

## PRACTICE OBSERVED

*Practice Research***Patients' assessment of out of hours care in general practice**

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**Abstract**

A sample of 177 patients drawn from 13 north London practices were interviewed shortly after they had sought help from their practice outside normal surgery hours. Patients were asked to describe the process and outcome of their out of hours call, to comment on specific aspects of the consultation, and to assess their overall satisfaction with the encounter.

Parents seeking consultations for children were least satisfied with the consultation; those aged over 60 responded most positively. Visits from general practitioners were more acceptable than visits from deputising doctors for patients aged under 60, but for patients aged over 60 visits from general practitioners and deputising doctors were equally acceptable.

Monitoring of patients' views of out of hours consultations is feasible, and the findings of this study suggest that practices should regularly review the organisation of their out of hours care and discuss strategies for minimising conflict in out of hours calls—particularly those concerning children.

**Introduction**

A recent consumer survey showed that patients and general practitioners regard out of hours care as an important indicator of the standard of care provided by a practice.<sup>1</sup> Though calls to general

practitioners outside normal surgery hours represent only a small percentage of all consultations, the caller usually perceives the patient to be in urgent need of medical attention and these calls are therefore a time of increased stress for both patient and doctor.

The general practitioner's view of out of hours work has been described,<sup>2,4</sup> but several authors have suggested that the lack of data about the patient's view limits realistic evaluation of the service being provided.<sup>5,6</sup> Some surveys of public opinion of primary health care have included questions about any out of hours consultations recalled by the respondent in the year or five years preceding the interview.<sup>7,9</sup> We have found only one study of patients' views on a specific out of hours consultation conducted immediately after the event. Prudhoe sent a short questionnaire to out of hours callers at her practice and found high overall levels of satisfaction; known general practitioners proved most acceptable and deputising doctors least acceptable.<sup>10</sup> This design is open to criticism of bias, however, in the response of patients to a questionnaire to be returned to their own practice.

We interviewed 177 patients shortly after they had made an out of hours call to one of 13 group practices taking part in this study. Our sample included patients managed by advice over the telephone and those who were visited by deputies as well as those who received visits from the practice doctors. The study aimed, firstly, to describe patients' responses to specific aspects of a recent out of hours call; secondly, to assess whether the needs of patients of all ages were being equally well met; and, thirdly, to examine the acceptability of different types of out of hours consultation (visit by the general practitioner, visit by a deputy doctor, and advice given by the general practitioner over the telephone).

**Patients and methods**

Fifty nine principals and 18 general practitioner trainees from 13 urban group practices participated in the study. All the practices had links with the department of primary health care of University College and Middlesex School of Medicine. The participating practices were widely spread across north London and were diverse in terms of the demographic characteristics of their lists and their organisation of daytime surgeries and out of hours

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cover. Ten practices used deputising services, and three covered all their own calls (but used an answering service to receive and pass messages). None of these deputising services responded to calls only by giving advice over the telephone. The four deputising services used by the participating practices all cooperated willingly with the research.

A two stage sampling procedure was used. Each practice recorded all out of hours calls received from patients using a specially designed recording card. Calls were recorded for four weeks; it was calculated that this should provide a sufficiently large sampling frame of callers and it was thought that the accuracy of recording might begin to fall off over a longer period. The deputising agencies concerned recorded calls for the same period and for one additional week. Collection of data was organised sequentially over four four week periods between January and June 1986. Three or four practices recorded calls in each four week recording period. Out of hours times were defined individually for each practice, beginning when the surgery switch-board closed in the evening and ending when it reopened the next morning and running from the close of any Saturday surgery until Monday morning.

A total of 1027 calls were recorded by the 13 practices and their deputising agencies. A sample size of 180 patients was aimed at, stratified firstly by age group (0-15 years, 16-59 years, 60 years and over) and secondly by mode of consultation (visit by the general practitioner, telephone advice given by the general practitioner, or visit by a deputy). The purpose of the stratification was to increase the proportion of elderly patients and patients visited by deputy doctors in the sample interviewed. During each four week recording period calls recorded at the practices were collected on a weekly basis by the researcher and a set number of patients in each stratification was sampled blind from the practices' pooled recording cards.

