Based on Surveys of Outpatient Departments

Authorship	Study Area	Main data collection methods from hospital records	Patient definitions	Range of specialties/departments	Supporting data collected
Oxford Regional Hospital Board (1963)	Royal Berkshire and Battle Hospitals of the Reading Combined Hospitals	100% recording of new patient attenders for 3 months, January, May, October, 1958 ——— patients followed up for a period of two years from the date of first attendance	new patients were defined as persons attending the hospital for the first time irrespective of the number of specialties seen and duration of follow-up	excluded casualty, psychiatry and contacts of tuberculosis, some new chest patients requiring x-ray only	
Scott and Gilmore (1966)	Edinburgh hospitals within the South-Eastern R.H.B.	1 sample day per week over 12 months 1961-62. Pro-forma completed jointly by clinic secretary and clinicians	new patients only recorded MOH* definition	excluded obstetrics, venereal diseases, child psychiatry, tropical diseases, casualty	30 gps in 10 practices recording referrals over 8 weeks; interviews with 250 gps, and 139 referred patients
Chamberlain (1966)	comparative study between a London non-teaching hospital group and a south coast hospital group	S.H.3 returns for each group 1955-1963; retrospective survey of approx.850 case notes in each group over 12 months	new patients selected MOH* definition	included all specialties But not studied were maternity, chest and fever hospitals	diagnostic open access records and domiciliary consultation records examined; small number of gp interviews
Backett et al (1966)	hospitals in Aberdeen plus peripheral hospitals/clinics in the counties of Aberdeen, Kincardine, Banff and Moray	10% sample of patients attending op clinics plus 100% census of new patients at some peripheral clinics, 6 months, 1962	new patients selected MOH* definition	included surgery, gynaecology, ear, nose and throat, orthopaedics, medicine, dermatology	surveys of sampled patients marked DNA - non-attenders, and of open access diagnostic records
Butterfield and Wadsworth (1966) and Chamberlain et al (1966)	Guy's Hospital (teaching)	5% sample of names on appointment lists, 1962	new patients selected MOH* definition	excluded venereal disease, dentistry, casualty	sampled patients interviewed by lay and medical workers
Montgomery (1968)	St. Thomas' Hospital (teaching)	random 5% sample of patient attendances, 6 months 1964-65	all outpatient attendances MOH* definition of new patient	excluded radiotherapy, venereal disease; chest, obstetrics, gynaecology and casualty studied separately	

* see over

Authorship	Study Area	Main data collection methods from hospital records	Patient definitions	Range of specialties/departments	Supporting data collected
Forsyth and Logan (1968)	80 hospitals in 11 hospital groups in 9 Hospital Regions	Routine information collected by record clerks on every new attender every fourth week for 12 months ——— More detailed information from 50 consecutive new referrals to each specialist over 6 months 1962	new patients - those referred for first time to specialty or had been to the specialty before but either discharged or not attended in past 12 months etc. Patients referred to one department but transferred to a second were counted as one new attender	excluded obstetrics, radiotherapy, dentistry	1. extraction from day books of x-ray and pathology depts. of investigations requested by gps plus supporting data from Ex.Councils and directories 2. questionnaires to consultants and S.H.M.Os.
Gruer (1972)	Outpatients resident in the Scottish Border Counties and referred to local clinics and Edinburgh hospitals	100% recording of new patient attendances at all Border clinics including L.A. clinics, plus new Border patients attending Edinburgh outpatient departments. Data collected routinely by hospital staff from clinical records 3 months, 1969 (see also col.6)	new patients selected D.H.S.S.* definition	excluded casualty, psychiatry, physiotherapy, x-ray, ante-natal, orthodontics	gps with patients residing in survey area undertook 2 months recording of referrals to hospitals outside survey area ——— follow-up of a stratified sample of the new referrals one year after date of first outpatient attendance
Trout (1973) and Trout and Martindale (1974)	Chesterfield Group of hospitals	100% Hospital Activity Analysis by medical records department 6 months 1970, and 12 months 1971	new patients recorded; definition as for S.H.3* returns	excluded obstetrics	new patients followed-up for 12 months

* For the MOH/DHSS/SH3 definition of a new outpatient, see Section 3.

For an analysis of outpatient services of the London teaching hospitals, 1951-61, see Blaney et al (1966). The social characteristics and diagnostic categories of Exeter outpatients, 1966-67, were presented by Ashford and Pearson (1970). A pilot survey for the Guy's Hospital study was described by Acheson et al (1963).

