PRACTICE ORGANIZATION

Problems of urgent consultations within an appointment system

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SUMMARY. Patients for whom there is no appointment who ask to be seen on the same day can be a source of irritation. During March 1978, 214 of these patients were compared with 749 who made appointments. No evidence was found that such patients were abusing the system, and almost half were found to be children. It was concluded that these consultations were inevitable, but the attitude of the doctors to them may have been affecting their management. The system used produces some loss of personal care, the effects of which need to be studied further.

Introduction

IN 1976 over 70 per cent of doctors in the UK were supplied with appointment diaries by Lloyd-Hamol (Drury, 1977) and were presumably operating an appointments system. Within such a system various ways of coping with patients who cannot or will not make appointments have been used. Empty slots may be left for them during each surgery, they may be fitted in as soon as possible, given the next free appointment, or seen at the end of the surgery. Stevenson (1967) pointed out that five per cent of his patients were fitted in in this way, but did not identify them. Bevan and Draper (1967) found that the lower social classes and the 45 to 64-year age group were less likely to say that they always attended by appointment, and elderly people of low intelligence and the working classes were most often mentioned by doctors as those unable or unwilling to make appointments.

Aim

In this study I attempted to look at consultations without appointments in more detail to find out whether better arrangements could be made for these patients, or whether these consultations were inevitable and should be regarded as an important part of our work.

Method

Aldermoor Health Centre is a practice of 8,500 patients in an area of rapidly growing housing estates, run by five principals who each work approximately half time in the practice and half time as academic staff in the Department of Primary Medical Care. Patients are encouraged to identify with a single doctor, but this is not always practicable. Two trainees are appointed each year who rotate six monthly between Aldermoor and a neighbouring practice. During the study period I was the trainee in the other practice.

Highly structured problem-oriented records for all consultations are kept, so reliable data can be retrieved from past consultations, including negative information. In the health centre there is an appointments system for all surgeries, but patients who feel they should be seen the same day, and for whom there is no appointment available, are seen after morning and afternoon surgeries by the duty doctor. This is either one of the principals or the trainee, each of whom does this in turn. The patients, not the receptionist, make the decision whether or not they should be seen at the same session in this way, and though their decisions may be influenced by the state of the appointments book, they are not asked what is wrong. These patients are known as 'fit-ins', and there is a tendency to regard them as an irritation.

I therefore formed several hypotheses about the differences between fit-in consultations and ordinary surgery consultations:

1. That patients who requested fit-in consultations consulted more frequently than average.
2. That such patients would include more men of working age who found it convenient to be seen later.
3. That they received more certificates than patients making appointments.
4. That they did not have more urgent medical problems.

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'Urgent' is clearly a subjective description and it could be argued that any patient who says he needs to be seen the same day has by definition an urgent problem. I therefore had to look at this last hypothesis by asking questions about the fit-ins which were not directly related to subjective feelings of urgency by patient or doctor, but could be answered from the data available. These were:

1. Did they consult more often about new problems (as opposed to follow-up of old ones)?
2. Were they more often asked to return by the doctor (i.e., he didn't think the complaint was trivial)?
3. Were they more often given drug treatment?
4. Were they more often referred to hospital?

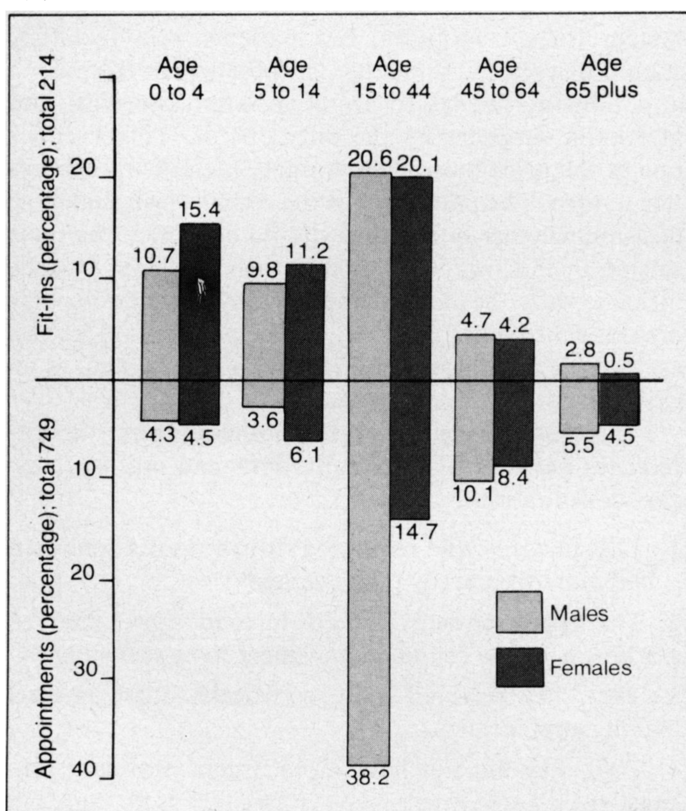
The answers to these questions were also affected by the doctors' attitudes to fit-in consultations. I tried to illustrate this with a limited study of prescribing.