A total of 247 patients were invited to participate. Of these, three subsequently died, nine proved too unwell to be interviewed, six left London or left Britain, 22 were not in at the appointed times and did not reply to subsequent letters or telephone calls or could not be contacted at all, and 27 declined to participate. We made clear to patients that participation in the study was entirely voluntary, and they were given the opportunity by post to decline to participate. A higher response rate might have been obtained if resources had allowed more than two return calls to patients' homes. Home interviews were obtained with 180 patients (a response rate of 73%), but three interviews were eventually excluded from analysis because the mental state of the respondents may have invalidated the data. Eighty four per cent of the interviews were carried out within five weeks of the out of hours call; all interviews were completed within 10 weeks. Later interviews were mainly with patients admitted to hospital after the out of hours call and with those who missed earlier appointments.

No standardised or validated instrument has yet been developed to measure patient satisfaction for out of hours care.<sup>11,12</sup> We developed an interview schedule through exploratory interviews with patients to ensure that the schedule reflected patients' concerns and criteria of evaluation. We piloted this schedule with patients from three of the participating practices. Three trained interviewers administered the final semistructured schedule. A five point positive to negative rating scale with a neutral midpoint was used by the interviewers to rate patients' satisfaction with aspects of the consultation. The reliability of the interview ratings was checked periodically against tape recordings of the interviews (taped with the respondents' permission).

The study was designed to be exploratory. The limited number of interviews that could be undertaken gave the study low statistical power. Analyses of contingency tables were performed with  $\chi^2$  tests.

## Results

In 100 cases the respondent was the patient, in 57 cases a parent, and in 20 cases a spouse, a sibling, a son or daughter, or some other person caring for the patient at the time of the call (including childminder or babysitter). Table I shows the age group and form of care received by the patients in the interview sample.

TABLE I—Type of out of hours care received by patients interviewed, by age group

Age group (yrs)	Mode of care			Total
	Phone advice	Deputy visit	General practitioner visit	
0-15	20	23	22	65
16-59	21	15	23	59
≥60	13	15	25	53
Total	54	53	70	177

## PRESENTING PROBLEMS

The out of hours callers described a variety of clinical conditions, including common minor illnesses such as influenza and otitis media, urgent conditions such as suspected myocardial infarction, and problems such as anxiety attacks, depression, and grief.

Respondents recalled their interpretation of the patients' symptoms before the call. Frequently mentioned fears included appendicitis, heart attacks, strokes, and fits or convulsions in young children. Not unexpectedly, older patients more frequently said that the call concerned continuing or chronic illness. In the week before the out of hours call 27% of the adults and 15% of the children had seen a doctor for the same symptoms or problem. Perhaps predictably, only seven of these 37 preceding consultations were rated positively by the respondents.

## CALLING THE DOCTOR

Our sampling frame contained only patients who had succeeded in contacting a doctor out of hours, so that we cannot estimate the total proportion of patients who wished to contact a doctor and encountered difficulties. Of those we interviewed, however, 22 (12%) had experienced difficulties in obtaining care. The problems encountered most often were the systems for rerouting telephone calls and waiting for a doctor to return the call. Patients who had no difficulty in contacting a doctor did not necessarily understand their practice's use of answering or deputising services despite the fact that 79% of respondents had previously contacted their current practice out of hours. Of all the callers, 59% spoke to a doctor eventually, 33% spoke only to a receptionist and the remainder did not know to whom they had spoken.

Of the 123 patients who received visits, nearly two thirds were seen within an hour of their call (64%), but respondents reported that general practitioners visited more quickly than deputies. Of the 70 patients visited by a general practitioner, 72% said that the doctor arrived within an hour of being called, and of the 53 patients visited by a deputising doctor, 53% said that the doctor arrived within an hour. Of all the patients visited by a general practitioner, 67% knew the doctor who visited. Of those visited by a deputy, 79% believed that the doctor was not a general practitioner from their own practice and identified the doctor as an "emergency doctor" or deputy of some sort. The remaining 10 patients thought that the doctor was a general practitioner, or could not guess the doctor's identity, or gave an unclassifiable response.