Table 4.1 The Range of Information Presented in Studies Based on Surveys of Outpatient Departments

Information collected from hospital records sampled and presented in the analysis	Oxford Regional Hospital Board (1963) 2 Reading Hospitals	Scott and Gilmore (1966) Edinburgh Hospitals	Chamberlain (1966) A south coast group, a London non-teaching group	Backett et al (1966) Aberdeen and 4 counties	Butterfield and Wadsworth (1966) Chamberlain etc. (1966) Guy's Hospital	Montgomery (1968) St. Thomas' Hospital	Forsyth and Logan (1968) 80 hospitals in 11 H.M.C. groups	Gruer (1972) Scottish Border Counties	Trout (1973) Trout and Martindale (1974) Chesterfield Hospital Group
Sex	*	*	*	*	*	*	*	*	*
Marital status	-	-	*	-	*	-	*	-	*
Age	*	*	*	*	*	*	*	*	*
Address/Distance	*	*	*	*	*	*	*	*	*
Occupation/Social Class	-	-	*	-	*	-	-	-	*
Source of referral	*	*	*	*	*	-	*	*	*
Reason for referral	*	-	*	-	*	-	-	*	-
Preliminary diagnosis by gp/referral agent	*	-	-	*	*	-	*	-	-
Hospital diagnosis	*	*	*	*	*	-	*	*	*
Waiting time to first attendance	*	*	*	*	*	-	*	*	*
Subsequent attend-ances/inpatient care	*	-	*	*	-	-	*	*	*
Status of clinician seeing patient	*	*	*	-	*	-	*	*	*
Other departments visited at each attendance surveyed	*	-	*	-	-	-	*	-	*
Investigations by gps	-	*	*	*	-	-	*	-	*
X-ray/path.etc. ordered first hospital attendance	*	-	-	-	-	-	*	*	*
Outcome of first visit	-	*	*	*	*	-	*	*	-
Outcome at end of survey period	*	-	*	-	-	-	*	*	*
Gp/hospital correspondence	-	*	*	*	*	-	*	*	-
Other e.g. domiciliary consults., non-attenders	*	*	*	*	*	*	-	*	*

Note: The nature of each item of information varied between studies according to the survey methods used.

Table 4.3 Referral Patterns to Outpatient Departments from Various Publications and Reports

A Sources relating to individual practices

Source	Description of practice	Method of recording and period	Open access to hospital departments	Annual crude referral rates to outpatients per 100 population	Comments
Crawford (1954)	South Belfast suburban, 1 gp, NHS practice pop. 1,400 approx. - high % elderly	all direct consults. 24 months, 1951-53	access to lab. services but not physio.	6.9 referrals to specialists only 16.4 if hosp.extern.depts. are included	excludes domiciliary consults.; no inform. re obstetrics
Brotherston and Chave (1956)	post-war L.C.C. housing estate. 6 gps, practice pop. 16,000 (2 practices), high % children, total reg. pop. in sample 4,067	direct and indirect consults. for 25% practice addresses, 12 months, 1953 av.reg.pop. in sample 3,710	some open access to labs., but x-rays not mentioned	21.8 referrals for av.reg.pop. 19.9 referrals for tot. reg.pop.	referrals for diag. invest. very low, approx.1.5 per 100, no inform.re obstetrics (rates for pats.17.7 av.reg.pop., 16.2 tot.reg.pop.) Note confused reportage of results
Hopkins (1956)	London practice, 1 gp, av.NHS list per year 1,355	day book recordings for 3 years, 1951-53	not available	25.3 referrals for av.list per year	37% of referrals to outpatients were for x-ray/path. investigations
Handfield-Jones (1959)	country practice, 1 gp, list size 2,187	12 months 1957	only part-time x-ray in gp hospital	11.3 patients per list	
Fry (1957) and (1959)	south-east London, 1 gp and 1 assistant practice pop. 1952-6 av. 5,064; 1957 5,502	av. of 5 years of day book recordings 1952-6 and all consults. recorded on punch cards, 12 mnths 1957	access to x-ray/path.	7.8 patients av.list 1952-6 3.7 patients 3.8 referrals 1957	1952-7 approx. 13% annually had x-ray/path.investigations. Included in the 1957 rates were some domiciliary consults; Note (i) % of inpatient referred patients for 1952-6 was 0.7, 1957 3.8 (ii) confused reportage of 1957 results

Note: referrals - the total number of occasions a referral is made to outpatient departments (some patients being sent on more than one occasion during a survey period),
patients - the total number of patients referred to outpatient departments.

