For Debate . . .

Outpatients: can we save time and reduce waiting lists?

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Abstract

The amount of time that one consultant urologist wasted on unnecessary administration while seeing outpatients was noted over six weeks. Searching for missing clinical data and the time spent on non-medical clerical tasks took up nearly half of the consultant's sessions. This seemed to be due to insufficient clerical and secretarial staff. Because low salaries are offered to such staff vast sums of money are being paid to agencies who are providing an appreciable number (40%) of the secretarial staff in our hospitals.

Urgent action from the government is needed to remedy this and thus make substantial reductions in outpatient waiting lists nationally. It would greatly improve morale in this important sector of the health service without increasing total costs.

Introduction

The Department of Health and Social Security and the government are regularly castigated in the national press for the increasing waiting lists for hospital outpatient attendances. Despite this we were unable to find any published studies that dealt with the efficiency of the doctor-patient interview.

Many clinicians have reluctantly become accustomed to the lack of adequate secretarial and clerical support. In more and more hospitals in the health service patients are being seen and even operated on without all the relevant clinical data to hand. Though administrators and managers are always collecting data, which they circulate among themselves, this seems to have little effect on the problems identified by both clinicians and patients. We have documented the activities of one consultant urologist at a district general hospital in an inner city area in the hope that other studies will be carried out and solutions will be found to better the lot of the patient and frustrated hospital staff.

Methods

The study was carried out over six consecutive weeks in the urological outpatients department of the Royal Northern Hospital, London. Before the clinic began the consultant saw all the notes, asked for data that were obviously missing, and selected patients for each member of the team to see. Comments on necessary investigations were written in the notes of the patients who were to be seen by the junior staff. New patients were allocated to the most junior member of the team for initial investigation, and the consultant saw the patients who were returning to the clinic for investigations and requiring management and follow up. The hospital is somewhat unusual because many procedures are now carried out at its sister hospital, Whittington Hospital.

During the six weeks of this study no student teaching was done or tea breaks taken. Two medical students sat in the clinic and recorded on two separate stop watches the time taken to perform the various functions noted below:

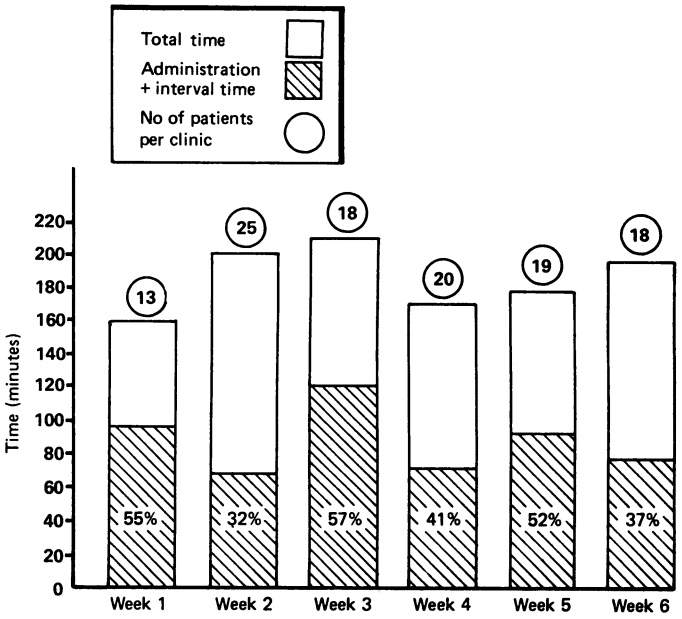
Total patient time was defined as the time from the first greeting to the time the patient left the room (recorded to the nearest second).

Administrative time was defined as the time taken up with unnecessary administration during the interview with the patient (recorded to the nearest second—those taking under 15 seconds were ignored). This included problems caused by lost notes, missing results of investigations, and the time taken over 15 seconds to fill out forms. It did not include the time taken for the history and the examination of the patient, writing the patient's prescription, writing in the patient's notes, or inquiries from junior staff, all of which were regarded as legitimate and necessary aspects of work with outpatients.

Interval time was the time elapsed between patient interviews and was recorded to the nearest second. All the patients who were about to be seen were in the clinic, but there were delays owing to the inability to trace notes or confusion about which data belonged to which patient.

Results

Table I and the figure show the amount of time spent by the consultant in the activities defined above. Table II shows (*i*) the number of patients for whom the medical record was incomplete or entirely missing, (*ii*) the number of patients for whom biochemical, haematological, and microbiological results were missing, and (*iii*) the number of patients for whom



Time spent by consultant urologist in activities (defined in Methods) when seeing outpatients.