## ASPECTS OF THE CONSULTATION

Respondents gave accounts of each aspect of the consultation and their response to it. Table II shows the interviewers' ratings of respondents' satisfaction with key aspects. Satisfaction with the doctor's assessment of the

TABLE II—Patients' satisfaction with various aspects of consultation. Figures are numbers (percentages) of patients

Aspect of consultation	Grade of satisfaction*				
	1	2	3	4	5
Examination/assessment	9 (5)	116 (66)	28 (16)	21 (12)	3 (2)
Diagnostic information	3 (2)	91 (53)	55 (32)	19 (11)	1 (1)
Treatment/medication	12 (7)	97 (56)	33 (19)	26 (15)	3 (2)
Prognostic information	1 (1)	44 (26)	97 (57)	25 (15)	1 (1)
Aetiological information	—	46 (27)	105 (61)	22 (13)	2 (1)
Reassurance	26 (15)	102 (58)	18 (10)	23 (13)	9 (5)
Doctor's manner	35 (20)	95 (54)	25 (14)	16 (9)	5 (3)
Overall	30 (17)	94 (53)	25 (14)	19 (11)	9 (5)

\*Patients' satisfaction was rated on a five point negative to positive scale with a neutral midpoint, from 1 (very satisfied) to 5 (very dissatisfied).

patient was fairly high: 71% of respondents expressed positive satisfaction (scoring 1 or 2 on the scale). When asked specifically whether they thought the doctor elicited enough information to make a reasonable assessment of the patient 17% of respondents for children said no compared with 7% of adult patients.

Patients aged over 60 were less likely to say that they had been given a diagnosis for their illness (53%) than other adults (76%) and children (71%). Those who did not receive a diagnosis often had neutral or mixed feelings about this (scoring 3 on the rating in table II).

Of the 123 patients who received visits, 70% received some sort of medication, either by prescription or from supplies carried by the visiting general practitioner or deputising doctor. Of those who received medication 68% thought that they had received an adequate explanation of that medication. Those advised over the phone mainly received advice about self treatment. On the overall satisfaction score for treatment 24% of respondents for children were dissatisfied (scoring 4 or 5), compared with 9% of the elderly patients. In two thirds of the cases the respondents said that the doctor did not discuss possible causes or prognosis. A large proportion of respondents gave neutral response on the overall satisfaction score for these aspects. Nearly a quarter of the respondents for children expressed dissatisfaction with information obtained about cause (24%) and prognosis (23%).

The interviewer asked respondents whether they were reassured by the consultation, in the sense of feeling more confident or better able to cope with the illness. Few people gave neutral responses about this aspect of the consultation. Of the respondents for children, 23% said that they did not feel reassured, compared with 10% of elderly patients.

We asked respondents to say whether they thought that the doctor viewed their call as appropriate ("sensible or reasonable"). Of the older patients 83% expressed satisfaction with what they perceived to be the doctor's view of their call, compared with only 48% of respondents for children. The doctor's behaviour or manner scored a high overall satisfaction rating (74%), but again satisfaction varied among the age groups. No older patients expressed dissatisfaction, but 17% of all other respondents recorded some degree of dissatisfaction.

#### OVERALL SATISFACTION WITH CONSULTATION

When they had described the consultation and its outcome fully respondents were asked to say how useful or worthwhile the call had been. Of respondents for children, 45% said it had been very worthwhile, compared with 54% of adults and 77% of older patients. Table III shows this difference in overall satisfaction among the age groups, which was significant ( $\chi^2$  16.01,  $df=4$ ,  $p=0.003$ ).

TABLE III—Patients' overall satisfaction with consultation by age group

Rating of consultation	Age group (yrs)		
	0-15	16-59	≥60
Very worthwhile	29	32	41
Fairly worthwhile	27	17	11
Not worthwhile	9	10	1
Total	65	59	53

$\chi^2=16.01$ ,  $df=4$ ,  $p=0.003$ .

TABLE IV—Patients' satisfaction with visits by general practitioner or deputy (among patients <60 years)

Satisfaction score	Deputy visit	General practitioner visit
1 Very satisfied	3	9
2	16	26
3	10	3
4	5	3
5 Very dissatisfied	4	4
Total	38	45

$\chi^2=3.83$ ,  $df=1$ ,  $p=0.05$ .

The interviewer also recorded a global satisfaction rating for the entire consultation based on all information gained in the interview rather than in response to a single question (see table II); this showed that the out of hours consultation had been a positive experience for 70% of all respondents, 14% had mixed or neutral feelings overall, and 16% were dissatisfied. The global satisfaction rating was analysed by type of out of hours consultation for the patients under 60 years (table IV).

Because of small frequencies these data were regrouped into a satisfaction variable positive (scoring 1 or 2) versus neutral/negative (scoring 3, 4, or 5).

