Qualitative insights into practice time management: does 'patient-centred time' in practice management offer a portal to improved access?

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SUMMARY

Background: *Different sets of literature suggest how aspects of practice time management can limit access to general practitioner (GP) care. Researchers have not organised this knowledge into a unified framework that can enhance understanding of barriers to, and opportunities for, improved access.*

Aim: *To suggest a framework conceptualising how differences in professional and cultural understanding of practice time management in Auckland, New Zealand, influence access to GP care for children with chronic asthma.*

Design of study: *A qualitative study involving selective sampling, semi-structured interviews on barriers to access, and a general inductive approach.*

Setting: *Twenty-nine key informants and ten mothers of children with chronic, moderate to severe asthma and poor access to GP care in Auckland.*

Method: *Development of a framework from themes describing barriers associated with, and needs for, practice time management. The themes were independently identified by two authors from transcribed interviews and confirmed through informant checking. Themes from key informant and patient interviews were triangulated with each other and with published literature.*

Results: *The framework distinguishes 'practice-centred time' from 'patient-centred time.' A predominance of 'practice-centred time' and an unmet opportunity for 'patient-centred time' are suggested by the persistence of five barriers to accessing GP care: limited hours of opening; traditional appointment systems; practice intolerance of missed appointments; long waiting times in the practice; and inadequate consultation lengths. None of the barriers is specific to asthmatic children.*

Conclusion: *A unified framework was suggested for understanding how the organisation of practice work time can influence access to GP care by groups including asthmatic children.*

Keywords: *access; time management; patient-centred time; practice-centred time; qualitative study.*

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Submitted: 17 December 2001; Editor's response: 21 May 2002; final acceptance: 28 August 2002.

Introduction

'LACK of time', suggests Dunn,[1] is seldom recognised as an obstacle in the National Health Service to recently renewed calls for patient-centred health care. This has much more to do with circumstances, he contends, than choice. For general practice, however, a focus on how little time is available, rather than how practices manage time, and on practices' lack of control over work time, ignores potentially adverse effects that have yet to be demonstrated necessary. These effects include impaired access to general practitioner (GP) services.

Three main sets of literature offer insights into how the organisation of time by practices can limit access to GP care. The first is directly associated with GP care, describing organisational systems which, to access services, patients must accommodate through their own time management. For example, some practices operate only by appointments.[2] Others offer open access[3] and some restrict telephone access to GPs.[4] Hours of practice operation may impede access,[4] as can delays in obtaining appointments,[5,6] long waiting times in practices,[7] and short visits.[8] Secondly, geographic literature[9,10] has considered how the physical time available for activities, and physical space, constrain the freedom of individuals to access services. A third set of literature perceives time as a social[11,12] and cultural artefact.[13,14] Hall[14] has suggested how cultural time and physical time operate to produce a map of, what he calls, 'meta-time'.

It is uncertain that practice time, and hence access, must be truncated, for knowledge of individual components of practice time management has yet to be unified into a framework conceptualising how practice time can be managed. Development of this framework involves considering how differences in cultural and professional understanding of practice time management influence access to GP services. By elucidating and consolidating barriers to access that reflect these differences, this paper aims to develop such a framework.

The framework is produced with reference to access to GP services for children with chronic asthma in New Zealand's (NZ) largest urban centre, Auckland. It focuses on professional and cultural perspectives on the ability of, and opportunities for, practice time management to accommodate GP care seeking, in particular by Maori (NZ's indigenous population) and Pacific Islanders. This is because NZ Europeans and Maori, for example, measure and indicate time in different ways.[13] Moreover, when relative need is

HOW THIS FITS IN

What do we know?

Temporal aspects of practice management can limit access to GP care.

What does this paper add?

The concept of 'practice-centred time' unifies five continuing barriers at the practice level — limited hours of opening, traditional appointment systems, intolerance of missed appointments, long waiting times in practices, and inadequate consultation lengths. These barriers indicate an unmet opportunity for practice management to reflect 'patient-centred time'.

considered, Maori obtain GP care less frequently than do NZ Europeans[15] and experience delays in getting it.[16] Pacific Islanders resemble Maori in these respects.[17] Both groups live disproportionately in Auckland, accounting for almost one-quarter of its population in 1996.[18]

Method

Qualitative research methods, involving a general inductive approach, were used to develop this framework. As part of a larger study of factors limiting access to GP care for children with chronic asthma, the framework was developed from personal, semi-structured interviews with two sets of selectively sampled subjects.