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TABLE I—*Time (minutes and seconds) spent by consultant in seeing outpatients (headings defined in Methods) (% in parentheses)*

	Week					
	1	2	3	4	5	6
Total patient time	107' 24" (66·6)	168' 55" (83·1)	168' 16" (78·8)	131' 29" (75·9)	122' 50" (67·4)	146' 51" (70·5)
Administration time during interview with patient	35' 04" (21·7)	30' 38" (15·1)	76' 01" (35·6)	29' 37" (17·1)	34' 43" (19·1)	16' 06" (7·8)
Interval time	53' 51" (33·3)	34' 18" (16·9)	45' 09" (21·2)	41' 46" (24·1)	59' 20" (32·6)	61' 26" (29·5)
Total time of clinic (100%)	161' 15"	203' 13"	213' 25"	173' 15"	182' 10"	208' 17"
No of patients	13	25	18	20	19	18

TABLE II—*Number of patients for whom the medical record was incomplete or missing, haematological and other results were missing, and results of x ray examinations were unobtainable*

	Week					
	1	2	3	4	5	6
Missing notes	4	0	1	5	0	1
Missing x ray results	0	5	4	1	5	2
Missing results of biochemical, pathological, microbiological, and haematological investigations	2	0	0	1	1	1
No of patients (100%)	13	25	18	20	19	18

TABLE III—*Salary scales: clerical and secretarial staff*

Clerical officer (age 16-20)	£2881-£3732
Clerical officer (age 21+)	£3887-£5315
Personal secretary	£4912-£5885
Higher clerical officer (medical secretary) (Add £1201 London weighting)	£5418-£6556
Average yearly fee for agency staff:	
Medical records clerk	£7887 (includes value added tax at 15%)
Medical secretary	£14 000-£16 000 (including VAT)

results of radiological investigations were unobtainable. Table III gives details of secretarial and clerical salaries which were obtained from the administrative staff of both the Whittington Hospital and the Institute of Urology.

Discussion

The consultant urologist adopted a policy to see patients at follow up appointments and to see patients who required investigations rather than patients who had been newly referred by their general practitioners. This was thought to be more efficient as the consultant was better able to use his time either to decide on management from the results of investigations before him or to ensure that the patients were not undergoing prolonged follow up when it was not necessary.

Many who read this paper will be appalled by the unacceptable amount of clinical data that were missing in these clinics. Others will find the situation familiar. Clearly, the problem is exacerbated by working on two sites, but this is not unique in the health service. The problem appears to be common in hospitals in large cities where staff are difficult to find. Written complaints to management have done little to ameliorate the problem, and it needs to be looked at urgently throughout the health service.

If patients are seen without their notes and the results of all of their investigations the doctor and health authority are laying themselves open to serious medicolegal consequences, and the higher awards being recommended by our courts to an ever more litigious public bear grim witness to this. Patients, who may be visiting the hospital for the first time, may find their confidence dwindling if clinicians do not even have their notes. General practitioners have to wait for delayed clinical decisions. Clinicians are faced with the unpleasant and embarrassing task of having to explain to patients that they are unable to treat them without the relevant information.

Forty five per cent of the consultant's time in this study was spent in doing avoidable administrative tasks and searching for lost results. The average amount of time between patients (all patients present in the clinic) varied from 1 minute 22 seconds to 4 minutes 9 seconds per clinic per patient. Though some delays do occur, this is unacceptable. Thirty seconds would be satisfactory. During the interval between patients delays were caused by searching for clinical data and confusion about incomplete notes. As much as one hour during consultations with patients was spent searching for lost data and in filling in forms. The use of sticky labels or other computerised methods of identification would have greatly reduced this time. Keeping forms simple rather than making them more complicated, as is the trend, would also help. Furthermore, notes are not properly kept, investigations are not inserted in the correct place, and vital notes on operations lie loose between the leaves of the folder. The trend of keeping duplicated notes in temporary folders, each containing different information about one patient, is dangerous and apt to cause serious mistakes. A modest improvement in wasted time—that is, a reduction from just under half (45%) to, say, a fifth—would result in 25% more patients benefiting from specialist advice. Alternatively, it would mean that the waiting time in the clinic would be cut by a quarter. Nationally this would have an enormous impact on waiting times for patients.[1]

Good secretarial and clerical support would solve this. Many years back such a situation would have been inconceivable. Vast sums of money are spent in the National Health Service on staff from agencies. In our hospital 34 of the 74 clinical secretaries are temporary staff at the time of writing. It would surely make sense to apportion the extra money paid to the agency to the permanent NHS staff to try to improve continuity, standards, service, and morale. The present solution is to cut the medical secretarial time by half so as to reduce the agency fees. No thought is given to providing services for patients, and this will undoubtedly result in further deterioration in a totally inadequate service.

The trend now is to appoint administrators to deal with this problem, but this is hardly likely to solve it. It is indeed an invidious position to be a manager without sufficient staff. Managers do not come to clinics to find out how they run. How can managers be trained to run an outpatients clinic if they have no experience of the clinical interface? Ten years ago lost notes were not a problem, outpatients departments ran smoothly, and there were no such managers. Readers must draw their own conclusions.

The government's recent election manifesto stated: "We will continue to ensure that the health service is as efficient as possible. The ultimate purpose of the health service is to serve the patient, that principle is at the heart of the government's policy."[2] The results of this study suggest that an area of glaring inefficiency has been identified and that no one—patients, doctors, or administrators—are being well served. If the problems identified in this study exist nationally we have described one way of decreasing waiting lists for outpatients.

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References

1 Stevens DL. Outpatient waiting lists. *Br J Hosp Med* 1985;**34**:197.
2 Anonymous. *The way forward: Conservative Party manifesto*. London: Conservative Party, 1987: 47-51.