There was significantly less satisfaction with deputy visits than with visits by general practitioners or telephone calls ( $\chi^2$  7.02,  $df=2$ ,  $p=0.03$ ). For patients aged over 60, however, visits by a general practitioner or a deputy seemed to be equally acceptable. Only nine of the 53 older patients were neutral or negative about the consultation overall; no clear pattern emerged by mode of consultation.

#### Discussion

This study set out to investigate how a sample of patients responded to a recent experience of calling a doctor out of hours. When the decision is made to seek the doctor's help out of hours the patient or family concerned is often anxious or distressed. For both doctor and patient this type of consultation can be a frustrating or negative experience. An unhappy out of hours experience is important as it may adversely affect the patient's future relationship with the practice. We were therefore pleased to find that for most respondents in our study (70%) the call was a positive experience, and most appreciated the attention they received. None the less, a few respondents expressed dissatisfaction with the personal interaction and with the doctor's technical skills in the consultation.

It is unlikely that we have overestimated patient dissatisfaction. Indeed, although it was clear to respondents in this study that the research was carried out by the university and not by their own practice, we cannot rule out the possibility of non-respondent bias, nor do we know the extent to which respondents sought to give socially acceptable responses (despite assurances of confidentiality). Similarly, the participating practices were all teaching practices and may not, therefore, be representative of typical London practices.

In this study dissatisfaction seemed related to both the patient's age and the mode of consultation obtained. In our sample doctors seemed to be meeting the needs of elderly patients better than those of patients of other ages. Parents of children under the age of 16 were consistently less satisfied than older patients. Differences between generations in attitude towards general practice have been noted elsewhere,<sup>9,10</sup> and may reflect more modest expectations among older patients (perhaps recalling care before the National Health Service); a reluctance to voice criticisms among older people; or real differences in the nature of the out of hours encounters.

We have evidence from the recording cards completed by general practitioners for our study (unpublished observations) that the doctors considered a larger proportion of calls from older patients to be absolutely necessary than those for children.

Previous studies have suggested that patients may assess services provided by deputising doctors less favourably than those from known general practitioners.<sup>7,10</sup> Though this was the case for patients under 60 years in our study, those over 60 years seemed equally satisfied with visits by deputies and general practitioners. In this study younger patients expressed greater satisfaction with visits by general practitioners than with visits by deputies. This may indicate that general practitioners manage these out of hours calls in a clinically more competent or appropriate fashion than deputies; alternatively it may reflect the more negative reaction of patients to doctors whom they identify as deputies.

Our respondents did not have a clear concept of deputising services; the deputy doctors were variously described as the relief doctor, emergency doctor, night service man, or locum, and there was confusion about where these doctors came from in terms of physical location and affiliation. As the notion of a personal or family doctor is central to the public image of British general practice the uncertain identity of deputising doctors may have considerable impact on patients' expectations and satisfaction.

We would suggest that practices may need to review management of out of hours calls on a regular basis, particularly in relation to calls concerning children, where conflict or misunderstanding seem most likely to occur. It was clear from our interviews that acute illnesses may generate high levels of anxiety—anxiety that doctors may believe to be disproportionate to the clinical urgency of the patient's condition. Doctors may underestimate, however, the need to take account of this anxiety. They may also underestimate the need of

patients and parents to "make sense" of the illness through an exchange of ideas and information about its possible cause and likely prognosis. To help patients to decide whether an out of hours call is appropriate, general practitioners, health visitors, and community nurses need to use educational opportunities during routine consultations, in well baby clinics, and whenever parents consult about a sick child. Discussion of the characteristics and management of childhood illnesses and likely effects and side effects of medication may greatly increase parents' confidence in their ability to cope with self limiting illness in their children.

Ease of access to the doctor during surgery hours is also clearly related to the level of demand for out of hours care, and special arrangements for seeing sick children quickly and telephone access to general practitioners for advice may help to reduce the number of out of hours calls made.

Finally, we believe that patients would benefit from up to date, written information about their practice's out of hours arrangements, including use of answering and deputising services, and some indication of what the practice considers to be appropriate use of the out of hours service. Out of hours calls are of greater importance for general practitioners and their patients than the fairly small percentage of all general practice consultations they represent indicates. The manner in which practices manage their patients' requests for help out of hours is likely to be a sensitive indication of the quality of care provided by that practice.