Sampling

The first set comprised 'key informants' (KIs) whose status and experience , as practitioners, managers, and consumer representatives, offer insights into factors influencing access to GP care. These insights underpin their own behaviour as professionals, contribute to negotiated understandings of 'truth' and may reveal what patients are unaware of or unwilling to discuss. Key informants were identified through personal contacts and then selected to yield a 'maximum variation sample'.[19] By varying considerably on age, sex, ethnicity, and stakeholder perspective, this sampling strategy aimed to provide detailed and diverse perspectives and reveal shared patterns. Key informants were asked to speak for themselves rather than on behalf of stakeholder groups with which they identify.

The second set of subjects comprised mothers who infrequently use GP services for child asthma. They were selected to speak directly and in different ways about factors influencing this behaviour, such as practice time management. Their children, as six- to 14-year-olds, had presented at the Emergency Department of Auckland's Children's Hospital with a primary diagnosis of asthma in the year ending 30 June 2001. Each child had experienced chronic (i.e. for more than three months), moderate to severe asthma (more than four asthma attacks over the previous year and/or asthma-associated sleep disturbance or speech limitations) but was reported by the mother to have visited a GP two or fewer times in the previous 12 months.

Tables 1 and 2 summarise attributes of the key informant sample and maternal sample, respectively. Both tables, particularly Table 1, reveal oversampling of Polynesians (Maori and/or Pacific Islanders) to elicit their perspectives. Each subject gave one face-to-face personal interview. By the twenty-ninth interview with key informants, the diversity sought within this sample had been achieved and stopped yielding information of value. Regularities subsequently emerged by the tenth consecutive interview with mothers of asthmatic children.

Interviews

The first author interviewed key informants between March and May 2001, mostly at their place of work, and mothers during September and October 2001, principally in their homes. The interviewer was a 40-year-old, NZ European. As a non-GP, in a University Department of General Practice and Primary Health Care, he sought to conduct the interviews in a non-judgemental manner and reflexively to assess and minimise any bias or influence he and the research process had on the data gathered.

An interview guide for semi-structured interviews[19] comprised potential topic questions, linked to probes, about influences on access to GP care, including characteristics of general practices. Questions were adapted over time to focus on the expertise of each informant and in response to emergent themes and to impressions that were recorded in a field journal immediately after each interview. With subjects' consent, all interviews were audiotaped and transcribed.

Analysis

The first and second authors read the transcriptions several times. They independently and systematically reduced and reassembled the text, making comparisons with the research literature, to identify conceptual categories that could serve as a preliminary framework for analysis. Through discussion, they agreed on salient themes. The first author used NVivo software to develop and connect broader themes or analytic categories. He defended the resulting framework to his co-investigators, who acted as sceptical peer reviewers.

All key informants were sent the analysis and asked to check its consistency with statements attributed to them. The feedback was generally corroborative. Discrepant responses were incorporated into the revised analysis, which links informants' anonymised attributes (Tables 1 and 2) to their own words. Readers can, therefore, check that our interpretation of these subjects' narratives is consistent with the evidence presented. Results from key informants and mothers are juxtaposed to enhance the credibility and confirmability of our interpretations.

Results

How practices manage or organise time underpins five barriers to asthmatic children accessing GP care. These barriers, of which none is specific to asthma, are: limited hours of opening; traditional appointment systems; practice intolerance of poor appointment keeping; long waiting times in the practice; and inadequate consultation lengths. The

Table 1. Attribute profile of key informants. ED = emergency department.

