

An audit of patients attending a general medical follow-up clinic

ABSTRACT—Of the 418 consecutive patients attending a general medical clinic for follow-up, 113 (27%) had appointments in another medical clinic for the same or a related problem; 98 of them (87%) were attending a clinic in a different hospital. The reasons for multiple clinic attendance were routine follow-up after hospital admission in 55 (49%), referrals from general practitioners to more than one clinic in 33 (30%), and cross-referrals from the 'parent' medical firm in 19 (17%). In six patients no clear reason for multiple attendances could be identified. More than half (55%) were over 65 years old, 45% lived more than five miles from the hospital, and 78% depended on ambulance, friends, or relatives for transport. We suggest that follow-up attendances at outpatient clinics should be stringently reviewed and should only be maintained if a clear reason can be identified. This would not only ensure a more effective service overall but would also save patients and relatives from inconvenience.

The government White Paper *Working for patients* has emphasised the need for both clinical and cost effectiveness in the delivery of patient care [1]. A major portion of the clinical workload is outpatient orientated. In the past it has been suspected that a number of patients attend multiple clinics. It has also been felt that the clinical problems which necessitated an outpatient follow-up could as effectively be achieved in the setting of a single clinic. The present study was conducted to determine whether patients were indeed attending multiple outpatient follow-up clinics, and, if so, what were the reasons.

Methods

All patients who attended the outpatient department of a single medical firm for follow-up between September 1987 and March 1990, and who were seen by one clinician (A.S.), were included. Each was asked whether he or she was attending other outpatient clinics, either in the same hospital or elsewhere in the city; if the answer was in the affirmative, the fact was con-

firmed through the appointment system of the hospital concerned. The reason for such multiple attendance was determined. The patients' diagnoses, age, distance of residence from the hospital, and dependence on ambulance, friends, or relatives for transport were also noted. Finally, the number of different types of medication taken by each patient was recorded along with the patient's own perceived need for multiple clinic attendance.

Results

The study comprised 418 consecutive follow-up patients. Twenty-seven per cent (113 patients) also attended other medical clinics for the same or a related medical problem. Of those, 98 (87%) went to a clinic in a different hospital in the city (Table 1).

The circumstances of and reasons for multiple attendance are shown in Table 2. The main diagnoses concerned were diabetes, hypertension, ischaemic heart disease, and chronic lung disease. For 55 of the patients who were regularly attending elsewhere, follow-up appointments had been initiated in the present medical clinic after an acute admission to the ward; 33 had been referred to a second clinic by their general practitioners; 19 had the second referral initiated by the 'parent' clinic to another medical specialist. In six patients no cause for multiple clinic attendance was found.

Table 1. Location of the other medical clinics

| Main diagnoses of patients attending multiple medical clinics | In same hospital | In another hospital |
|---------------------------------------------------------------|------------------|---------------------|
| Diabetes mellitus | 5 | 0 |
| Hypertension, ischaemic heart disease | 4 | 41 |
| Chronic obstructive airways disease | 0 | 33 |
| Lethargy, malaise | 0 | 18 |
| Epilepsy | 3 | 0 |
| Rheumatic problems | 3 | 0 |
| Not known | 0 | 6 |
| <i>Total</i> | <i>15</i> | <i>90</i> |

ASHOK SAMANTA, MD, MRCP

YASSER HAIDER, MRCP

CHRISTINE ROFFE, MRCP

Department of Clinical Pharmacology and Therapeutics, Leicester Royal Infirmary

Table 2. Reasons for patients attending multiple medical clinics

| Main diagnoses of patients attending multiple clinics | General practitioner referral ^a | Ward follow-up ^b | Cross referral ^c |
|-------------------------------------------------------|--------------------------------------------|-----------------------------|-----------------------------|
| Diabetes mellitus | 5 | 0 | 0 |
| Hypertension, ischaemic heart disease | 4 | 31 | 10 |
| Chronic obstructive airways disease | 6 | 24 | 3 |
| Lethargy, malaise | 18 | 0 | 0 |
| Epilepsy | 0 | 0 | 3 |
| Rheumatic problems | 0 | 0 | 3 |
| <i>Total^d</i> | <i>33 (30%)</i> | <i>55 (49%)</i> | <i>19 (17%)</i> |

^a Referred to second clinic by the general practitioner while already attending one

^b Follow-up after ward discharge by one team while already attending another team's clinic

^c Cross referral by medical clinic of first contact to specialist clinic

^d In six patients the reasons could not be identified.

