

# Patient access to general practitioners by telephone: the doctor's view

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**SUMMARY.** *Few general practitioners have extensive daytime telephone contacts with patients. Forty nine general practitioners responding to a postal survey who reported handling a mean of nine or more calls a day were interviewed about their experiences. The nature of telephone contacts with patients and the organizational strategies employed to minimize disruption to surgeries were explored. Views on the rewards and frustrations of being accessible by telephone and its impact on other aspects of workload were also sought. Recommendations are made for practices contemplating extending telephone access for patients.*

**Keywords:** *telephone consultation; doctors' attitude; workload; access to GP; patterns of work.*

## Introduction

TELEPHONE consultations are a routine feature of primary care in many developed countries. They have been extensively studied and documented in North America where mean numbers of up to 23 calls a day for physicians have been reported.<sup>1-4</sup> In Scandinavia, Swedish health centres manage about 20 million telephone consultations a year (approximately three calls per person)<sup>5,6</sup> and Danish primary care physicians provide telephone advice under the terms of their contracts (Pederson P, personal communication).

In the United Kingdom, studies of telephone contacts have primarily related to out of hours calls.<sup>7-10</sup> Little has been reported on daytime contacts.<sup>11</sup> Surveys among patients indicate that they would welcome the opportunity to talk to their doctors by telephone but the majority have never tried to do so.<sup>12-14</sup> Anecdotal evidence has suggested that general practitioners in the UK discourage telephone approaches by patients. However, in a recent survey of general practitioners in England and Wales 97% said that they were prepared to accept daytime calls, although the mean daily number of calls was estimated to be only four.<sup>15</sup>

The interview survey reported here was conducted among the small minority of respondents to a previous survey<sup>15</sup> who received substantial numbers of calls. It explored the nature and content of calls, the organization of telephone access and the perceived rewards, frustrations and effect upon workload of extensive telephone contacts with patients.

## Method

A postal survey of telephone use in general practice was conducted among 1980 randomly selected general practitioners in England and Wales of whom 1459 (74%) responded after two reminders. One hundred and thirty five respondents reporting the highest rates of telephone contact with patients during surgery hours (nine or more calls) were identified. Nine regional

health authorities providing a broad balance between geographical areas were selected, and the 80 'high users' practising within them were invited to take part in interviews. The regional health authorities studied were northern, north western, West Midlands, Trent, East Anglia, Oxford, north west Thames, Wessex and south western.

A structured interview schedule was designed, based on development work and results from the original postal survey, group discussions and loosely structured pilot interviews. Interviews took approximately one hour to complete. To provide a focus, during the week prior to interview doctors were asked to record for all telephone contacts with patients: the time of the call, the relationship of the caller to the patient, the patient's age and sex, reasons for calling and the actions taken using a simple log book. The interviews took place between May and July 1990.

Log sheets were analysed at a basic level using the *SPSS-X* statistical package for the social sciences. Completed interview schedules were subjected to content analysis.

## Results

Of the 80 general practitioners selected, 49 (61%) agreed to be interviewed. Table 1 shows the characteristics of those selected for interview, those identified as high users of telephone consultations and the total respondent population from which they were drawn. Identified high users differed from the total respondent population in age, sex, years in practice and telephone access arrangements. Those interviewed were broadly representative of all high users except that they were more frequently located in rural areas.

### *Number of telephone contacts with patients*

Primarily as a result of recording telephone calls in the logbook, 13 general practitioners revised their previously estimated daily number of calls downwards (Table 2). In part, original overestimates were attributed to failing to allow for seasonal variations in the number of calls and to including calls relating to, but not with patients, such as statutory agencies seeking or conveying information.

### *Content of telephone calls*

**Assessing symptoms.** While 10 respondents estimated that only 20% or less of daytime telephone calls involved symptom descriptions, eight respondents estimated that 60% or more of calls did so. There was thus considerable variation. Symptoms were noted as the reason for 42% of day time calls in the logbook entries.

