Middle Articles

GENERAL PRACTICE OBSERVED

Appointment Systems in General Practice. How Patients Use Them

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After many years of indecision appointment systems in general practice have been given official recognition. They are definitely "in." Yet despite this there is still insufficient information available to enable the doubtful to decide for or against. More and more doctors are considering introducing appointments but, because of lack of certain factual data, are unable to decide whether or not appointments would suit their particular circumstances or their particular interests.

The gap in our knowledge is mainly concerned with how patients use appointments. This was emphasized to my partners and me by our inability to answer many of the questions posed by doctors who came to visit our practice following the publication of a survey of patients' reaction to the introduction of appointments and its more general effect on the practice work load (Stevenson, 1966). Questions like: Are your patients now using appointments more sensibly than they did when you first introduced them? How are the majority of appointments made? Do many patients come without appointments? And, if they do, how do you deal with them? Has the number of patients who fail to keep appointments diminished? Do many emergencies crop up in and out of surgery to disrupt the flow of consultations? Has the new certificate of incapacity eased the work load in the surgery? Are you able to see everyone who wishes to be seen on any particular day? Do many patients decide to wait and see a particular doctor if he is fully booked on the day they wish to consult him? Do you have to give many extended appointments beyond the normal time? How often are the consulting sessions fully booked? What happens during holidays and sickness?

Information Sought

We already had the answer to some of these questions (Stevenson, 1966), but it was felt that more comprehensive data could be obtained very simply by inserting a code letter or symbol opposite each appointment. It was also thought that, as our appointment system was nearing the end of its fifth year, it would be an appropriate time to take stock and compare the results with more limited information we had gathered during November and December 1962 at the end of our first year of appointments. The same two months—November and December—were therefore chosen for study in 1966.

The information sought was: How do patients make their appointments? How many keep their appointments and how many don't? How many patients insist on being fitted in when no appointments are available? How many patients are content to wait till the following day? How many chose to wait to see a particular doctor in the group? How many emergencies interrupt consultations? Are consultations spread

more evenly throughout the week? Do patients in general make fuller use of appointments than they did initially?

However, before starting to consider these questions a short description of the practice is necessary to allow comparisons and explain the general background from which the data were obtained.

The practice is essentially industrial and is conducted from a central purpose-built surgery by four partners sharing the work equally. Two full-time and one part-time secretary-receptionists are employed. The total number of patients averaged 9,279 during 1966. The majority are employed in the chemical industry, live in council houses, and fall in the main into social group III. In 1962 only 12% had telephones in their homes, and there is no reason to suppose that this proportion has increased significantly.

Information Obtained

The data collected during November and December 1966 were analysed, and most of the information obtained is shown in the Table.

Total Number of Appointments Made, How They Were Made, and the Numbers of Appointments Kept and Not Kept, November-December 1966

Total No. of Appointments Made	By Telephone	By Calling	Return Visits
4,000 (100%)	2,112 (52.8%)	1,453 (36.3%)	435 (10.9%)

Appointments							
Kept	Not Kept	Kept	Not Kept	Kept	Not Kept	Kept	Not Kept
3,884 (97.1%)	116 (2.9%)	2,053 (97.3%)	59 (2.7%)	1,417 (97.3%)	36 (2.7%)	414 (95.1%)	21 (4.9%)

Surgery Attendances.—During the two months a total of 4,088 patients attended the surgery. Of the 4,000 appointments made 3,884 (97.1%) were kept and 116 (2.9%) were not. Of 204 (5%) who attended with no definite appointment only 12 were true emergencies, who were seen without waiting.

Methods of Making Appointments.—These are shown in the Table. By far the largest proportion of patients (52.8%) made their appointment by telephone. A considerable number (36.3%) called at the surgery for their appointments and about one in ten had been seen before and had made a reappointment at the time of their previous visit. Apart from telephoned appointments, which remained virtually unaltered in proportion, the figures show a change in the pattern previously recorded in 1962. At that time return visits accounted for 29.5% of appointments made and only 18.8% of patients called for appointments (Stevenson, 1966). The change is probably due to four main factors: (1) our new premises are more central, (2) there is a greater awareness among our patients that appointments can be made at any time between 8.30 a.m. and

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6 p.m., (3) the new certificate of incapacity which has undoubtedly reduced the number of revisits required, and (4) the predetermined policy of the partners to judge more strictly the criteria for asking a patient to make a return visit.

Patients Not Keeping Appointments.—Only a small proportion (2.9%) of appointments made were not kept (see Table). There was no proportionate difference in those not keeping appointments made by telephone or by calling—both had a defaulting rate of only 2.7%. However, there was a slightly higher proportion of defaulting (4.9%) among those given return appointments, but this compares favourably with a defaulting rate of 11% in our 1962 figures and scarcely warrants our introducing return appointment cards, which we had previously decided not to use because of the extra work this would throw on to our receptionists. Details of those not keeping appointments are shown in the Table.