Informant (identification number)	Age (years)	Sex	Ethnicity	Stakeholder perspective Managerial perspective	Practitioner perspective	Consumer perspective
1	30–39	Female	Maori		Maori GP care	
2	30–39	Female	Maori		Practice nursing	
3	30–39	Female	Maori			Quality in primary care
4	30–39	Male	Maori	Maori health research		
5	40–49	Female	Maori	Maori health at district level	Nursing	
6	40–49	Female	Maori		Community health work	
7	40–49	Male	Maori	Primary–secondary care integration	GP care	
8	40–49	Male	Maori		GP care	
9	70–79	Female	Maori			Maori women's welfare
10	70–79	Female	Maori			Child refuge and foster parenting
11	30–39	Female	NZ European	Childhood immunisation	Maori GP care	
12	30–39	Male	NZ European		GP care	
13	30–39	Male	NZ European		Adolescent paediatrics	
14	30–39	Male	NZ European		Children's hospital ED care	
15	40–49	Female	NZ European		GP research on domestic violence	
16	40–49	Male	NZ European		Accident and medical care	
17	40–49	Male	NZ European	Children's hospital ED care	Children's hospital ED care	
18	60–69	Female	NZ European		Child health nursing and public health	
19	30–39	Female	Samoan		Pacific GP care	
20	40–49	Female	Samoan	Pacific practice management		
21	40–49	Male	Samoan	Pacific health at hospital level		
22	50–59	Female	Samoan		Pacific practice nursing	
23	70–79	Male	Samoan		Pacific GP care	
24	10–19	Male	Tongan		Community health work and church	
25	20–29	Female	Tongan		Practice and asthma nursing	
26	30–39	Male	Tongan		Pacific GP care	
27	40–49	Female	Tongan	Pacific health at district level	Nursing	
28	40–49	Male	Tongan		Community paediatrics	
29	60–69	Male	South Asian		New settler GP care	

Table 2. Attribute profile of mothers interviewed and children.

Mother (identification number)	Ethnicity	Marital status	Number of children	Child's age (years)	Sex
1	Maori	Married	1	6	Female
2	NZ European	Married	3	7	Female
3	Maori	Single	5	8	Male
4	South Asian	Married	2	9	Female
5	NZ European	Single	1	10	Male
6	Samoan	Married	5	10	Male
7	Maori	Married	4	12	Male
8	NZ European	Married	2	14	Male
9	NZ European	Married	2	14	Female
10	NZ European	Married	4	15	Male
11	NZ European	Married	3	10	Male

NZ = New Zealand.

persistence of these barriers, and need for change, are less striking than their consolidation into a framework comprising two mutually exclusive constructions of practice time management — 'practice-centred time' and 'patient-centred time' — that reflect different, privileged values.

Barriers to accessing GP care in some practices indicate that practice-centred time dominates practice time management. The working day and calendar are divided into and ordered by tangible, numbered units of fixed value. One event occurs linearly before another and practice schedules acquire a life of their own. Practices socially impose this system of time management on patients to meet work needs of the practice. Core values of practice-centred time appear to be orderliness, precision, objectivity, predictability, effectiveness, and efficiency.

The barriers to access produced by practice-centred time indicate an unmet opportunity to organise practices according to patient-centred time. This defines a system of time management that responds flexibly to the needs of patients in individual practices, most easily where providers are salaried. It describes what patients want and at least some practice staff agree they are entitled to and ought to get. As such, it allows for significant patient autonomy in negotiating temporal boundaries of practice care. Its core values are flexibility, accessibility, relationships, respect, and tolerance. Temporal barriers to and needs for accessing GP care indicate the absence of and scope for patient-centred time. In support of this framework, the following five barriers serve as evidence of practice-centred time and of a potential need for the qualities enshrined in patient-centred time.

Limited hours of opening

Restricted hours of opening indicate practice-centred time because they are focused on the needs of practice staff. Meanwhile, some patients are inconvenienced by and cannot accommodate restricted practice hours. Consider teenagers, for example. As adolescent paediatrician KI13, noted, care has to be available at times that fit in with teenagers' lives:

> *'If you go to school, that doesn't leave much time in the day to get to a place that's open 8 'till 5; there is some time after school but you might have a job after school, you might have other roles in the household where you have to look after other kids.'*

Teenagers may also need a parent to take them to the GP. Yet, as a mother in paid work, mother M10 is *'not at home after school'* to take her 15-year-old son to the GP and *'he's not open on the weekends'*. The need of M6 to look after her five children has led her to stop making afternoon appointments:

> *'We've got the kids coming home from primary school, so we can't keep taking off … and we've got no other support around us.'*

Most mothers said they would increase their use of GP services if practices' usual hours of opening were extended.

