Receptionists, appointment systems and continuity of care

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SUMMARY. The influence of receptionists on continuity of care in four group practices was examined. Twenty two receptionists were observed making 543 appointments and afterwards were interviewed about their personal priority for continuity of care. One of the practices ran a personal list system. It was found that the personal list practice attracted more requests for a specific doctor and time which were then more difficult to satisfy. Most receptionists thought it was important that patients should see the same doctor but their influence seemed to be small compared with that of the doctor as expressed in practice policies. Marked variation in demand for individual doctors was seen in two of the practices without a personal list system.

Introduction

WITH the increasing predominance of group practices[1] there has been a reduction in personal continuity of care.[2] Such personal care is built into the British and European definition of a general practitioner and is often referred to by those who defend general practice.[3]

However, more than 20 years ago Cartwright found that over one third of patients would be prepared to see another doctor straight away rather than wait half an hour to see their own doctor.[4] Thus, in group practices with equal access personal continuity of care might break down. One solution is to have personal lists within the groups.[2,5]

Hand in hand with the rise of group practice has been the introduction of appointment systems administered by receptionists. Receptionists have sometimes been criticized for coming between doctors and patients, but if they are not given sufficient available appointments they are almost bound to seem obstructive.[6] They often have little training and critical attention has been paid to this recently.[7]

In the author's own practice it was noticed that two receptionists typically made different responses when the patient's first choice of doctor and time was not available — one offered the same doctor at a different time, while the other offered alternative doctors at or near the requested time. It thus seemed that receptionists' beliefs and attitudes could have an important effect on continuity of care. No previous study has addressed this point and few papers have reported systematic observation of receptionists at work.

The aims of the study were to: observe receptionists making appointments, especially their action when the patient's first choice was not available; investigate receptionist's beliefs about continuity of care, what priority this merited and what circumstances might modify such priority; compare beliefs with observed behaviour; assess the impact of practice policies such as personal lists and systems for handling urgent requests; and assess the influence of the receptionists relative to factors determined by the doctors.

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The study was carried out in large practices as a questionnaire study[8] had suggested that doctors' priority for continuity of care increases with list size.

Method

Four large practices in Southampton agreed to take part in the study. Three practices (A, B and C) had shared lists where patients could see any doctor of their choice while the fourth (practice D) ran a strict personal list system. Each had six or seven principals, between four and eight receptionists and an average total list of 12 500 patients. Two practices (B and C) worked from the same health centre and shared a branch surgery where list sizes were nearly as large as those at the health centre.

A non-medical research assistant was employed to observe the receptionists making appointments. The receptionists were not told the purpose of the observation until later. The sessions covered a variety of different times of the day and week always including a Monday morning. The aim was to see each receptionist making at least 20 appointments. Follow-up appointments made as the patient left were excluded, otherwise all requests were eligible. The great majority were made by telephone and therefore only half of each conversation could be heard.

Pilot studies showed that it was possible to record all the salient features of the patients' requests with only occasional clarification needed between observer and receptionist. For each appointment the following data were recorded: receptionist; doctor and session requested, offered and agreed; additional details if more than one request/offer and reasons for any protracted negotiations. To avoid influencing behaviour the receptionists were not interviewed until data collection was complete. A structured format was used, followed by an opportunity for free discussion.

Results

Over the period October 1987 to May 1988 22 receptionists were observed making 543 appointments and were later interviewed (mean 25 observations each, range 4–61). While all practices were affected by absence of doctors owing to holidays and so on, practice B was worst affected during the period of observation with one full time and one part time principal absent and a full time locum in post.

Observation of appointment making

Type of request. Requests were classified according to the degree of specificity — asking for both a particular doctor and session or merely requesting either a doctor or a session. Table 1 shows that the distribution varied between the practices. In practices A and B a large minority of patients did not ask for a particular doctor while in practice D it was not possible to make an appointment without naming a doctor.

In practices C and D the variation in the rates of requests for individual doctors varied less than twofold but in practice A this variation was up to threefold and in practice B up to eightfold. In practices A and B the most requested and least requested principals were full time males and none were on leave during the observation period.

Success of requests. Patients were more likely to have their request satisfied if the request was less demanding (Table 2). In

Table 1. Appointments requested by practice and specificity of request.