Immediate Appointments.—Quite often patients telephoned or called during a consulting session which was not fully booked and were given a time for that particular session. In this way 133 (6.3%) of telephone appointments were made and 219 (14.4%) patients who called for an appointment were seen either immediately or after a short wait. The proportion of patients thus seen was 9.6% of all those attending by appointment.

Patients "Fitted In."—The total of 4,088 surgery attendances included 192 (4.9%) patients who demanded to be seen at a particular time when no appointments were available. These patients were usually "fitted in" at the end of the day, and though their numbers were not sufficient to cause any great upset to the efficient running of the system, they were reprimanded if their demands to be seen by jumping the queue seemed unreasonable.

Postponed Appointments.—Of the 4,000 appointments made 127 (3.2%) were postponed either by our receptionists because the session was fully booked for the time the patient wanted or by the patient because he wished to see a particular doctor; 59 patients came into the former category and 68 into the latter. It is significant that less than 2% of our patients were prepared to wait because they were unable to see the doctor they preferred and were unwilling to consult one of his partners.

Extended Appointments.—These are given for special examinations or psychotherapeutic sessions and last for up to 30 minutes. Eleven of these were given during the two months under review.

Surgery Sessions and Doctor's Absence (Holidays or Sickness).—When all four partners are present there are four one-and-a-half-hour morning consulting sessions and three two-hour afternoon sessions on Mondays, Tuesdays, Thursdays, and Fridays. On Wednesdays and Saturdays there are two two-hour sessions and on a Wednesday afternoon an antenatal and well-baby clinic. When one doctor is absent during holiday or due to sickness his routine consulting sessions are completely removed and the load is spread as evenly as possible among the remaining three partners. During the two months under review three of the four doctors were absent, at different times, on holiday. This accounted for a loss to the practice equivalent to one doctor being away for three weeks and four days. A total of 246 consulting sessions were held throughout the whole period. When all four doctors were present 37 sessions were fully booked and 15 were oversubscribed. When one doctor was absent 43 were fully booked and 33 oversubscribed—that is, only 128 (52%) of the sessions were either fully booked or oversubscribed despite the absence of one of the doctors for almost half of the time.

Spread of Work Load Throughout the Week.—Despite attempts made to spread the consultations work load evenly throughout the week there is still a tendency for the beginning of the week to be heaviest. As Mondays, Tuesdays, Thursdays, and Fridays are similar working days only these have been compared. The average surgery attendances for those days during the period were 116, 107, 102, and 80 patient attendances respectively. If the average Saturday morning attendance of 35 was added to Friday's total this would bring it more into line with the others and would seem to make the attractive idea of a five-day consulting week quite feasible.

Antenatal and Well-baby Clinics.—During November and December 281 expectant mothers were seen by appointment at the antenatal clinic and 90 babies attended the well-baby clinic for inoculation and immunization. The latter clinic is the only part of our work that is not done by appointment, the average wait being negligible.

Repeat Prescriptions.—Selected patients on long-term therapy have the privilege of using repeat prescription cards, which we have

had specially printed on durable cardboard. During the two months reviewed 262 patients made use of these. If each had required a five-minute appointment a further 13½ hours of consultations would have been required.

Pharmaceutical Representatives.—All the partners are present when representatives are interviewed. Twenty were seen by appointment during the two months. When one considers that we accept these appointments for only three mornings of the week and limit all representatives to two visits a year the number does seem excessive and appears to be growing. At present the generous time which we set aside for these interviews is almost fully saturated and we shall have to give serious thought regarding our future policy towards the problem. The pharmaceutical industry may well require to exercise more restraint if it is not to lose the good will of doctors who have given freely of their time in the past.

Discussion

The purpose of this paper was to try to shed some light on the way patients used appointment systems in general practice. In doing so answers have been found to many of the questions asked by doctors contemplating the introduction of appointments. Some of these are listed below and answered from facts gathered over two periods—one in 1962, the other in 1966.

1. *How do Patients Make Appointments?*—If the patient is able to make his appointment at any time between, say, 8.30 a.m. and 6 p.m., by telephoning, or by calling at a centrally sited surgery, or by getting a return appointment after consultation, then it has been our experience that out of every 10 patients five will make their appointment by telephoning, four by calling at the surgery office, and one will have a return appointment. These proportions are slightly different from those recorded previously (Stevenson, 1966), the differences being mainly due to the fact that our surgery is more central, encouraging more patients to call for appointment, and the new certificate of incapacity, which has undoubtedly reduced the number of reappointments required.

2. *Does the Patient's Use of Appointments Improve in Time?*—The simple answer is Yes. In 1962 only 77% of patients attended by appointment and by 1966 the proportion had increased to 95%. These figures also answer the third question.

3. *Does the Number of Patients who Come without Appointments Lessen in Time?*—The fall was dramatic—from 23% in 1962 to 5% in 1966.

4. *Does the Number of People who Fail to Keep Appointments Lessen in Time?*—Again the answer is Yes. The proportion of defaulters fell from 7% of 2,252 appointments in 1962 to 3% of 4,000 appointments in 1966.