A Sources relating to individual practices (contd.)

Source	Description of practice	Method of recording and period	Open access to hospital departments	Annual crude referral rates to outpatients per 100 population	Comments
Scott et al (1960)	Edinburgh, 2 practices, 4 gps, av.reg.no.patients 4,805 Univ. teaching unit, high % < 5 yrs.	routine recording of direct consults. including multiple diagnoses, 12 months 1956-7	access to x-ray/path.	ambiguity in the reporting of results allows the calculation of two possible referral rates per practice pop, 20.8 which appears to include direct admissions and domiciliary consultations, and 16.2	
Bloor (1962)	rural Staffordshire, 2 gps but results for 1 gp's 2,700 patients	12 months 1959	access to path and obstetrics. Not x-ray	6.4	some doubt if numbers relate to referrals rather than patients
Carmichael et al (1963)	industrial, Ayrshire 3 gps, practice pop.av. 5,585	recording of outpatient referrals 12 months date unknown	not known	9.5	some ambiguity between patients and referrals
Wood (1964)	Penshurst, 2 gps but results for 1 gp's 2,354 patients	list of all referrals, 12 months 1959	access to path. Not x-ray	9.4 patients	excludes domiciliary consults.
Longmore (1967)	rural, Scotland, 1 gp practice pop. 1,289	patients records	access to x-ray/path.	8.7	undefined if referrals or patients
Evans and McBride (1968)	Stratford-upon-Avon, 4 gps, practice list 7,800	survey of all hosp. referrals, 7 months, 1966	access to x-ray/path. also physio	6.2 referrals	
Morrell et al (1971) see also Morrell (1971)	inner London, 3 gps, practice pop. 4,455 age/sex register	recording of direct and indirect consultations plus additional data for referrals 12 months 1967-8	access to x-ray/path.	11.9 referrals 11.0 patients	if obstetric referrals are excluded, the revised rates are 10.5 referrals and 9.6 patients Note: confused reporting of results between the two papers
Fry (1971) and (1972)	see above, Fry (1957) 2 gps, practice list 9,000 approx.	review of workload trends 1951-72	access to x-ray/path.	3.1 referrals 1970	
Walker (1973)	urban Newcastle-upon-Tyne 8 gps, age/sex register 17,507 High % of elderly	routine workload from day books, etc. plus 2 weeks of morbidity recordings and separate hospital referral and follow-up recordings	access to x-ray/path.	7.4 referrals	excludes ante-natal clinic bookings

Table 4.3 contd.

B Sources relating to multiple practices, the data recording being undertaken by general practitioners

Source	Description of practices	Method of recording and period	Open access to hospital departments	Annual crude referral rates to outpatients per 100 population	Comments
Logan (1953)	8 practices England: rural/urban	every NHS consult. 12 months 1951-52	not known	11.3 referrals 4.4 - 23.6 practices	
Logan (1954)	9 practices	recording over 3 years	not known	11.8 episodes 4.8 - 25.9 practices	Source: Carstairs & Skrimshire(1968)
Starey (1961)	30 gps in Berks, Bucks and Oxon NHS practice pop. approx. 70,000	recording of each out-patient referrals, 13 weeks 1960	variable access to x-ray, path. and physio	7.9 referrals individual gp range, 2.0 - 17.3	5.4% of referred patients were for investigations in departs. without direct access. Includes a few domiciliary consult.and only complex obstetrics
Wright (1968)	members of the South-west of England Faculty of RCGPs, 68 gps 167,800 approx.pop.	direct and indirect consults 1 week recording periods in each quarter over 1964-65	variable access to x-ray, but path. open to most gps	11.3 referrals	
Williams (1970)	members of the Welsh Faculty of RCGPs 68 gps, 153, 420 patients	method as above 1965-66	not known	17.7 referrals	includes domiciliary and private consults. with specialists
Ashford and Pearson (1970)	35 gps within Exeter city	morbidity data recorded for all direct consultations 12 months, 1966-67		data presented was not sufficiently specific to enable the calculation of referral rates	
Clarke and Bennett (1971)	approx. 100 gps in the catchment area for a new hospital planned for the Frimley area 1966 pop. approx 220,000	gps recorded all referrals excluding diagnostic 13 weeks 1969-70 Also 1 month validation check in some OP depts.	not known	9.6 crude referral rate	readjusted for under-recording, 12.8 referrals

Table 4.3 contd.