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## ONE HUNDRED YEARS AGO

IN addition to his claims on our attention and respect as a great scientific surgeon, Sir James Paget has two qualities which make any of his speeches worthy of careful study and consideration. First, he is a master of English, clothing all his thoughts in the purest and most elegant language; secondly, he has the power of cheering and heartening the humble labourer on the borderland of science, not only by showing that his work may be of real value, but also by pointing out the direction where success may be most probably sought, and by indicating the means most likely to attain it. In his last Saturday's address to the students of the London Society for the Extension of University Teaching, these characteristics were well shown.

In a speech of much eloquence he first of all defended the Society, whose students he addressed, from the old proverb launched at all such bodies, "that a little knowledge is a dangerous thing," declaring, with Charles Lamb, that like nearly all such popular proverbs, the very reverse of this one was the truth. He insisted that it was the quality not the quantity of knowledge possessed which made it dangerous, and that nothing was really to be so much dreaded as absolute ignorance. But he said that the Society really imparted much more than a little knowledge, and that its teaching was of great value.

The main part of Sir James Paget's address, however, was occupied with a consideration of the things learnt in a scientific education. They were four: first, the power of observation; secondly, accuracy; thirdly, the difficulty of attaining a real knowledge of the truth; fourthly, the methods by which they could pass from that which was proved to the thinking of what was probable. He pointed out to the students he addressed that even though they lived in London there was much they could study—the wild birds of the parks, for instance, or the wild flowers and weeds that grow on every piece of waste ground.

In speaking of accuracy he drew a portrait, which we shall most of us recognise, of that considerable body of men "who would not for their lives tell a lie, but who nevertheless seemed as if for their lives they could not tell the exact truth."

Perhaps the most valuable part of the address was the one in which the speaker dealt with the place and method of theoretical thought in science; inductive reasoning being probably not the strong point of the class of students he addressed. He gave the example of Darwin to show that theories should not be arrived at by vainly and vaguely guessing at possibilities, but by the slow and laborious collection and consideration of facts, and then by working out the probable truth from such material, or, as the great John Hunter said, "Don't think; try."

In his concluding sentence, Sir James dealt with a subject which Carlyle has also treated in his *Sartor Resartus*, the proneness of man to wonder and to take pleasure in wonderment—the quickness with which familiarity makes the subjects of wonder commonplace and ordinary. Perhaps it is not without interest to compare the different modes of thought exhibited by these two men. The scientific surgeon accustomed to deal with facts, to accept them and make the best of them, speaks calmly of these peculiarities of man; they are there, and must be taken into consideration in any dealings we have with our fellows. The philosopher, who believes he has a mission to regenerate the world, rages at the same peculiarities, and by excess of praise and blame seeks to alter those things which the surgeon treats as inherent and unalterable.

"There is another faculty in the human race," says Sir James, "another desire—the love of wonders. Everyone admires them, and nearly all have an insatiable appetite for the knowledge of wonders." And then he goes on to remark: "It is singular to notice how the love of wonders passes from scientific men in their every-day occupation. You look at a machine, so perfect in construction, so exact for the purpose for which it is built, made with such foresight and such precision that the mind of the inventor really seems to be in it; it seems to be working by mind; and there stands the workman by the side of that machine, but his sense of wonder has long since passed away. He knows what is going on; he knows how all is come to pass, and to him that which you think to be a wonder is a common experience of every-day life."

How different Carlyle! "The man who cannot wonder, who does not habitually wonder, were he President of innumerable Royal Societies and carried the whole of the Mécanique Céleste and Hegel's Philosophy and the epitome of all laboratories and observatories, with their results, in his single head, is but a pair of spectacles, behind which there is no eye." And, again: "Strange enough how creatures of the human kind shut their eyes to plainest facts, and by the mere inertia of oblivion and stupidity live at ease in the midst of wonders and terrors. But indeed man is and always was a blockhead and a dullard, much readier to feel and digest than to think and consider. Prejudice, which he pretends to hate, is his absolute lawgiver; mere use-and-wont everywhere leads him by the nose. Thus, let but a rising of the sun, let but a creation of the world, happen twice, and it ceases to be marvellous, to be noteworthy or noticeable."

Sir James Paget's address ought to be of real use both to the students he addressed and to others who read it.

(*British Medical Journal* 1888;i:542)