Traditional appointment systems

When asked, 'Is it important for you to go to the same doctor every time?', M1 replied, *'No. It's important to get in that day if I need to'.* However, while some practices seek to accommodate same-day appointment requests, others are heavily booked at the start of each day and carve out a portion of their full schedule for emergency slots. Added M1, *'You might say you want to go that day but they say, "Sorry, we don't have any appointments if it's not urgent"'.* Consequently, many patients with 'routine' problems must wait longer than they consider necessary (KI20). There is a tendency for these patients to be aged over five years. As M2 noted:

> *'They'll say, "How old is the child?" If I've got an 18-month-old, they'll try and fit that child in, but now that my daughter is older (she's seven* [years old]*) it's not seen as urgent that she get seen today necessarily.'*

Assertive mothers such as M2, can therefore become very demanding in negotiating appointments with receptionists. M2 added:

> *'I have to be quite, I don't want to say pushy but I have to make an absolute point of explaining that I think she needs to be seen today and I'm not happy.'*

Other mothers, she suggested, might not have that same confidence. As a result, observed KI16, the Medical Director of an Accident and Medical Centre, patients *'get stuck at the receptionist … and sometimes the appointment is too late'*. KI20, who manages a Pacific Island health centre, commented that if Pacific Islanders *'don't get an appointment today we might feel better tomorrow and put if off for another day'.*

Appointments, no matter how they are organised, were suggested to be inappropriate for patients who function poorly by linear time and/or have the most discretionary time. This is because, suggested GP KI15:

> *'Someone who is unemployed and maybe has several children but doesn't have a very structured life in a lot of ways has a different concept of time and days may slip by.'*

Practice intolerance of missed appointments

KI11, a NZ European GP at a Maori health clinic, spoke of patients who *'recurrently turn up an hour and a half late or a day late for appointments with all the best will in the world'.* Practices operating by practice-centred time were indicated to lack the ability to accommodate lateness for appointments. In NZ they operate typically on a fee-for-service basis, losing income when patients do not attend for booked appointments (KI11). Their staff may be unaware of barriers beyond patients' control, such as problems with transportation and child care and unfamiliarity with appointment systems (KI1). Moreover, said KI11, staff may perceive 'chaos' in the lives of patients who have not acquired the '*habit of being at an appointment at a certain time*'. During informant checking, a Maori GP (KI1) condemned this perception as

'victim blaming'. She suggested that some patients miss appointments because when they turn up they have *'to wait for an appointment for a long time, so why bother turning up on time?'*

Practice staff may show little tolerance for missed appointments, limiting access to GP care. Said GP, KI11, *'I see GPs, even in my own practice, turn them away because they don't turn up on time'*. Drawing on over 25 years' experience as a child and public health nurse, KI18, now retired, likewise commented on the difficulty for some patients *'of having to be there at a certain time and if you aren't there you get growled at and you've missed your appointment'*. Certain mothers, however, reported their own experience of always receiving a frosty reception. Said Maori mother, M7:

> *'It might be a race thing … you just walk in and oh, you can just feel it … maybe it's because they're paying customers, more money. It might be a money thing.'*

KI1 thus indicated a need to increase staff awareness of barriers to appointment keeping, which many patients cannot easily verbalise, and of assumptions they make subconsciously about individual patients.

Long waiting times in practices

Long waits in practices were generally reported to be disconcerting for mothers who present with a child, especially one experiencing an acute event such as an asthma attack. These waits can leave patients anxious for immediate medical attention (M3 and M5) and, even for non-urgent visits, discourage attendance. In one of M7's practices; for example, *'We've got to wait an hour to an hour and a half … the wait puts me off going because it's real time-consuming'*. Similarly, M8 reported waiting *'half an hour. If I book an appointment I never get in on time. He's so busy. He's always fully booked, my doctor'.*

Patients kept waiting in a practice despite appointments, and because they perceive booking intervals to be too short, may circumvent the system. M7 said she sometimes feels compelled to visit a second GP in a different practice where, by comparison, the wait is shorter. M1 and M3 reported a different solution. They attend community-based Accident and Medical Centres to avoid long waiting times in their own practice and especially in the hospital Emergency Department. In contrast, said M8, '*If I turn up at half past eight he'll see me straight away because he's got to see me before he starts taking his appointments*'.

