Managing patient demand: a qualitative study of appointment making in general practice

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SUMMARY

Background: *Managing patients' requests for appointments is an important general practice activity. No previous research has systematically observed how patients and receptionists negotiate appointments.*

Aim: *To observe appointment making and investigate patients' and professionals' experiences of appointment negotiations.*

Design of study: *A qualitative study using participant observation.*

Setting: *Three general practices on Tyneside; a single-handed practice, a practice comprising three doctors, and a seven-doctor practice.*

Method: *Participant observation sessions, consisting of 35 activity recordings and 34 periods of observation and 38 patient and 15 professional interviews, were set up. Seven groups of patients were selected for interview. These included patients attending an 'open access' surgery, patients who complained about making an appointment, and patients who complimented the receptionists.*

Results: *Appointment making is a complex social process. Outcomes are dependent on the process of negotiation and factors, such as patients' expectations and appointment availability. Receptionists felt that patients in employment, patients allocated to the practice by the Health Authority, and patients who did not comply with practice appointment rules were most demanding. Appointment requests are legitimised by receptionists enforcing practice rules and requesting clinical information. Patients volunteer information to provide evidence that their complaint is appropriate and employ strategies, such as persistence, assertiveness, and threats, to try and persuade receptionists to grant appointments.*

Conclusion: *Appointment making is a complex social process where outcomes are negotiated. Receptionists have an important role in managing patient demand. Practices should be explicit about how appointments are allocated, including publishing practice criteria.*

Keywords: *practice management; appointments; patient attitude; staff attitude.*

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Introduction

IN general practice, problems of need, supply, and demand focus on patient difficulties in making appointments.

Strategies for managing patient appointment demand include: setting aside appointments for 'extras', adjusting appointment length, triage by nurses of requests to see the doctor the 'same day,' better use of telephone consultations, and promoting self-care.[1-5] The receptionist also has a key role as gatekeeper to appointments with the doctor or nurse.[6,7] Only one study has systematically observed the work of receptionists. This concentrated on the receptionist's ability to offer appointments that maintain continuity of doctor care.[8] It did not focus on patients and how receptionists negotiate other demands.

This study therefore aimed to observe appointment negotiations in general practice, to investigate patients' and professionals' experiences of negotiating appointments, and to see how these might be influenced by practice organisation and policy.

Method

Between May 1998 and September 1999, appointments were studied by participant observation; this consisted of activity recording and observations with informal interviews and by patient and professional interviews. A reflective diary was also kept by MG.

The principal researcher (MG) is a general practitioner based in a Northern Research Network (NoReN) research practice in South Shields. During the observations and interviews MG and JG presented themselves as health care researchers from the Department of Primary Health Care at the University of Newcastle upon Tyne

Settings and subjects

The research was conducted in three general practices on Tyneside. Practice A has 1700 patients, one general practitioner, and three receptionists. Practice B has 6500 patients, three doctors, and five receptionists. Practice C has 10 500 patients, seven doctors, and five receptionists. None are teaching practices. The waiting time for a routine appointment in these practices was up to five days.

Activity recording and observations

Activity recording consisted of recording appointment making and other activities for 30-minute periods. Its purpose was to identify the nature, frequency, and range of observable practice activities. Spreadsheets were used to record activities. Activity recording was conducted in the waiting

HOW THIS FITS IN

What do we know?
The receptionist has a key role as a gatekeeper to appointments with the doctor and nurse.

What does this paper add?
Appointment making is a complex social process where outcomes are negotiated by receptionists and patients. Outcomes are dependent on the process of negotiation, patients' expectations and appointment availability.

room and behind the reception counter.

Observations were conducted in the same settings and also in administrative and relaxation areas. Observations lasted from one to three hours. Questioning of professionals and patients, to clarify the meanings of observations, proceeded alongside observations or as soon after observations as possible. Fieldnotes, which included observational records and personal impressions, were made while observing or soon afterwards. Receptionists and patients could opt out of being observed through a notice at the reception desk.

Interviews

There were three patient interview phases. The first was three interviews in Practice A, to develop the patient interview guide. The second phase, in Practice B, was a group of 12 people attending an 'open access' surgery. These short interviews of 10 to 30 minutes' duration explored reasons for consulting and experiences of making an appointment.