Table 3 shows details of patients attending multiple clinics. More than half the patients were aged over 65 years, and more than one-third resided over five miles away from the hospital and depended on friends, relatives or the ambulance service for transport. Two-thirds were taking at least five or more drugs and two-thirds did not see the need for multiple attendance.

Discussion

The present study shows that 27% of patients attending a general medical clinic are concurrently followed in another medical clinic for a similar or related problem. Data were collected from the outpatient service of a single medical firm, and variations in the practice of other consultants cannot therefore be entirely ruled out. Nevertheless, the available evidence suggests the need for such audit on a wider basis.

The reasons for attendance at multiple medical clinics were identified as: (a) follow-up initiated after a ward admission (49%), (b) direct referrals from general practitioners (30%), and (c) cross-referrals initiated by the 'parent' medical team (17%). All the patients in the first group had longstanding chronic respiratory diseases. They had been attending another medical clinic within the city for the same condition and had come under the care of the present medical firm as an acute medical admission due to cardiorespiratory

Table 3. Details of 113 patients attending multiple medical clinics

| | No. (%) |
|--------------------------------------------------------|-----------|
| Age over 65 years | 62 (55) |
| Taking more than 5 different drugs | 72 (64) |
| Residence more than 5 miles from clinic | 51 (45) |
| Dependent on friends/relatives for transport | 40 (35) |
| Dependent on ambulance for transport | 48 (42.5) |
| Perceived lack of need for multiple clinic attendances | 79 (70) |

decompensation. Subsequent follow-up was arranged as a routine measure. The general practitioner referrals were mainly for symptoms of lethargy and malaise, but some were to specialist medical clinics for conditions such as diabetes, ischaemic heart disease, and chronic respiratory problems. It is possible that some general practitioners had sent patients to a second clinic for another opinion, although this would probably not account for any significant number of multiple attendances. The cross-referrals were to specialist medical clinics for diabetic, cardiological, neurological, and rheumatological problems. However, follow-up was continued with the 'parent' medical firm as well as the specialist clinic.

Outpatient clinic attendance is a costly procedure, especially when patients are dependent on ambulance services, or on friends or relatives who have to take time off work to transport them. There is therefore an urgent need stringently to review reasons for giving patients follow-up appointments. Routine follow-up, either after hospital admission or initial clinic referral by general practitioners, should be avoided and, if it is initiated, a precise reason should be identified. General practitioners appreciate being telephoned about patients under their care; the benefits of the telephone, both in general [2] and consultant [3] practice, have been recognised. It may indeed be possible that many general practice referrals will not require hospital follow-up. This has been shown in the past in paediatrics [4], and could become relevant in adult medical practice, especially as general practitioners are now moving towards holding their own budgets. If it is decided to cross-refer a patient to a specialist medical clinic, then again it would seem unnecessary to continue follow-up at two different sites.

There is a need to review the reasons why patients are asked to attend for follow-up appointments. Outpatient appointments make considerable demands on health service and personal resources. Such audits would not only be important for achieving a more

effective service, but may also benefit one's own practice [5].

Acknowledgements

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References

- 1 Department of Health. *Working for patients*. London: HMSO, 1989.

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- 5 Hartog M. Medical outpatients. *J R Coll Physicians Lond* 1988;

Address for correspondence: Dr A. Samanta, Consultant Physician, Department of Rheumatology, Leicester Royal Infirmary, Leicester LE1 5WW.

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