

Patients' preferences for appointment times

Nigel Cartwright, Christine Johnson, Sue Jones

The Surgery, 51 Station Road, Preston PR5 6PE
Nigel Cartwright, MRCP, trainee in general practice

Sandy Lane Surgery, Sandy Lane, Leyland PR5 1EB
Christine Johnson, MRCP, trainee in general practice

Department of General Practice, Queen's Medical Centre, Nottingham NG7 2UH

Sue Jones, MPHIL, lecturer in general practice

Correspondence to: Sue Jones.

Br Med J 1990;300:848

A major aim of the government's white paper *Working for Patients* is to make the services provided by general practitioners more responsive to patients' needs.¹ Patients consider that the convenience of surgery hours is important,^{2,3} but no reliable information exists to show what appointment times patients prefer. We therefore collected and analysed data on this subject.

Subjects, methods, and results

We performed the study in a general practice in Leyland, Lancashire, that had seven partners and a list of 11 655 patients. Surgeries were held continuously from 8 am to 6 pm on Mondays to Fridays. All patients on the age-sex register of the practice who were over 18 and had their birthday in April were sent a questionnaire that asked what time they would prefer to attend the surgery, both generally and for specific clinics; how often they had visited a doctor at the surgery in the past year; and whether inconvenient times of access had caused problems. Patients with children were asked what time they would prefer to have appointments for them, and whether this differed from their choice for their own appointment. Patients were also asked when they worked and whether they would like surgeries at weekends.

We sent 949 questionnaires and 586 (62%) were returned completed. Four hundred and fifty three patients had a convenient time in mind when they made a routine appointment. Clinics before 9 am were preferred by 133 patients, from 9 to 11 am (the conventional time of morning clinics) by 192, from 3 to 6 pm by 147, and after 6 pm by only 29 (table). Appointments between 9 and 11 am were preferred by the largest proportion (44%) of parents with children aged under 5. Women with children aged under 5 were significantly more likely to want an appointment between 9 am and 11 am for their children than for themselves ($p < 0.0001$, χ^2 test). One hundred and nine (57%) parents with children of school age preferred appointments for them between 3 and 6 pm. Patterns of work influenced preferences: the 29 patients who preferred appointments after 6 pm all worked during the day, and the 20 who worked only in the afternoons preferred to attend during the morning. The table shows the appointment times preferred by people attending well woman clinics and for health checks.

Three hundred and eighty one patients thought that the practice should offer appointments at weekends for routine problems; 312 on Saturday morning, 103 on

Number (percentage) of patients preferring particular appointment times for themselves and their children at a general practice

Preferred appointment time	Appointments for:				
	Routine consultation	Children under 5	Children of school age	Well woman clinic	Health check
7-8 am	33 (6)	1 (1)	1 (1)	2 (8)	22 (4)
8-9 am	100 (17)	15 (16)	41 (23)	33 (10)	62 (11)
9-11 am	192 (33)	41 (44)	29 (16)	122 (36)	164 (30)
11-1 pm	43 (7)	6 (6)		30 (9)	44 (8)
1-3 pm	36 (6)	9 (10)	2 (1)	39 (12)	39 (7)
3-5 pm	61 (10)	12 (13)	66 (37)	23 (7)	51 (9)
5-6 pm	86 (15)	5 (5)	37 (20)	36 (11)	92 (17)
6-7 pm	21 (4)	5 (5)	5 (3)	27 (8)	44 (8)
7-8 pm	8 (1)			22 (7)	31 (6)
Total	580	94	181	340	549

Saturday afternoon, 83 on Sunday morning, and 31 on Sunday afternoon.

Comment

Our results show that the common pattern of twice daily surgeries, in the morning and afternoon, meets the general preferences of most patients. Groups with special preferences were, however, identified. These preferences may reflect daily routines, parents preferring appointments for children aged under 5 to be mid-morning and those for older children to be just after school. Similarly, patients who worked preferred appointments during their free time. Most patients thought that routine appointments should be offered at weekends, and this also may reflect a wish to attend the surgery outside working hours.