The third phase, comprising 23 long patient interviews, was conducted throughout all three practices. Six groups of patients were sampled: parents of children aged 16 years and under (three patients), patients between the ages of 16 and 65 years (six patients), patients over the age of 65 years (five patients), patients who complained about appointment making (three patients), patients who complimented the receptionists (three patients), and patients who waited for more than one hour in the waiting room (three patients). Patients were selected because they belonged primarily to one of these groups, although they could also be secondarily classified as belonging to one or more other groups. Interviews lasted 30 to 90 minutes. Six of these were joint interviews with other family members. Topics included: access to care, experiences of appointment-making, attitudes to receptionists, and experiences of waiting.

Patients were recruited to the first two phases from the waiting room. All were interviewed in the practices. Most patients for the third phase were recruited by telephone from the practice appointment record for that day. Five of these patients were recruited during observations. The third phase of interviews was conducted in patients' homes within five days of consulting. One patient chose a telephone interview.

Fifteen professionals from the three practices, including ten receptionists, two general practitioners, two practice managers, and a practice nurse, were also interviewed. Interviews lasted between 30 to 90 minutes and covered practice policies, appointment-making experiences, and attitudes to different groups of patients. A key informant was interviewed in each practice. All interviews were audiotaped and transcribed along with fieldnotes.

Sampling

The three practices were chosen by purposive sampling as they offered a range of practice cultures and settings for observing appointment making. Practice A was chosen first as it was single-handed. It is known that patients from small practices are more satisfied with service provision than patients from large group practices.[9] Practice B was selected next because it was 'medium-sized' and had an 'open access' surgery, where it was possible to interview people consulting 'urgently'. Preliminary analysis of data from Practice A had identified 'urgency' of consultation as an important issue. Practice C was chosen finally because it was a large organisation with a new nurse triage service. Observations and patient and professional interviews were chosen to illuminate areas of interest as analysis proceeded (theoretical sampling).[10] For example, conceptual coding of observational data from all three practices identified six groups of patients meriting further investigation by long interview.

Data analysis

Transcripts of observations and interviews were analysed using a grounded theory approach by making comparisons and by theoretical coding to identify concepts and categories of data[10] Concepts and their relations were accepted, changed or rejected during analysis by examining earlier data and during later data collection and analysis. Analysis proceeded alongside data collection. NUD*IST software was used to organise and search manuscripts.[11] Several approaches were used to enhance the quality of the research (Box 1).[12-15]

Results

Activity records and observations

Context of appointment making: diversity. A total of 228 appointment-related events were noted on the activity records. Seven types of appointment-related activity were identified: requests for 'routine', 'urgent' or 'emergency' appointments and for home visits, registering the patient's arrival for an appointment, changing a previously booked appointment, and telephone calls to resolve queries. Other activities visible at the reception desk included managing repeat prescription and other queries, dealing with visitors to the surgery, and social interactions between patients and receptionists.

Both larger practices had receptionists who specialised in appointment making. In contrast, receptionists in the small practice had several functions, including making appointments. Only in Practice A was it possible to record details of all telephone and reception appointment requests. For example, during six 30-minute periods of activity recording, 18 appointments were requested on the telephone and 16 at the reception counter.

The process: complexity. Seventy-eight appointment negoti-

Reliability
- Two periods of joint observation with an independent researcher, with comparisons and discussion of observations and conceptual coding.
- Where feasible, the facts and interpretation of observations were verified with the receptionist or patient as soon after they had occurred as possible.
- More weight was given to analysis of data about individuals or incidents that had been verified by more than one observation, or where observations had been supplemented by informal or formal interviews.
- Three experienced researchers compared coding and interpretation of three observations and three interviews.

Validity
- Responder validation: the interpretation of the data and preliminary analyses were discussed with key informants, three patients, three professionals, and other practice personnel.

Trustworthiness

Credibility
- Prolonged engagement in the field, persistent observation, triangulation of observations with the activity recording, interview data, and literature.
- Negative case analysis.
- Use of numeric data where appropriate.

Dependability and confirmability
- Reflexive journal

Box 1. Measures taken to enhance reliability, validity, and trustworthiness.

ations were observed and recorded in fieldnotes. Appointment-making has repetitive and ritualistic elements, such as receptionist greetings, appointment requests and offers, and appointment closure. Offers consist of offers of time, day, doctor, nurse, routine or urgent appointment. There may be multiple offers and refusals, until the patient accepts, declines, or is refused, an appointment. This process was dependent on availability of appointments, and patients' expectations of when they should be seen. The two larger practices had a 'house style' for opening and closing appointment negotiations, particularly on the telephone. This included the repetition of standard phrases.

