Patient use of a mixed appointment system in an urban practice

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Abstract

The number of practices that run appointment systems has sharply increased recently. Such practices may have difficulty in fitting in urgent or extra consultations. A study was made of 639 patients who attended a practice whose surgeries are run on a mixed system of open access and by appointment. There were important differences in the type of patient and problem seen in the two types of surgeries, notably in age, social class, and presenting complaint. Some patients may be disadvantaged by surgeries that are run by appointment only.

Introduction

The number of practices that run appointment systems has substantially increased. In 1951 only 2% of practices had one and by 1977 three quarters of practices were seeing patients by appointment.¹ Indeed, most consultations with general

practitioners are now by appointment only, with just 8% of practices offering a combination of open access and surgeries by appointment.¹

The Lache Health Centre in Chester has 5500 patients on a list, with two principals and one trainee. Since 1971 it has run a mixed system of open and appointment surgeries so that patients may attend open surgeries each weekday morning and afternoon or be seen by appointments that are available each day. The aims of this study were to look at the relative use of the two types and compare the type of patient and problems being presented at open and appointment surgeries.

Methods

During a two week period in November 1983 every patient who attended for consultation was asked to complete a confidential questionnaire. Further information was then recorded by the consulting doctor. The data were analysed with the help of a micro-computer. Only those patients who attended open or appointment surgeries (excluding antenatal clinics) were included in the analysis.

Comparison of patients attending appointment or open surgeries

Factors compared	Appointment (n = 312)	Open surgeries (n = 221)
Age groups (years)	Appointment (%)	Open (%)
0-4	14	37
5-14	15	34
15-44	28	29
45-64	19	14
65-74	10	10
75+	14	10
Sex		
Men	204	78
Women	108	143
Social class		
I	19	6
II	11	5
III	130	64
IV	11	10
Unemployed	26	16
No answer	10	4
Presenting complaint		
Infectious	15	21
Mental	31	9
Nervous system and sense organs	29	27
Cardiovascular	40	32
Respiratory	40	32
Skin	12	11
Unspecified	23	17
Unidentified	31	24
Supplementary	15	11
Telephone	265	160
Other	46	60
No answer	1	1
Duration of symptoms		
2 weeks	11	17
2 weeks	11	17
1 year	66	72
1 year	66	72
No answer	9	1

*Per 1000 patients in practice.

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Any patients who attended for a subsequent consultation during the study period were excluded from repeat analysis.
The statistical analysis was done by a χ^2 test for all the factors compared. Information concerning the practice population as a whole came from the age-sex register.

Results

During the study 639 patients were seen, 388 by appointment and 251 by open access. In addition, three temporary residents and three patients as emergencies were seen. Of the appointment group, there were 312 patients suitable for further analysis. Patients who attended antenatal clinics and those consulting for a second or subsequent time in the study period were excluded. Of the open group there were 221 patients suitable for analysis. Retainers and patients who left before being seen were excluded. Twenty three patients failed to stop appointments. Twenty nine patients attended open surgery only because they were unable to get an appointment. Of the 639 patients, five (0.8%) were dissatisfied with the system.

The table gives the consultation rates for two weeks for the different age groups of patients who attended open surgeries or by appointment, the distribution by social class, the nature of the presenting complaints of the two groups, and the results of statistical analysis.

Discussion

When the open surgeries were retained it was hoped that they would be used by patients who wanted an urgent consultation and by those who were having difficulty making appointments. The findings of this study suggest that the combination of open surgeries and consultations by appointment has worked well. Patients with a short duration of symptoms were generally seen at open surgeries, whereas patients with chronic diseases generally attended by appointment. Moreover, few extra consultations were needed, with little disruption to the running of the practice.

In this practice the patients in the two groups were different.

ONE HUNDRED YEARS AGO There has been of late a considerable popular outpouring in favour of the provision of seats for assistants in shops. This movement is laudable one, with which no fault can be found; but the advocates of the movement have now gone a step further, and propose to limit compulsorily the hours of shop-workers in the same manner as those of factory-people are now limited. A bill has been introduced into the House of Commons, under the title of the Shop-Hours Regulation (Liverpool) Bill, which, did not bear on its back the highly respectable names of all three members for Liverpool, might provoke some sarcasm. It will undoubtedly send the Vigilance Association into hysterics. The Bill proposes that on and after the first day of October next it shall not be lawful for any premises, i.e., shops and warehouses, to be open Sundays for any period whatever, nor shall it be lawful for them to be open on any of the first five days of the week beyond the hour of eight o'clock in the evening, or on Saturdays beyond two o'clock in the afternoon. Section 5 imposes a penalty not exceeding £10 for each offence, and the schedule exempts the following from the operation of the Act: milk-sellers; tobacconists' shops where tobacco and smoking-utensils alone are sold; shops licensed for the sale of refreshments; and apothecaries' shops for the sale of drugs only. We shall not be accused of any lack of sympathy with the object which this Bill proposes to forcibly carry into effect, if we say that it introduces local opinion of a very dangerous and undesirable description. That a majority of people who approve this Bill should be able to dictate absolutely to their fellows at what hours they shall do their shopping, is a somewhat risky innovation from the politico-economic point of view. Hence we fear that any direct prohibitive legislation of this sort will fail of its effect. The most practical way of limiting shop-hours of work is to educate and enlighten local opinion upon the hardships and physical discomforts which long hours entail upon the persons employed. Abundant medical evidence has been adduced to prove these points; but any limitation of hours will have, we feel

In general, younger patients of lower social classes presented at open surgeries with diseases such as coughs and sore throats. Patients coming by appointment generally came from higher social classes, were more elderly, and presented with chronic diseases such as hypertension and arthritis. The total number of patients with a telephone was higher than expected, given the deprived area in which the practice is situated, but there was still a noticeable difference between the two groups.