The proportion of patients who said that they would like to attend health promotion clinics after 6 pm was higher than the proportion who preferred late routine appointments. Thus some late evening or weekend appointments are desirable, particularly to encourage those wishing to take part in health promotion activities, for which a fee is proposed in the new contract.

Although the times of surgeries should be sensitive to patients' needs, the introduction of extended surgery hours would affect the workload of general practitioners, the working hours of ancillary staff, and the running costs of practices. Hence the experiences of practices that already have extended evening and weekend surgeries need to be evaluated.

We thank Dr J Everiss and partners for allowing us to use facilities at their practice, and the patients for their cooperation. This work was supported by the Claire Wand Fund.

1 Secretaries of State for Health, Wales, Northern Ireland, and Scotland. *Working for patients*. London: HMSO, 1989. (Cm 555.)

2 Consumers' Association. Making your doctor better. *Which?* 1987;May:230-3.

3 Arber S, Sawyer L. Changes in general practice: do patients benefit? *Br Med J* 1981;283:1367-70.

4 Ritchie J, Jacoby A, Bone M. *Access to primary health care*. London: HMSO, 1981.

(Accepted 5 January 1990)

Oxford Regional Rheumatic Diseases Research Centre, Stoke Mandeville Hospital, Aylesbury, Buckinghamshire HP21 8AL

K K Chakravarty, MRCP, research registrar
M Webley, FRCP, consultant rheumatologist

Correspondence to: Dr Chakravarty.

Br Med J 1990;300:848-9

Disorders of the shoulder: an often unrecognised cause of disability in elderly people

K K Chakravarty, M Webley

Disorders affecting the shoulder girdle may impair the function of the arm and lead to disability. A previous study of disorders of the shoulder in a group of elderly patients in hospital suggested that such disorders were

underreported.¹ Our community study assessed the prevalence of disability occurring as a direct consequence of disorders of the shoulder girdle in an elderly population.

Subjects, methods, and results

One hundred apparently healthy people (50 aged 65-74, 50 aged ≥ 75) were selected at random from the age-sex registers of three group practices around Aylesbury. Subjects with rheumatoid arthritis, other inflammatory arthropathy, polymyalgia rheumatica, and symptomatic cervical spondylosis were excluded.

	Subjects aged 65-74 (mean 68.7 years)	Subjects aged ≥75 (mean 78.4 years)
No of men: women	24:26	24:26
Previous medical illnesses*:		
Diabetes (non-insulin dependent)	1	
Thyroidectomy	2	
Cardiovascular disease	7	3
Transient ischaemic attack	1	1
History of trauma to shoulders	2	1
History of using walking aid for < 6 weeks	1	1
Painful shoulder:		
Mild	2	3
Moderate	13	7
Severe	3	6
Clinical diagnosis:		
Glenohumeral osteoarthritis	3	4
Tendinitis of rotator cuff	11	7
Chronic rupture of rotator cuff	2	4
Arthritis in acromioclavicular joint	2	1
Functional assessment (Katz scale):		
Totally independent	38	32
Dependent in three of the six functions (disabled group)	12 (3 men, 9 women)	18 (7 men, 11 women)
Occupation before retirement:		
Manual	7	5
Non-manual or housewife	43	45

*None of this group had shoulder symptoms.

Informed consent and approval of the ethical committee were obtained before the start of the study. All the subjects were interviewed and examined, during afternoons, by one of us (KKC).

Histories of illness, disability, trauma, use of walking aids, and pain were recorded for each subject. Pain was graded as none, mild, moderate, or severe. Functional disability was assessed with the Katz scale of index of independence in the activities of daily living.² The criteria of Cyriax³ were used to define lesions or rupture of the rotator cuff; those of the American Rheumatism Association for osteoarthritis of the knee¹ to diagnose glenohumeral osteoarthritis; and those of Bateman and Fornasier⁵ to diagnose arthritis of the acromioclavicular joint.