During March 1978 the names and identification numbers of all fit-ins and ordinary appointments were recorded. Patients were excluded who had attended special clinics (e.g., contraception, hypertension) and surgeries arranged specially for undergraduate teaching. On a few days some lists were mislaid, and all patients seen on these days were also excluded. This left 214 fit-ins and 749 patients with appointments. The very high proportion of fit-ins is accounted for by the large number of special clinics run at Aldermoor and also by the fact that I studied a very busy month with an exceptionally large number of patients to be seen.

Fit-ins included a large excess of children, so I chose an age/sex matched group of 214 patients from the ordinary appointments for comparison. From the notes of these 214 matched pairs I then extracted data from the consultation in question, and also a consultation rate, calculated over the previous three years where possible. If the patient had been with the practice for less than one year no measure of consultation rate was made; if data on any point were missing from the notes, the equivalent information for the matched pair was excluded from the comparison.

Finally, to examine one aspect of doctors' attitudes, I looked at their use or non-use of drugs in fit-ins and appointments for some defined conditions. I selected, from the matched pairs, patients with a group of respiratory problems commonly assumed to be viral and self-limiting so that the likelihood of a doctor giving a medication might be dependent not only on the clinical problem, but also on his attitude to the consultation. The problem categories were: upper respiratory tract infection, respiratory tract infection, cough, cold, coryza, laryngitis, and tracheitis.

Figure 1. *Age and sex distribution of fit-ins and appointments.*



Results

Age and sex

Two hundred and fourteen patients who had not made appointments were compared with 749 patients with appointments (Figure 1). There was a large excess of children in the fit-in patients, most obviously in the 0 to four age group, but also in the five to 14 age group, with about half of the total aged under 15 years. There was no difference in the number of working-age men (aged 15 to 64) who were 24·3 per cent of the fit-ins and 23·1 per cent of the controls. The sex ratio of 462:287 females to males among the appointments was due to a large number of women in the reproductive age group (15 to 44) but the fit-in patients showed no difference between the sexes in this age group, and differences in other age groups were not significant.

Table 1. Characteristics of fit-ins and matched pairs.

	Fit-ins	Appoint-ments	Number of pairs	
Average consultations per year (over three years)	7.3	6.4	152	
Certificates	19	21	202	
New problems	155	100	201	$p<0.01$
Asked to return by doctor	26	47	197	$p<0.01$
Medication given	147	120	202	$p<0.01$
Referrals to hospital	9	10	202	

Consultation rate

One hundred and fifty-two matched pairs were compared (Table 1). (Information regarding consultation rate was absent for many newcomers to the practice.) There was no significant difference in consultation rate between the two groups. The average rates measured were of course higher than most reported annual consultation rates as they were a selected group of patients who had all attended the surgery at least once.

Certification

Two hundred and two matched pairs were compared (Table 1). There was no difference between the numbers of patients receiving certificates.

Urgency of problems

One hundred and ninety-seven or more matched pairs were compared (Table 1). There was a greater number of new problems (as opposed to follow-up of old ones) in the fit-in group, but they were asked to return less often by the doctor. They were more often given drug treatment, but the referral rates to hospital were similar.

Medication for minor respiratory illness

Doctors more often gave a medication to a patient with one of the chosen respiratory problems if he was a fit-in, but with the numbers available this could have been due to chance (Table 2).