The differences in the social class of the groups may be significant, particularly in view of the findings of the Black report, which suggested that people of lower social class make less use of health services, including primary care.² This has been challenged recently by Crombie, but he also noted the pronounced difference in the use of doctor initiated consultations by different social classes.³ The results of this study suggest that patients who are unemployed and those in the lower social classes are poor users of appointments. Perhaps the practices that run surgeries by appointment only further disadvantage these two groups, who may need flexible access to their general practitioner. A mixed practice has much to be said for it to both patient and doctor and it has worked well in providing primary care to our practice population.

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assured, to be made voluntary if it is to succeed at all. What is bad for shop-assistants cannot, of course, fail to be bad also for factory-workers as well; and it is with the object of strengthening, as far as possible, the hands of those who are agitating for seats in shops and workplaces that we draw attention to some recent remarks of Mr. Redgrave, the Chief Inspector of Factories and Workshops. Mr. Redgrave observes in his last report, that in some factories the hands, when not actually occupied, as "dozers" of spinning-frames, for instance, are permitted to sit idle, and that the hands are placed so close together, side by side, front and back, and back to back, so that no seat could be placed. It is gratifying to learn, therefore, that an attempt has been made at several places to give the weavers and operatives an opportunity for rest during their hours of work. At Stourport an entire seat has been constructed for 19, which can be fitted to any factory or shop. The seats cannot be damaged, and will not wear out. They may be thrown upon the floor without injury, and as the socket into which they fit does not project more than one inch from the surface to which it may be attached, the seat-faces cannot infringe materially upon the narrow space behind any shop-counter. Similar seats have also been provided to several factories in Kidderminster, and are gratefully appreciated. At any odd moment when the weaver is not engaged at another part of the loom, he or she can sit down, and thus obtain rest for the legs during the lengthened period of daily labour that ten hours of work entail upon the life and limbs of a factory-weaver. The circumstances of a shop-hand and of a weaver doubtless differ in many respects, but in both cases the injury brought about by constant standing is the same, and what is necessary for the one is undoubtedly necessary for the other. (*British Medical Journal* 1884;3:962.)

Life Changes

Retirement

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After war service in the RAF I became a local government housing manager. Over the years, and after many moves, I was eventually employed as head of a large department, serving a population of 225 000, employing 400 people, and managing 25 000 properties. I was thus accustomed to meeting a great number of people every day of my working life and making decisions that could affect the lives of many people.

It was a post of great responsibility and stress, so after a slight stroke I was pleased to be offered retirement, on lucrative terms, a year or two earlier than I would normally have retired. I was left a daughter in the north of England, but in retiring to Sussex we were not coming among strangers. Our son and his family were settled in the area and we had previously lived here for 12 years, so we had many friends and acquaintances in the district.

In the early weeks of retirement all seemed well. I was busy doing maintenance jobs about the house and garden and, although I had found my former position interesting and absorbing, it was very exacting and I was pleased with the new found freedom. Gradually, however, I became aware that my life was fundamentally different. It was now one of the crowd and, although I was reluctant to admit it, I felt deflated—after having had authority and prestige I was now a "nobody." The days and weeks seemed to become never-ending and I constantly searched for something to occupy my time and my mind, as during working life.

I became aware of small pains and stiffness in my body and, instead of putting this down to the normal process of aging, I tended to dwell on them. This was something I had never done before and it was, therefore, disturbing. I also missed the routine of working life, feeling, sometimes, that there was nothing to get out of bed for in the mornings. The days seemed to be a constant search for something to occupy my time. For some months, therefore, I was depressed, irritable, and even I realised that something would have to be done to alter the situation.

Fortunately, the call for voluntary workers in this area is strong. Also, I remember that the housing association movement offers to trained people the opportunity to take part in their work as part time volunteers. I am now happily working with a national housing association and also with one based in Sussex. The work puts me back into the swim and, although demanding, it is a God-send to me. I also do occasional voluntary community work in the town.

I will remember towards the end of my working life being

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future which suddenly seems much shorter than before, all may take their psychological toll. The optimum time to consider these issues is in the year or two before retirement, and for many people attendance on a retirement course arranged by their firm or by the local authority may help considerably.

The social consequences of retirement may make or break the person's ability to adapt successfully. No longer does work and responsibility automatically present itself. For some this is a relief, but many people have to search for rewarding occupations to fill the long days and maintain their need to remain useful.