All receptionists offered alternatives to an appointment to try and curtail doctor demand. These included refusing requests, deferring them to another day, deflecting or diverting requests to other services, offering telephone advice, or speaking to the doctor on behalf of the patient. Patients preferred speaking to receptionists who offered a menu of options for them to choose from.

We rarely observed discord. Most dissatisfaction at the reception counters were responses to lack of appointments, such as, 'I could be dead (by the time I get an appointment)!' or facial expressions indicating displeasure.

Interview content

Patient differences. All patients between the ages of 16 and 65 years (6/6) had experienced problems with accessing care. This confirmed findings from the short interviews of patients attending an 'open access' surgery. In contrast, most parents felt that they had good access to care (5/7) for their children. Again this confirmed earlier findings from the short interviews.

How quickly a patient wanted to be seen was usually contingent on the patient's or parent's assessment of the severity and urgency of the patient's condition. A 'minor' problem could wait, but a 'serious' problem merited an urgent appointment.

All bar one patient attending the open access clinic in Practice B (11/12) preferred seeing any doctor quickly to seeing their usual doctor.

Receptionists' views. Receptionists believed that older people 'deserve a different service'. Children were seen by some receptionists, and all patients, as vulnerable — 'You can't tell what's wrong with them' — and most deserving of appointments. Patients who test appointment rules, allocated patients, and people who did not wish to take time off work to attend, were viewed as particularly demanding.

Legitimising appointment requests. Legitimising patients' requests is the process by which receptionists allocate appointments according to practice rules and includes judgements about the genuineness of the person or the condition. Three strategies are used to legitimise appointment requests: enforcing practice rules, volunteering and requesting information, and asking patients to judge the urgency of their problem.

Enforcing practice rules. If the patient's request lies outside the usual parameters adopted by the practice then the practices rules may enforced. This was evident in observations and interviews. Usually this is by a statement such as 'You can't do that', or 'That's not the practice policy'.

Information requesting and giving. Some patients believe that giving the receptionist information about their condition provides evidence to legitimise their requests (4/23 long interviews).

> *'I think it* [giving information] *sort of backs my case up really. I feel I have got a reasonable request that I want to see the doctor. I am not wasting time, and I do want to be seen, and this is the reason why.'* (Patient interview 3.3, text unit 174, complimenter, Practice C.)

Four patients (long interviews) felt that this was acceptable, and seven felt it was unacceptable. Patients were more accepting of assessment by a nurse, who was thought to be 'more highly trained' than the receptionist.

> *'I explained everything to her, what was happening and she said, "Look, can you come down within the next half hour, and I will get you to see the doctor." Mind she was excellent. She understood.'* (Patient interview 3.17, text unit 145, parent, Practice B.)

Receptionists feel that asking patients for clinical information enables them to direct patients to alternative sources of help. In Practices B and C patients were asked to judge if the problem was 'urgent' or 'could wait'. The official policies were not to ask the patient about their problem, but most receptionists solicited information to inform decision-making. Receptionists did this by creating silences during phone or face-to-face consultations for the patient to fill with information. A discussion about the authenticity of the patient's problem might then ensue.

'If you can actually find out what [is wrong with the patient] *you can offer people other things. … If somebody said "I want my blood pressure checked" we would then say, "You don't need to see the doctor … We can give you an appointment with the nurse." Or if someone says, "I want to discuss my brother's cholesterol check … with the doctor, because I think mine will be high." We would say, "We have a dietician. You can see the dietician to discuss things like that". … We would not normally ask if there is no pressure. If there is no demand. And I am talking about urgent demand.'* (Receptionist interview 1, text units 145, 159, Practice A.)

'More often than not they will back off and give the patient the benefit of the doubt and I will see them. And certainly if it is elderly patients or if it's young patients. I will just accept that. I am not going to shout at them. … I think if you have beautifully managed appointment systems you often have disgruntled patients because the appointments system runs wonderfully for the practice but does not necessarily run particularly well for the patients.' (General practitioner 1, text unit 21, 22, Practice A.)