B Sources relating to multiple practices, the data recording being undertaken by general practitioners (contd.)

Source	Description of practices	Method of recording and period	Open access to hospital departments	Annual crude referral rates to outpatients per 100 population	Comments
Fraser et al (1974)	East Midland city, 18 gps in group practice, total list participating doctors, 42, 290	gps recorded all referrals to all hospital services, 11½ weeks, 1970	some tests unavailable	7.3 referrals	with obstetrics included the rate was 8.0
OPCS (1974)	115 gps, 53 practices England and Wales	'E' book recording of all diagnoses in direct consults and matched against age/sex registers	not known	8.6 referrals 6.0 Wales rural to 16.1 East Anglia rural	Note: validation revealed a recording omission rate of 14.6%

Table 4.3 contd.

C Sources relating to outpatient data collected within Hospital Departments

Source	Description of study area	Method of recording[1] and period	Open access to hospital departments	Annual crude referral rates to outpatients per 100 population	Comments
Oxford Regional Hospital Board (1963)	Royal Berkshire and Battle Hospitals of the Reading Combined Hospitals	100% recording of new patient attenders 3 mnths in 1958	not known	7.9 referrals Reading County Borough	Includes referrals from other agents, inter-specialty transfers and obstetrics. Excludes casualty, psychiatry, tuberculosis and chests for x-ray Assumed all Reading pop. would be referred to local hosps.
Logan (1964)	Bolton (covering 38 practices)	all new attenders 4 months 1962	access x-ray/path.	5.7 referrals all practices 2.9 - 10.5 range for all practices 5.9 referrals 18 solo gps	Data collected as part of national study, see Forsyth and Logan (1968).
Scott and Gilmore (1965)	Edinburgh hospitals within the South-Eastern R.H.B.	1 sample day per week over 12 months 1961-62, MOH definition	access x-ray/path.	11.8 referrals Edinburgh pop. 0.6 - 25.8 individual gp range (Note: 10.8 for gp only referrals. Carstairs and Skrimshire 1968)	Includes only gp and other community agencies' referrals. Excluded, obstetrics, venereal diseases, tropical diseases and child psychiatry, inter specialty transfers and non-attenders.
Forsyth and Logan (1968)	80 hospitals in 11 HMCs in 9 hospital regions	all new attendances at outpatient departments 13 separate weeks for 12 months 1961-62	access x-ray and some path.	4 - 8 majority of gps <2 to >20 some gps	Individual rates calculated for 369 gps were grouped and presented in a graph (which was inaccurately drawn).
Gruer (1972)	referrals to hospitals of persons resident in the Scottish Border Counties 1966 sample census pop. 101,490	all new attendances at outpatient departments within Borders and Edinburgh, etc. see Table 4.1 3 months 1969	access x-ray/path. Not physio.	8.7 referrals for population of Border Counties	

[1] For fieldwork definitions see Table 4.1

Table 4.4 Distribution of New Patients According to Specialty (from Various Studies and England 1973)

Distribution of new patients according to specialty	Oxford Regional Hospital Board (1963) 2 Reading Hospitals	Scott and Gilmore (1966) Edinburgh hospitals	Chamberlain et al (1966) Guy's Hospital (teaching)	Montgomery (1968) St. Thomas' Hospital (teaching)	Forsyth and Logan (1968) 80 hospitals in 11 HMC Groups	Gruer (1972) Scottish Border Counties[1]	Trout (1973) Chesterfield Hosptls.	DHSS (1974d) England 1973
	%	%	%	%	%	%	%	%
Orthopaedic surgery	11.7	7.9	9.0	5.4	11.4	28.9	24.6	14.5
General surgery	14.5	22.6	15.1	8.0	18.1	21.0	17.6	12.1
Obstetrics	5.3	excluded	5.2	n.a.	excluded	excluded	excluded	8.8
Ear, nose and throat	16.3	12.7	11.2	9.1	8.8	16.5	11.8	7.8
Ophthalmology	9.3	8.2	4.7	n.a.	8.8	5.4	7.9	7.3
Gynaecology	8.3	6.1	5.1	n.a.	11.6	8.5	9.0	6.7
General medicine	6.5	9.3	13.0[2,3]	36.6[2]	16.2[2,3]	10.4	8.2	6.6
Dental surgery	3.0	n.a.	excluded	n.a.	excluded	excluded	1.4	6.1
Dermatology	8.1	9.8	7.8	3.1	5.8	4.1	9.7	5.2
Venereal diseases	n.a.	excluded	excluded	n.a.	excluded	n.a.	n.a.	4.1
Diseases of the chest	10.1	2.0	1.1	17.6[1]	5.9	n.a.	4.1	4.0
Psychiatry	excluded	1.8	3.1[4]	4.3	5.8	excluded	4.0	2.2
Paediatrics	3.0	5.2	1.9	4.5	6.0	n.a.	1.1	2.2
Physical medicine/ rehabilitation	1.9	n.a.	9.5	15.9	n.a.	excluded	n.a.	1.9
Radiotherapy	n.a.	n.a.	4.0	n.a.	excluded	n.a.	n.a.	1.2
Neurology	n.a.	n.a.	3.8	n.a.	n.a.	n.a.	n.a.	1.1
Urology	n.a.	2.7	2.3	n.a.	n.a.	n.a.	n.a.	1.0
Diabetic clinics	n.a.	1.9	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.