There is often a major decision to be made about moving house to be nearer family or a favoured part of the country. Here I must put in a personal plea. I work in a town on the south coast of England with the highest proportion of elderly people in the country. The idea of "retiring to the seaside" attracts like a magnet, but sadly it sometimes fails to fulfil its retiring promise. To leave the locality in which one has spent one's working life, and the friends made over the years, to enjoy warm, sunshine filled days by the sea frequently turns out to be a mistake. It may be difficult to make friends, regular contact with children and grandchildren may be missed, and even the weather year round may not match those fondly remembered day trips when it seemed such a good idea. If, shortly after moving, one of the couple falls ill or even dies, one has the support of a local disaster. In my view the support of family and good friends is the most important social factor after retirement and geographical considerations can be poor second.

What is the general view of patients who have been removed to retirement? I am sure that opinion will differ and many family doctors will consider that it is a "non-medical" matter which need not concern them. Others, myself included, prefer an anticipatory approach which need not be particularly intrusive to be effective. A simple inquiry about the patient's attitude and future plans may show that no assistance is required from the doctor, but at least it gives an opportunity for people to ask for advice, help, or reassurance if they need it. We make offers of help to our patients at other times—for example,

support for the mother with a new baby, and helping families through serious illness or bereavement. Such offers are regarded as good anticipatory care and may be taken up or declined according to the patient's needs. So why not routinely include an inquiry about future plans in consultations with patients who are within a few years of retirement, and mark their records accordingly?

In our town examples abound of retired people who continue to make a valuable contribution to the community. Our community has been bought with public donations, and a group of volunteers act as drivers and conductors. I have a blind patient who travels around as a speaker for the Association for Guide Dogs for the Blind. The hospital car service is manned chiefly by retired people, and for such public benefits the medical society becomes an anonymous and less privileged member of society. Other factors, such as the abrupt drop in income, being "under the wife or husband's feet all day," and the need to plan for a

position to provide this advice.

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the relieving officer was found. In country districts, where considerable distances have to be travelled, and much time occupied, in observing obdurate and obstinate patients, the relieving officer is often obliged to be authorised to act as they saw fit in serious or urgent cases of illness, with reference to conveyance and admission of patients to hospital; and the sooner the Local Government Board's instructions of October 9th, 1883, are so modified the better. When Dr. Carey issued the order for immediate removal of the patient to hospital, his duty ended, as no objection was made to it, and he does not appear to have been aware of the delay, or he, no doubt, would have waited the result. It is not the duty of the medical officer to be present at the removal of a patient, as supposed by Dr. Carey; were it so, the doctor would often have to wait many hours and neglect other cases. If Dr. Carey could have given the order on his own authority alone, the woman could, according to the evidence of the relieving officer, have been removed the same day. With regard to the second point, Dr. Carey stated in evidence that he had no power to order simulants. From a full review of the facts, it would appear that the patient died on the ninth or tenth day of typhus, or, at the very least, it should be remembered that, even the best cared patients, with every comfort and necessary at hand, who have not been removed to hospital or elsewhere, very frequently die of typhus about that day of the disease, especially persons from thirty to fifty years of age. No one can say whether the patient would not have died at home on the same day, in the receipt of every care and attention; but the case discloses a state of things which is a reproach to the Local Government Board of Ireland; and we trust that the Board will take steps to remedy the evil brought so forcibly under their notice by the case of this poor woman. (*British Medical Journal* 1884;3: 577.)

ONE HUNDRED YEARS AGO It is difficult to convince the bureaucratic mind that, in dealing with sickness and disease, it is absolutely necessary to be courteous and considerate to the patient and to recognise that the responsible medical officer is the proper person to decide questions of life and death. A poor woman living at Ballyboughan, near New Ross, was taken ill on February 19th and 20th, on February 25th, Dr. Carey, the medical officer of the St. Mullins Dispensary District, saw the patient, and finding that she was suffering from typhus fever, certified that she was "in a fatal state" and removed her to the Fever Hospital at New Ross. The patient's husband had to walk eight miles across a mountain to the relieving officer, who wrote an order for a van and nurse to be sent from New Ross, nine miles off, to Ballyboughan, the husband, who had to return to his wife and children, for two women were suffering from fever, sent the order to be posted at Ballyboughan, eight miles. Owing to the necessity to observe these formalities, the van did not arrive at the sick woman's house until forty-eight hours after it was ordered, and the patient died in the Fever Hospital on the following day. An attempt was made to call blame on Dr. Carey on two grounds: firstly, because he was not present when the woman was removed; and, secondly, because he had not ordered her simulants; but it is quite clear that Dr. Carey acted up to his duty. He visited the patient immediately after the ticket requiring his presence had been presented to him, and recognising the nature of the case, he acted properly in ordering her removal to hospital as speedily as possible. The patient was certified to be in a fit state to be removed, and the orders of the Local Government Board were complied with. It appears, from the circular letter of the Board of October 9th, 1883, that the medical officer should not, even in a case of urgency, go so far as to recommend the workhouse master to admit the patient, unless the relieving officer could not be found. In this case,