Practice	Number (%) of appointments: Doctor and session specified	Doctor only specified	Session only specified	Total
A	64 (59)	10 (9)	34 (31)	108
B	66 (50)	14 (11)	52 (39)	132
C	80 (67)	17 (14)	23 (19)	120
D	175 (96)	8 (4)	0 (0)	183
All	385 (71)	49 (9)	109 (20)	543

Table 2. Proportion of successful requests, by practice and specificity of request.

Practice	Number (%) of successful patients: Doctor and session specified	Doctor or session only specified
A	45 (70)	43 (98)
B	37 (56)	51 (77)
C	56 (70)	39 (98)
D	102 (58)	7 (88)
All	240 (62)	140 (89)

practices A, C and D only one less specific request was unsuccessful. Not surprisingly success rates for more specific requests were lower at 56–70% with less inter-practice variation. Thus, overall the combined list practices A, B and C had higher success rates (67–81%) than practice D (60%) because of their much greater number of less specific requests.

Allocation of patients not granted specific requests. Of the 385 patients specifying both doctor and time when asking for an appointment 113 (29%) were only successful in one of these. In practices A and B the outcome was much more likely to be at the chosen session rather than with the chosen doctor and only in practice C was a patient's choice of doctor more likely to be successful (Table 3).

Receptionists' beliefs

The 22 receptionists were aged from 17 to 60 years (mean 37 years) but with none aged 26–37 years. Practice B's receptionists were older than the mean and practice D's were younger.

The receptionists were asked: 'If a patient's first choice of doctor and time is not available do you normally offer the same doctor at a different session or offer the same session with a different doctor?' Sixteen of the receptionists (73%) would normally give priority to the same doctor although two qualified their answer if the problem seemed urgent. One receptionist said she normally gave the patient both options to choose from.

When asked: 'In general do you think it is more important for a patient to see the doctor of their choice or to be seen as quickly as reasonably possible?' a large majority again preferred the 'doctor' option (77%). Only one preferred the 'be seen quickly' option and she qualified that by saying that patients with ongoing problems should be seen by the doctor of choice. The other four receptionists said 'it depends'.

However, only half the receptionists preferred the chosen doctor option in both questions (none preferred the time option in both). The most striking difference between reported action and stated opinion occurred with the three oldest receptionists in practice A who all thought it was more important for patients to see their own doctor but who usually offered a different doctor at the requested time. Conversely, while the generally younger team in practice D all reported implementing the practice policy for patients to see their own doctor whenever possible, three of them indicated that their own opinion was more flexible.

Matching actions and beliefs

Table 3 shows that except in practice C receptionists were more likely to satisfy patients' requests for time than for doctor when both were specified. Table 4 shows that there was a definite correlation between this behaviour and the stated belief of receptionists in combined list practices. When receptionists believed that it was important for patients to see the same doctor they acted accordingly in half the possible instances, whereas when they did not have this belief none of the appointments were made with the doctor of choice. In the personal list practice there was little difference. Thus, it may be necessary for a receptionist to believe that seeing the same doctor is important or for the practice to have such a policy (that is, a personal list system) to override a patient's priority to be seen at a certain time rather than to see a particular doctor.

Discussion

The assumption underlying this study is that giving patients appointments with the doctor they request will increase personal continuity of care. Patients choosing to change are likely to be a small but important minority, the ability to choose being an obvious advantage for a group practice without a personal list system. However, the converse is self evident, that personal continuity is likely to be frustrated by any system which impedes patients' access to the doctor of their choice.

This study showed that receptionists have an influence on per-

Table 3. Allocation of patients unsuccessful in their requests for both a specific doctor and time.

Practice	Number of appointments: With doctor requested	At session requested	Total
A	4	14	18
B	4	19	23
C	16	8	24
D	22	26	48
All	46	67	113

Table 4. Allocation of unsuccessful requests for a specific doctor and time by receptionists' priorities.

Practice	Receptionists' priority	Number of appointments: With doctor requested	At session requested	Total
Combined list practices (A,B and C)	Seeing chosen doctor	24	24	48
	No rule/choice	0	17	17
Personal list practice (D)	Seeing own doctor	14	15	29
	Being seen quickly or 'it depends'	8	11	19

sonal continuity — especially in a combined list practice without too many other constraints — but that the effect is small in relation to other factors which are ultimately decided by the doctors themselves. It is thus for doctors to decide what priority to give personal continuity of care and to be aware how their policies affect that variable.