Other legitimising strategies. To overcome receptionist reluctance to give appointments, patients used strategies such as compromising; using advocates such as health visitors, chemists, and other doctors; and trying to create a dialogue with the receptionist.

'I am always willing to go halfway. I don't like having doctors come out because I don't like wasting their valuable time.' (Patient interview 3.11, text unit 132, parent, Practice B.)

'She [the health visitor] *works closely with this family with my little boy having so many medical conditions. … For instance, yesterday, if I couldn't get in to see the doctor with* [child's name] *'til Friday ... I would have automatically phoned the health visitor. … she is very interested, now that they have stopped open access, to see how long it is actually taking for appointments for children.'* (Patient interview 3.15, text unit 212, parent, Practice B.)

'… If my little boy was really bad with asthma or whatever I would just phone Casualty and ask for advice. And they would say you have the right to a doctor, you phone the doctor out. But as I say, I don't like phoning doctors out unless it is a total emergency.' (Patient interview 3.15, text unit 224, parent, Practice B.)

'… They say, "Well if you ring back at such and such a time I will have a word with the doctor or you can have a word with the doctor." They tend to find you alternatives if they cannot fit you in. (Patient interview 3.16, text units 138-139, parent, Practice A.)

Other strategies for obtaining appointments include alluding to one's social standing, being assertive, threatening to 'call the doctor out', and exaggerating their condition.

'You have got to be fairly straight to the point and badger them, if you like. Because if they can they will fob you off with two days', three days' time which basically isn't any good.' (Patient interview 3.7, text unit 50, aged 16-65, Practice C.)

'She turned round and said … "The nearest appointment we have got is on Wednesday." … I said, "That's no good to me. I am in pain. I have got to see the doctor today. … If not, I want the doctor out.' (Patient interview 3.5, text units 102-104, complainer, Practice C.)

'…If she's been sick once I'll say she's been sick about twice, three times. If they've got a temperature a little bit I will say they have got a canny temperature … and they will say, "Ah well, bring them down." (Patient interview 3.16, text unit 106, waiter, Practice A.)

Receptionist strategies included referrals to other professionals, using advocates (doctor or receptionist) and assertiveness. They also 'fit patients in', and reserve appointments for those that they think need to be seen soon. Most of these patient and receptionists strategies were observed as well as disclosed during interviews.

'So if they say it's not urgent then I do try and talk them into something else. I must admit I do. … if it can wait for another day or two I tend to try and weigh the situation up and try and fit them in then.' (Receptionist interview 4, text unit 62-72, Practice B.)

Discordant negotiations. In contrast to the observations, patient dissatisfaction with appointment making was a feature of the long interviews. Dissatisfied patients felt that receptionists did not acknowledge their requests or distress, and that their primary function is to 'get me off the phone', and 'protect the doctor'. This was most evident with requests for 'urgent' appointments.

'To save getting the emergency doctor out I waited until Monday morning, phoned the doctor at twenty to nine, they were open at half past eight. Reception comes on. I says, "I want an appointment to see the doctor." She says, "Well, the nearest appointment is on Wednesday." That's like three days to wait for an appointment. I says, "That's no good." … So I just blew my lid on it. … It's just the idea — I thought it was an emergency and they were going to try and make us wait.' (Patient interview 3.5, text unit 12, complainer, Practice C.)

Practice policies

Two practices had written appointment policies. These emphasised the organisational aspects of appointment making, and were not made available to patients. In two of the practices the receptionists, managers, and doctors shared responsibility for managing patient demand.

Discussion

Quality and rigour

Several strategies were used to enhance the reliability and

validity of the study (Box 1). Owing to theoretical sampling, there is a bias to selective observations and interpretations. This is inevitable, but joint observing with an experienced researcher highlighted similar experiences and concepts. Comparing coding of observations and interviews also revealed similarities and helpful differences in findings between researchers. Similarly, consulting widely with patients and professionals about our findings suggest that they are grounded in day-to-day practice.

Managing demand and access

Making an appointment is a complex social process. A satisfactory outcome for the patient and the practice depends on the interplay of many factors, including patient illness behaviour,[16] patients' expectations, receptionist actions and attitudes, appointment availability, and the process of negotiation (Figure 1).