n.a. figures not presented in the published tables

excluded i.e. data was not collected for these specialties

[1] Includes Local Authority clinics

[2] Includes cardiology

[3] Includes neurology and/or diabetes

[4] Includes some child psychiatry

Note: For study definitions of new patients see Table 4.1.

Table 4.5 Percentages of New Patients Seen by Consultants at First Outpatient Attendance (from various studies)

% of new patients seen by consultant at first attendance	Oxford Regional Hospital Board (1963) 2 Reading Hosptls.	Scott & Gilmore (1966) Edinburgh hospitals	Chamberlain (1966)		Butterfield & Wadsworth (1966)	Forsyth & Logan (1968)	Gruer (1972)	Trout (1973)
			South Coast Group	London Non-Teaching Group	Guy's Teaching Hospital	80 Hosptls. in 11 HMC Groups	Scottish Border Counties	Chesterfield hospitals
	%	%	%	%	%	%	%	%
All new patients	89.5	60	82	69	56		Edinburgh 71	83.1
Individual specialties							Border Hosps/ Clinics 93	
orthopaedic surgery	92.6	< 50				80		65.1
general surgery	93.5	< 50				89		93.6
obstetrics	83.1	-				-		-
ear, nose and throat	88.9	> 80				82		99.5
ophthalmology	86.5	< 50				93		80.6
gynaecology	91.0	> 90				92		93.4
general medicine	87.7	-				88		48.6
dermatology	92.4	< 50				88		98.5
diseases of the chest	96.7	-				94		94.5
paediatrics	97.4	-				92		91.3
psychiatry	100.0	-				89		93.6
% of patients seen by the consultant requested in the referral letter		75 (66% in some specialties)			65		Edinburgh 75	

Table 4.6 Outcome of Patients' First Attendance at an Outpatient Department (from Various Studies)

Outcome of patients' first attendance at an outpatient department	Scott & Gilmore (1966) Edinburgh hospitals	Chamberlain 1966 South coast group	Chamberlain 1966 London Non-teaching group	Butterfield and Wadsworth (1966) Guy's Teaching Hospital	Backett et al (1966) Aberdeen and 4 counties[1]	Gruer (1972) Scottish Border Counties	Starey (1961) 30 Thames Valley gps[2]	Walker (1973) 8 gps Newcastle
	%	%	%	%	%	%	%	%
Admitted immediately / 24-48 hours	3.4	nk	nk	nk	1.0	3.6	3.5	0.8
Waiting list/ delayed admission	15.9	15.9	14.0	16	27.5	30.1	31.4	20.7
Other hospital	4.5	nk	nk	nk	nk	8.5[3]		-
Other outpatient department	7.3	4.3	6.9	7	3.2	4.5	3.4	5.6
Proceed as outpatient	43.8	48.8	57.0	53	43.1[4]	30.0	37.7	48.8
Refer back to gp or other referral agent	24.5	27.9	18.9	4	20.2	22.0	19.8	14.6
Discharged without reference	3.6			16		0.7		9.8
Not known/other	0.1	3.0	3.2	4	5.1	0.5	2.3	-

nk not known

1 Six specialties only

2 Includes outcome of small number of domiciliary consultations

3 Other hospital outpatient department

4 Includes those patients returning for the results of investigations