It was apparent that only in certain situations did receptionists have an influence on which doctors the patients saw: first, when the patient had made a specific request which could not be satisfied and this only happened in about a fifth of all requests (113/543); secondly, when the receptionist had a choice of doctors and appointments to offer and would need to override her practice appointments policy, but this seldom occurred.

There were three practice policies which limited the influence that receptionists had on the outcome of the booking. The first factor was reserving appointments for same day or emergency booking in order to increase urgent short term choice at the expense of less important long term choice. This policy, implemented in practices A and B, seemed to work well as long as it accurately reflected short term versus long term requests and was not overridden. In practice A it worked for all but one principal and in practice B it had the paradoxical effect that it was easier to book the most popular doctors on the same day than a few days in advance. In practice B afternoon appointments were reserved for emergencies only and were not bookable until 14.00 hours. This policy was disliked by their receptionists, who worked closely alongside those in practice C, where appointments were bookable any time in advance both mornings and afternoons.

The second factor limiting receptionists' influence was the distribution of doctors between premises. All the combined list practices (A, B and C) had branch surgeries. By distributing all its doctors (including trainees) at both main and branch surgeries for some sessions each week practice B gave a wide choice of doctors but a seriously limited choice of times. Practice C's policy of limiting five out of seven principals and the trainees to either of the practice premises gave a smaller choice of doctors with a wide range of times; this system gave maximum flexibility to its receptionists.

The third factor, the personal list system, was confined to practice D. This system gave a minimal choice of doctor except in urgent cases, but with single premises, no trainees and no reserved appointments, the choice of times was the maximum possible within the total number of apointments allowed. Even so, the success rate of appointment requests was only 60%. However, this practice achieved a high rate of personal continuity of care (unpublished results) and so the policy was achieving its aim.

One unexpected factor limited the receptionists' options in two of the three combined list practices. The majority of patients in the combined list practices (61–81%) named the doctor they wished to see but in practices A and B there was marked variation in rates of requests for individual doctors (up to threefold and eightfold, respectively). It may be that the lesser degree of choice available in practice C helped reduce this problem. One advantage of groups should be to even out the day-to-day variations in workload for individual doctors but no receptionist or appointment system can be expected to cope with an eightfold variation in demand for particular doctors.

Two examples of how receptionists did influence the outcome of the booking were observed but not recorded. First, when a patient's first choice was not available some receptionists would make one specific counter suggestion while others offered a menu of options — the latter obviously gives more power to patients. Secondly, even in the same practice receptionists varied in the responsibility they would take for fitting in extra patients — some did this on their own initiative while others referred all decisions to the doctors.

In this study 19–39% of patients in combined list practices did not specify a particular doctor when requesting an appointment, the higher percentages occurring in the practices (A and B) offering the widest choice of doctors. Patients' behaviour is likely to be conditioned by previous experience of the appointment system but also by the strength of their attachment to a particular doctor. If the choice is too large it is difficult for patients to get to know any particular doctor unless they make a special effort to do so and the advantages may not be apparent to patients even if they seem real to doctors. Too much choice, then, encourages the collusion of anonymity referred to by Balint.[9]

One area of misunderstanding between patients and doctors may be the tolerance of delay. Once the decision to ask for an appointment has been made many patients seem unwilling to wait to see a particular doctor. It may be difficult to provide personal continuity for acute problems within a combined list appointment system as reported by Arber and Sawyer,[10] who also point to an earlier study showing that appointment systems benefit those with chronic conditions.[11] The same priority for chronic and emotional conditions is stated by Gray.[5] There is a potential clash here between giving patients greater autonomy and doctors' belief that seeing the same doctor is best for patients. At present the clash can only be resolved by doctors making themselves more available. To take the argument further it is necessary to know more about patients' own priorities for personal continuity of care and to augment the scanty evidence that personal continuity actually helps patients.[12] Further studies are in progress to try and answer these questions. Meanwhile the contradictions inherent in using appointment systems for rationing demand rather than adjusting or spreading it will continue to make life difficult for receptionists. This study suggests they have less influence than some patients think.

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