The last solution, however, indicates patient-centred time, as do waiting times lengthened by patients receiving longer than the usual allocation of time for an appointment. Some patients noted their willingness to wait for a visit they do not perceive to be short. In particular, according to KI27, a manager of Pacific health, Pacific Island migrants are *'used to hanging around and waiting. In the Pacific you go and sit* [in the hospitals] *and it's kind of a social thing. It's like that here.'*

However, Samoan practice nurse, KI25, spoke of Pacific patients who say, *'we are not going to come back again because we have waited too long to see the doctor'*. Samoan GP, KI23, explained this apparent contradiction: *'the ones who have been in NZ long … have learnt the system and they are the ones who become very critical if they wait over 15 minutes'*. In addition, *'Samoans are different from the other Pacific Islanders, even though I say it myself. They are very well controlled … very patient because of their culture.'*

Inadequate consultation lengths

Key informants — though seldom, mothers — articulated this theme. M7, however, noted that *'some of the other doctors I don't like either because they just want to get you in and out and that's it'*. This can be especially problematic for teenagers. Adolescent paediatrician, KI13, explained that:

> *'Primary care does not afford appointments that are very lengthy and sometimes teenagers take a little time to warm up, to giving their stories and to getting the information they want*.'

Pacific Island patients likewise tend to dislike short visits. A Pacific manager, KI27, stated that NZ GPs see patients *'for eight minutes. That's not our* [Pacific Island] *way; it takes us eight minutes to say "hello" …* [and] *it takes longer to deal with "we"* [collectivistic cultures] *than "I"'.* KI28 said that such patients expect them *'to deliver the goods at the end, regardless of how quick or long it takes'*. *'To rush'*, added KI27, is *'disrespectful; when you are with someone it takes as long as it takes'*. Increasing the need for visits of increased length is that:

> *'… the person you are talking to might not be* au fait *with the kind of terminology and the things that you use …* [and] *might not be the caregiver. It may be that this is the person who has the transport.'* (KI28.)

Discussion

This paper has elucidated how differences in professional and cultural understanding of practice time management influence access to GP services. Ensuring representation of Polynesian perspectives, it has identified, from barriers reflecting these differences, a framework that conceptualises approaches to managing practice time. In the context of existing research literature, this framework emerged from personal interviews with key informants and infrequent attenders at GP services for children with chronic, moderate to severe asthma in Auckland.

Main findings

The interviews contributed NZ evidence of factors, associated with practice time management, that impede child access to GP care. In agreement with existing, mainly international, literature, these are: limited hours of opening; traditional appointment systems;[2,3] intolerance of missed appointments; long waiting times in practices;[10,11] and inadequate consultation lengths,[7] especially for groups such as teenagers.[20] However, what distinguishes this research is its consolidation of these barriers into a framework conceptualising a predominance of practice-centred time and unmet opportunity for patient-centred time.

Practice-centred time describes an approach taken by

practices to organise their time in an orderly and equitable manner but around their own work needs. Hours of opening and systems for managing patient throughput are thus made predictable to achieve efficiencies and use resources productively.[21] Traditional appointment systems; for example, seek to 'smooth out the peaks and valleys of patient flow and gain some control over professional demands'.[21]

Yet, practice-centred time underpins the foregoing barriers to access by patients, whom NZ and UK governments now recognise must be at the centre of their health systems.[22] Some mothers, who appeared to prioritise access ahead of provider continuity, resented how appointments are offered, including the use of criteria, such as the age of a child, to assess urgency for an appointment. Where 'too ill or unable to wait for the next appointment',[6] such patients may miss out on the GP care they request and are dissatisfied or complain.[1] Assertive patients may demand appointments, as may busy ones.[23] However, other patients, it was speculated, may lack the confidence to negotiate appointments, and appointment making is difficult for people who, with few competing demands on their time, lack consciousness of or are indifferent to time.[24] Mothers reported using different strategies to circumvent time constraints imposed by practices.