Discussion

This study has been carried out in a practice which is unusual because of the doctors' other commitments. There is a tendency for patients to see different doctors for each illness in order to avoid waiting for an appointment, though in this rapidly growing area few patients have been registered for more than a few years. I personally believe this relative lack of identification with a doctor to be unfortunate, but it might be expected to reduce any differences between patients with an appointment and patients seen as fit-ins, as some of the appointments are with unknown doctors for new illnesses. The ratio of 214:749 fit-ins to appointments appears to show the appointments system to be at fault but I do not think this was so, for the reasons given above. There were no special clinics for children; however, many of them identify with one principal who is especially interested in paediatrics.

Table 2. Doctor's approach to upper respiratory problems.

	Medication	No medication	Total	
Fit-ins	30	6	36	Not
Appointments	14	9	23	significant

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It is apparent that at a less busy time of year, some of the fit-in patients would have been able to make appointments, so that there is a variable dividing line between the two groups. In spite of this, and the perhaps already diminished degree of personal care offered in the practice, it is interesting that some notable differences have emerged.

My initial hypotheses, which tended to regard fit-in patients as abusers of the system have, on the whole, not been proved. Fit-in patients did not consult more frequently and they did not include more men of working age or patients receiving certificates. The question about the urgency of their problem showed marked differences between the two groups but these are open to several interpretations.

First, there were more new problems reported in the fit-in patients. This may reflect a justifiable anxiety on the part of the patient or parent, but may also be related to doctors' attitudes; for example, it may be simpler at 18.00 hours on Friday for an unfamiliar doctor to manage a child's disturbing cough as a new problem rather than part of a long-term family problem.

Secondly, fewer fit-in patients were asked to return by the doctor. This does not necessarily deny the urgency of the problem since acute illnesses, especially in children, may often be dealt with in a single consultation. The fit-in patients were also shown to include a large excess of children instead of the extra women of reproductive age who were seen in ordinary surgeries. This is not surprising since children are a group in whom illness, and therefore anxiety about illness, is always more acute, parents requiring immediate reassurance.

Thirdly, the tendency of fit-in patients to receive more medication may reflect the urgency and severity of their complaints, but I suspect strongly that this was not the case, and that doctors were more likely to give a medication at a fit-in consultation because of their feeling about this work. I have tried to show this by comparing similar diagnoses, but the numbers were too small to show a statistically significant difference.

Conclusion

I conclude, therefore, that although consultations with patients seen the same day without appointments are different from others, there is no evidence that they are less useful or important. However, two problems have been raised. First, the results may be interpreted as showing that the irritation associated with these 'extra' consultations is affecting the management of the patients. This situation might be improved if doctors were agreed about the importance of this work; time could be made available as appropriate, and the irritation would thus be reduced.

Secondly, if these consultations were allocated to the duty doctor, instead of the personal doctor, which is likely to be the least irritating system for the doctors, there would be a certain further loss of personal medical

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care over and above that which is tending to occur in some group practices. The benefits of being treated when possible by one's own doctor have been much discussed but are difficult to prove. Before we pass more and more consultations to duty doctors and deputizing services, further work needs to be done on the effects of losing the personal aspect of primary medical care.

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Coronary bypass for stable angina

To evaluate the effects of coronary artery bypass, 100 patients with stable disabling angina were randomized to medical (49) or surgical (51) therapy. There was no statistical difference in major cardiac events after three years (death in five medical versus four surgical, infarction in eight versus 10, and unstable angina requiring operation or re-operation in eight versus three cases). Surgical patients with three vessel disease had fewer major events ($p<0\cdot05$) than the comparable medical group and less unstable angina requiring operation ($p<0\cdot02$). All unstable angina was less frequent in the surgical group (15 versus six, $p<0\cdot01$).

Functional classification improved more in surgical patients at six months ($p<0\cdot01$) and at late follow-up examination ($p<0\cdot05$). After six months, surgical patients achieved significantly higher exercise workloads ($p<0\cdot01$), exercise heart rates ($p<0\cdot05$), maximum paced heart rates ($p<0\cdot01$) and myocardial lactate extraction ($p<0\cdot01$).

On the basis of this interim report of a relatively small group of patients, we conclude that bypass results in greater functional improvement and less unstable angina than medical therapy. The likelihood of death and myocardial infarction is unchanged by operation.

Reference

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