The table shows the general characteristics and medical histories of the subjects. Twenty four subjects had symptomatic lesions and 10 had clinical evidence

of symptomatic disease of the shoulder joints. Most resultant disabilities were reflected in activities such as bathing, dressing, and toileting. Only 16 of the 34 subjects with a painful shoulder had consulted their general practitioner about it on more than two occasions; most accepted their symptoms and disabilities as an inevitable part of getting old. A possible frozen shoulder had been diagnosed by the general practitioner in six subjects, and 10 subjects had been advised that their symptoms were incurable due to age. The treatment offered by general practitioners had generally been physiotherapy or non-steroidal anti-inflammatory drugs; neither had conferred much benefit. Some patients had stopped the drug treatment because of associated side effects. No subject with shoulder pain had received a local intra-articular injection of steroid.

Comment

Our study suggests that an appreciable number of elderly people in the community are disabled because of disorders of the shoulder girdle. The disabilities seem often to go unrecognised, although they could possibly be reduced by intra-articular or soft tissue injection of steroid. Full assessment of patients by an occupational therapist, with provision of appropriate aids and appliances, might also improve their quality of life.

Although elderly people generally accept that illness and disability are part of the process of aging, we think that greater awareness is necessary among those who provide their primary care; examination of the shoulder girdle should be an integral part of the health screening of the elderly that has been suggested in the new general practitioners' contract.

- 1 Chard MD, Hazleman BL. Shoulder disorders in the elderly (a hospital study). *Ann Rheum Dis* 1989;46:684-7.
- 2 Katz S, Akpom CA. A measure of primary sociobiological functions. *Int J Health Serv* 1976;6:493-507.
- 3 Cyriax J. *Textbook of orthopaedic medicine*. Vol 1, 8th ed. London: Bailliere Tindall, 1982:144-8.
- 4 Altman R, Asch E, Bloch D, et al. Development of criteria for the classification and reporting of osteoarthritis: classification of osteoarthritis of the knee. *Arthritis Rheum* 1986;29:1039-49.
- 5 Bateman JE, Fornasier VL. *The shoulder and the neck*. London: W B Saunders, 1978:201-374.

(Accepted 11 January 1990)

Resuscitation: experience without feedback increases confidence but not skill

Theresa M Marteau, GERALYN WYNNE, W KAYE, T R EVANS

Royal Free Hospital and School of Medicine, London NW3 2QG
Theresa M Marteau, PHD, lecturer in health psychology
Geraldyn Wynne, RGN, resuscitation training officer
T R Evans, FRCP, consultant cardiologist
W Kaye, MD, visiting associate professor of surgery and medicine

Correspondence to: Dr Marteau.

Br Med J 1990;300:849-50

The accuracy with which doctors judge their clinical skills is crucial to managing patients successfully. Misplaced confidence can result in performing procedures ineffectively, and doctors are unlikely to see the need to improve their skills. In a previous study we found that nurses' confidence in performing resuscitation was unrelated to skill, but it was positively related to the number of cardiac arrests attended.¹ We report on a study of the relations among confidence, experience, and resuscitation skills in house officers attending a required advanced resuscitation training programme² and how they perceived the importance of their skills in influencing the outcome of a resuscitation attempt.

Methods and results

Twenty eight preregistration house officers starting their second appointment at the Royal Free Hospital took part in the study. They had received basic resuscitation training in medical school but no further training since qualifying.

Resuscitation skills were assessed by trained instructors (GW and WK), using a checklist based on the 1984 guidelines of the Resuscitation Council and the American Heart Association advanced cardiac life support course. The total score of 49 was derived from scores for basic resuscitation,^{1,2} bag-mask ventilation,^{1,3} and management of ventricular fibrillation.^{2,4}

Confidence in performing resuscitation was assessed using a seven point scale ranging from "not at all confident" to "extremely confident." Experience of resuscitation was measured by the number of cardiac arrests attended in the previous six months.

The perceived importance of the doctors' skills in influencing outcome was measured by asking them to rate on seven point scales the relative importance of the patient's age, the diagnosis, the doctor's skill, and the skill of the resuscitation team. They rated two hypothetical resuscitation attempts, one in which the