5. *How Long is Allowed for each Consultation?*—Patients are normally booked at five-minute intervals except in the case of special extended appointments. This interval was arrived at after timing each of the doctors over a large number of consulting sessions before appointments were started in 1962. The time is about right—what is lost on the roundabouts is usually gained on the swings. Wherever possible care is taken to book each session straight through without leaving time-wasting gaps in the middle. If the time given does not suit the patient he is given another for a subsequent session.

6. *How Many Extended Appointments are Required?*—There were 11 extended appointments given in the two months surveyed. This is roughly one in every 24 consulting sessions, or four in every three weeks.

7. *How Many Surgery Sessions are Fully Booked?*—It was surprising to find that, though three of the four doctors were absent from the practice at various times amounting to almost half of the period surveyed, only 52% of the surgery sessions were either fully or oversubscribed. (This emphasizes the importance of booking the sessions systematically in strict rotation to allow the doctor to leave the surgery and attend to other busi-

ness when he has seen all those who have appointments for him. To have to wait to see someone at the end of an otherwise quiet session is an extravagant waste of valuable time.) Our yardstick of 1½ hours' consulting time a week for every 200 patients (Stevenson, 1966) allows for the absence of one doctor and seems to be adequate.

8. *Is Everyone Seen who Wishes to be Seen on a Particular Day?*—Yes. We have always thought that we have a contractual obligation to see every patient who demands to be seen. However, after completing our examination, if we think the patient's insistence on demanding a selfish or needless consultation has been unreasonable we explain this to him in the hope that he will use the service more thoughtfully in the future. It is the doctor's responsibility to maintain discipline within his practice. He should not shrink from this duty. In November and December 1966 5% of all surgery consultations were "fitted in," the patient having no appointment.

9. *How Many Patients are Content to Wait when the Day's Sessions are Fully Booked?*—If sufficient time is set aside for consultations normally everyone who wishes to be seen in any day can have a consultation. However, there are times, particularly at the beginning of the week, when sessions are fully booked. Under these circumstances our receptionists are instructed to ask the patient if he would be willing to come on the following day—1.4% of all patients receiving appointments were content to wait.

10. *How Many Patients Wish to Wait to See a Particular Doctor?*—Since only 52% of our consulting sessions were either fully or overbooked the chances of any patient getting the doctor of his choice at a first attempt were fairly high. However, there was a surprisingly low proportion, somewhat under 2%, of patients who were prepared to wait for a day, or at the most two, to see a particular doctor. Could this flimsy evidence suggest that the significance attached to the doctor-patient relationship is more important to the doctor than to the patient? Are the attempts of the profession to cling to the idea of one doctor, one patient fully justified? Doesn't the insistence of any doctor to maintain this relationship smack of egotism and infallibility? Perhaps the greatest asset of ideal partnership practice is the constant scrutiny of the individual doctor's work by his partners. The patient certainly benefits—and what's more, doesn't seem to object.

11. *Are there Many Patients who Cannot Attend Surgery Before 6 p.m.?*—The answer is undoubtedly No. Their numbers in our practice were found to be so small as to be almost insignificant. This vindicated our decision to abolish evening consultations in September 1964. Individuals who are completely unable to attend before 6 p.m. can be seen by special arrangement. This is seldom necessary.

12. *Do Many Emergencies Interrupt the Flow of Consultations?*—No. These emergencies include casualties interrupting consultations and urgent requests for home visits during con-

sultations when the doctor has to leave the surgery. Both occur infrequently—only 12 emergencies were recorded during the two months under review.

13. *Is There a More Even Spread of Consultations Throughout the Week?*—Generally speaking, there is. But, despite encouraging patients to come towards the end of the week, Mondays and Tuesdays remain the busiest days. There is, however, a dramatic fall in consultations on Fridays; indeed, it was found that if average consultations on Fridays and Saturdays were added together they would approximate closely to the average for Mondays. This adds weight to the argument that Saturday consultations should be abolished. Many doctors have already found this possible.

14. *What Happens When a Doctor is Absent owing to Sickness or Holidays?*—Holidays are usually taken during the quieter months of the year. The absent doctor's consulting sessions are merely removed from the appointment book. This allows the work load to be spread more evenly among the remaining partners.

15. *What Effect do Appointments Have on Work Load?*—Though it is not the only factor, our appointment system has played a very real part in the continuing reduction of our work load. We recorded a total consultation rate (surgery and home consultations) of 4.5 per patient for the year 1966. This was composed of 1.5 home visits and 3.0 surgery consultations per patient. One now finds it difficult to imagine that only 10 years ago we were overdoctoring our patients to the extent of more than seven contacts per patient per annum and spoiling them by giving almost half of these consultations in their homes (Stevenson, 1964). Now we are older and wiser.

Summary

The ways in which patients use appointment systems are described and discussed. It has been found that with the passage of time the patient makes fuller use of the amenities afforded to him by appointments. Answers to many of the questions asked about appointments are given from data collected during a two-month period of fact-finding, and it is suggested that the introduction of appointment systems is one of the most important factors in bringing about a reduction in work load, and consequently a more economic use of the doctor's time.

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REFERENCES

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