Receptionists are the main controllers of access to care; however, patients participate in the negotiation with strategies aimed at increasing their chances of getting an appointment. Some patients do not understand or accept the criteria used for allocating appointments and dislike giving clinical information. These problems could be addressed by practices publishing, and displaying in the waiting room, guidelines for allocating appointments. Receptionists could also give people a choice about whether they wish to give information during appointment negotiations. This could be done by a specific verbal invitation by receptionists, where the patient is not penalised if they don't wish to elaborate on the context of their appointment request. A more patient-orientated approach to appointment making could foster a more equal partnership between patient and receptionist.[17,18]

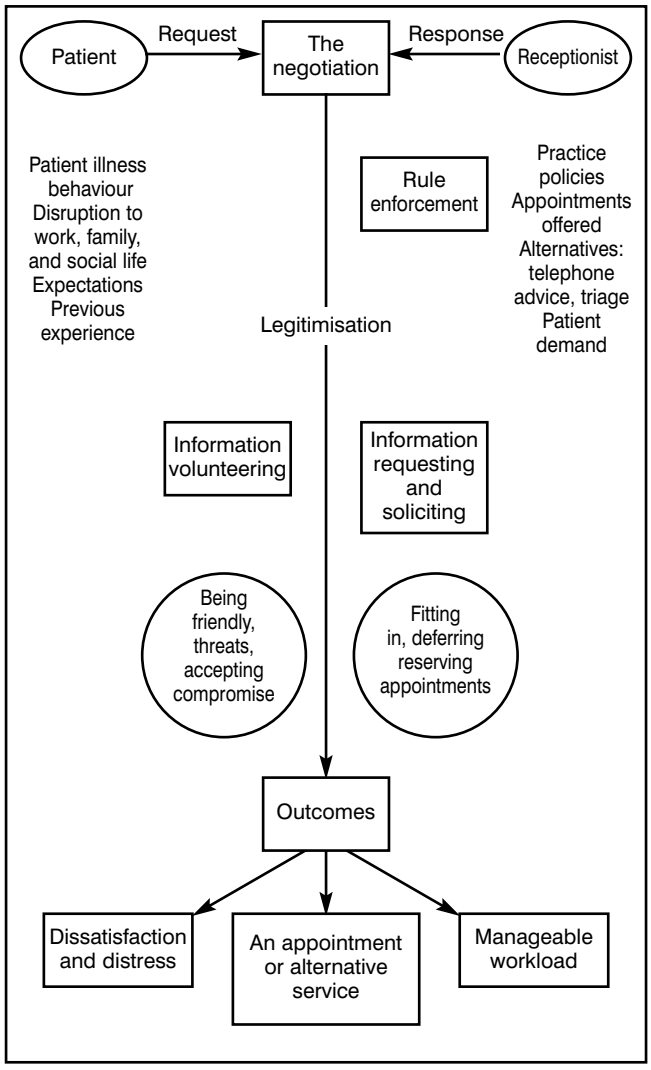

Figure 1. A model of appointment making in general practice.

There is considerable variability in what receptionists offer patients, even in the same practice.[8] There is also considerable evidence that receptionists covertly break practice rules by soliciting clinical information from patients when allocating appointments. Without this pragmatic and flexible approach receptionists could not effectively sort patients' requests to see the doctor or nurse.[19] It is an example of 'the principle that officials in contact with clients redefine abstract procedures in terms of the exigencies of the situation and the dominant objectives of their work.'[20]

Another important factor in making an appointment is appointment availability. Receptionists felt they had a daily struggle to make available appointments fit patient demand. This reflects reported sources of receptionist stress, such as difficult patients, pressure of work and appointment difficulties, with inadequate appointment systems being a major source of conflict between patients, receptionists, and doctors.[21]

Inappropriate demand

The relationship between need, supply (of health facilities), and demand (the expression of want) is complex and contested.[22] Of interest is the concept of 'inappropriate' demand from patients such as 'frequent attenders'.[22-23] This socially constructed medical judgement articulates doctors' negative feelings about patient behaviour.

In our study, receptionists, managers, and doctors labelled some groups of patients as consulting inappropriately. These were middle-aged people in employment, allocated patients, and patients unwilling to comply with practice rules on appointment making. These findings concur with previous research identifying 'ideal types' of patients who are preferable to manage and treat.[22-24]

Conclusion

Appointment making is a complex social process where outcomes are negotiated. The control of appointment making largely resides with receptionists influenced by practice policies and rules. Practices could make these polices available to patients, and be more open and explicit about how they manage appointment demand.

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