The onus to manage these constraints need not be singularly on patients. Practices could choose to incorporate patient-centred time, facilitating entry to GP care. The barriers to access identified in this paper highlight the need for such an approach to practice time management, which is flexible and supported by a foundation of mutual respect and positive relationships. Encapsulating these attributes, patient-centred time can stretch, within limits, to accommodate one or more tasks during visits. It draws on cultural beliefs that are central to Maori and Pacific Islanders[13] and consistent with those of populations inhabiting the Mediterranean, Latin America, and Asia.[14] These beliefs include progression and completion of tasks ahead of pressures to squeeze a single task into fixed time limits. Patient-centred time can incorporate such beliefs in the practice setting.

A potentially adverse effect of patient-centred time might be to increase waiting times that, in NZ, average approximately 20 minutes for booked patients.[7] Yet, some patients, especially Pacific Island immigrants to NZ and traditional Maori, are unconcerned about 'wasting' time through waiting, particularly if they consider visits to be long enough to meet their needs.[25] Although short consultation lengths were identified as a barrier to access, booked appointments in NZ have a median length of 15 minutes.[26]

In summary, the distinction between practice-centred time and patient-centred time helps to define and inform practice time management, and highlights opportunities to improve access to GP care. It questions whether the major problem is lack of practice time or how practices manage their time; whether practice time management has much more to do with circumstances than choice; and whether an approach to time management that centres on the needs of practices is an appropriate means of ensuring equitable, and not merely efficient, care. Patient-centred time is identified as a likely portal to improved access.

Strengths and limitations

How practice time management shapes access to care is an overlooked area, bedevilled by unsupported assumptions relating to, for example, constraints on practice time. This paper has confronted such issues, using qualitative research methods inductively to conceptualise a framework from interviews with diverse informants. Our purposively rich and explicit samples, and the universality of the barriers identified, commend the transferability of this framework. It builds on previous literature through its reference to practice time management, enhancing understanding and suggesting how access to GP services can be improved.

However, the narratives were analysed and interpreted within researchers' minds. To minimise this limitation, which is intrinsic to qualitative research, verbatim evidence, in the form of direct quotations, was offered for our findings. Informant checking, multiple investigators, and sceptical peer review were also used.

Implications

Qualities of patient-centred time, such as flexibility and responsiveness; diversity of world-views and values that cut across individual patients and practice populations;[11,12] and dimensions of quality such as acceptability, respect and choice, all require that patient-centred time be able to find practical expression in different forms. It should reflect patients' elicited preferences; for example, regarding waiting times, and inform the management of practice time. However, preferences of each practice population may need to be negotiated with practice staff to reveal, through dialogue, expectancies from which new temporal boundaries in practice management can be agreed. This is because pressures on GPs to manage demand,[21] transform time into money,[27] safeguard professional power,[28] and preserve social control over patients[29] may discourage practices from functioning by patient-centred time. Indeed, such barriers may help to explain why the use of patient-centred care has been reported to be probably still limited.[30]

The challenge of minimising these obstacles invites future research. For now, Box 1 draws on our embryonic conception of patient-centred time to anticipate a menu of strategies at the practice level for implementing this approach to practice time management. For example, practices could choose to adopt same-day scheduling for any problem to minimise waiting times and maximise visit lengths,[5] offer open access, and use linear time as merely a convenient device to bring people together. Causes of lateness may be sensitively sought from patients, who could, where appropriate, be made conscious of and helped to manage time as a resource for accessing GP care; for example, some practices offer free transport services for GP care (KI25, KI2). To such ends, practice staff must be professionally and culturally qualified. In New Zealand, there is also a need for increased numbers of Maori and Pacific GPs and for development of Maori and Pacific health services whose ethos can accommodate patient-centred time.

Put patients' healthcare needs first

Elicit preferences of the practice population; for example, for waiting times

Make self-help information available via the internet

Accurately match predicted total daily demand with trained practice staff to: schedule same-day visits with the patient's usual GP; minimise waiting times in the practice; and maximise flexible visit lengths

Seek to understand lateness for appointments, offering support where possible

Address first in each consultation the patient's reason(s) for attendance, and negotiate the use of remaining time

Encourage and enable patients' informed involvement in decision-making

Encourage the use of, and provision of care by, one primary care provider (team)

Box 1. Possible practice strategies for increasing patient-centred time.

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Acknowledgements

We are grateful to the Health Research Council of New Zealand, which made this research possible through a project grant. Dr Allan Adair is thanked for offering helpful comments on the final version of this manuscript.