De taken van de huisarts : resultaten van een taakanalyse in 91 huisart[s]praktijken

Summary.

This thesis represents the results of a task analysis among 91 Dutch general practitioners. Attempts have been made to explain quantitiative differences in task performance by some characteristics of the working-enviroment, the working-method and the general practitioner.
The commencement of this study is discribed in chapter 1. A global review is given of the rise of family medicine as an occupation in the Netherlands. In the fifties a concurrential crisis took place in family medicine/general practice with regard to the specialised medical care services. The origin of the crisis had to be sought in the radical technological changes in medicine and in morbidity-pattern after World War II. By means of rationalisation and professionalisation this situation could be won.
The early seventies proved to be the beginning of a new era for general practice in the Netherlands. Health care services threatened to be an expensive undertaking. The government began to direct the policy of strengthening the primary health care system. Suddenly new opportunities arose for family medicine/general practice.
In order to show his contribution to the health care services a job-description of the family physician/general practitioner was indispensable for that planning. However there was a lack of empirical data to issue such a job-description. As a result of this deficiency a recourse has been taken to visions speculations and intentions to describe the general practitioners job-description. In the issued job-descriptions the broad spectrum philosophy of the "Woudschoten" conference (1959) concerning the general practitioners tasks is fully present.
The necessary empirical substructuring of the set of jobs actuated my decision in executing this study. I intended to search for task dimensions in the daily activities of general practitioners and to explain the differences in time-spent in task-performance by means of structural and personal variables.

In chapter 2 a commentary is given on the literature in relation to the objectives. Most of the important practice-analyses studies in the Netherlands appeared to have been directed either to parts or special aspects of the general practitioners medical performance. The data concerns only a limited number of practices. These studies give certain indications for a task-structure

and for those variables correlating with the variance in task performance.

In chapter 3 the design of the observation-instrument has been described. For that design reference is made to the job-description as issued by the National Dutch Association of General Practitioners. The observation categories have been elaborated in sets of activities as operationalisations of the following tasks: diagnostics therapeutics, referral attendance and prevention. Besides these tasks additional groups of (supporting) activities were identified. In this manner the entire scope of the daily occupational activities of the dutch general practitioner could be covered. It was proved that the observation-instrument had an appropriate validity for the objective in this study. To establish the task perception a questionnaire was presented to the general practitioners. Statements on the following topics were formulated in this questionnaire:

- the scope of task-performance
- the level of diagnostics and therapeutics
- the willingness to co-operate with other health workers
- the desire availibility of time and supporting health care facilities.

The design of the study and the manner in which it was executed are described in chapter 4. Behaviour-observations in a select representative sample of 91 general practitioners were conducted by specially trained medical observers during 20 hours per general practitioner, spread over 4 to 5 days in one week in the period March till June 1979. All the activities performed by the general practitioner in those 20 hours were recorded by means of a registration device which made it easily possible to ensure quick processing of all data. The task perception questionnaire was not only presented to the 91 general practitioners in the observation-study, but also to 614 general practitioners forming a representative national sample according to relevant features for this study. In four tests it could be proved that the observations had a sufficient level of objectivity where the scores of the individual observers were concerned as well as to the authors testscorses.

The mean time-spent to each of the observed activities are given in chapter 5 as well as the mean scale-scores of the task-perception. It seems that the general practitioners time is predo-

minantly occupied by diagnostic and therapeutic activities, travelling time, registration and practice-management in comparison with prevention and attendance to which only a relatively small amount of time is spent. An average of 10% of all patients attending the general practitioner is referred to specialists and to other workers within the health care system. Referral to professional assistance outside the health care system occurs extremely seldom.
A wide range of dispersion in which little structure is found turns out to be present in the task-perceptions. The clustered answers out of the questionnaire show conspicious differences with regard to the extent of the width of the task-perception. There is however more unanimity regarding the desired level of diagnostics and therapeutics.

In chapter 6 the results of the factor analysis on the relative time spent on the observation categories is reported. Six factors or task dimensions were found:
- somatic curative care
- co-operation with other disciplines and teaching
- gathering useful information concerning patient care and the post-graduate education
- secundary prevention and surveillance
- primary prevention for women in fertile age and for young children
- interactive communication and counselling.

With these six factors indications could be obtained for six behaviour characteristics:
- the family doctor who is evindently directed to intercurrent somatic cure and care
- the general practitioner who more than averagely co-operates with other health care workers acts as a teacher and performs a modernistic style of exercising
- the general practitioner with a more than average time-spent on post-graduate education and consultating specialists
- the general practitioner with special interest in secundary prevention who refers relatively few patients to specialists
- the general practitioner who is specially directed to primary prevention of women in fertile age-period and of young children

- the general practitioner with special interest in interactive communication and counselling.

The task-stucture revealed by me in this study seems to fit into the job-description issued by the national Association of General Practitioners, however that description is much more wide-ranging.
That difference can be attributed to differences in state. My empirical task-structure is in fact the result of a task analysis without simultaneous measurement of quality aspects or problem-supply. The issued job-description has an evident normative tendency. It describes in detail what the doctor has to do in the different conditions that can occur.

In chapter 7 an explanation of the variance in time-spent to the "new" tasks has been sought after. This has been undertaken by a simple regression analysis. It turns out that structural variables have the strongest correlation with the relative time-spent on "somatic curative care", especially the age features of the population the patient-load the ratio surgery contacts-home visits and the proportion of laboratory investigations. But the patient-load and practice-size hardly correlate with "prevention" and "interactive communication and counselling". These results give no indication that decreasing practice-size will give rise to a relatively more time-spent on "prevention", "attendance" and "counselling and interactive communication".

In chapter 8 the relevance of the results is discussed. As has been shown by Bergsma (1984) the patient-load is not an independant phenomenon. He found that about 60% of all people who attended their general practitioner were in one form or another recalled by him. It would be better to speak of a circular model in health care assistence. Perhaps this organisational peculiarity can prohibit the expected effects of decreasing practice-size on the desired shift in time allocation to "prevention" and "attendance". On the contrary I recieved indications that the attitude, the task-perception, is one of the important driving forces in the behaviour of dutch general practitioners. Therefore, I state that by employing general practitioners with complementary affinities with regard to task performance, such as family physicians with somatic, preventive and communicative affinities in patient care the foundation of group practices