Three central themes in the management of such calls emerged. The first was the imprudence of offering telephone advice alone if any element of doubt existed, for example:

'We operate a fail-safe policy. It's got to be positively OK not to see the patient rather than positively necessary that you do see them.'

The second was the importance of prior knowledge of the patient, in order to distinguish those who minimized or exaggerated their symptoms from those whose accounts were generally reliable. Thirdly, if patients appeared at all unhappy with the

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**Table 1.** Characteristics of the general practitioners selected for interview, those reporting to be high users of telephone contacts and those responding to the postal survey.

Characteristics	% of GPs:			
	Selected			Responding to postal survey (n = 1459)
	Interviewed (n = 49)	Not interviewed (n = 31)	High users <sup>a</sup> (n = 135)	
<i>Age (years)</i>				
<35	10	6	11	20
35-44	37	32	37	36
45-54	31	35	30	24
55-64	14	26	19	17
65+	4	0	1	3
Unknown	4	0	1	1
<i>Sex</i>				
Male	92	90	89	80
Female	8	10	11	19
Unknown	0	0	0	1
<i>Years in current practice</i>				
< 5	8	10	11	22 <sup>b</sup>
5-9	27	23	23	22
10-19	37	35	40	30
20-29	16	19	17	15
30+	8	13	7	6
Unknown	4	0	1	4
<i>Practice area</i>				
Rural	20	10	13	12
Semi-rural	27	13	24	24
Suburban	22	29	24	27
Urban	22	35	28	28
Inner city	4	13	7	8
Other	0	0	1	1
Unknown	4	0	2	1
<i>Reserved time for patient telephone calls</i>				
Yes	29	26	24	20
No	71	74	76	80

n = number of GPs in group. <sup>a</sup>Respondents claiming to hold nine or more telephone consultations with patients during surgery hours per day. <sup>b</sup>106 respondents returned an abbreviated version of the questionnaire which did not include this question, percentages are therefore based on 1353 respondents.

**Table 2.** Revised estimates of the number of daily telephone contacts with patients among the 49 doctors interviewed.

Estimated no. of calls each day	No. (%) of GPs
5-6	8 (16)
7-8	5 (10)
9-10	20 (41)
11-12	8 (16)
13-14	1 (2)
15-16	4 (8)
17-18	0 (0)
19-20	0 (0)
21+	3 (6)

advice given, a face-to-face consultation would be offered. Thirty eight per cent of logged calls resulted in a face-to-face consultation.

Throughout, it was clear that management options were not a simple 'see or do not see' dichotomy. The telephone could be used as a holding device, with patients calling again if the problem did not improve. Decisions not to see patients were not irrevocable, and if face-to-face contacts were indicated, the urgency of these contacts could be assessed. Five respondents were loath to manage any symptom-related calls by telephone. While potential pitfalls were acknowledged, there was considerable agreement on what could be handled by telephone. Minor, self-limiting conditions, particularly those associated with the respiratory or digestive tracts, and recurrent conditions where neither doctor nor patient would benefit from face-to-face contact were widely quoted. Exacerbations in previously diagnosed chronic conditions, minor injuries and simple endemic or epidemic problems were also mentioned.

There was also wide agreement on particular symptoms and patients where telephone advice was inappropriate. Chest pain, abdominal pain, breathing difficulties, any illness in a young child or a new patient, non-traumatic bleeding and high fever were frequently quoted examples. However, no rule was without exception, for example:

'I would usually see chest pain, but even that's not immutable. Some chest pains of known origin and history might not need seeing.'

The nature, duration and severity of symptoms, the patient's age, past history and perceived reliability all played a part in the assessment process.

**Screening home visits.** Forty seven of the doctors were involved in assessing home visit requests. Nineteen of these doctors had a formal policy of being involved in the screening of all requests, estimating that they screened a mean of four calls a day. The other 28 doctors either screened requests which receptionists considered required professional assessment (one or two a day) or only urgent or trivial but insistent calls (one or two a week). Forty six doctors felt that this reduced the number of home visits made, although the level of reduction depended on the system involved, and on the general practitioners' attitude, which ranged from 'pressing patients quite strongly to attend' to 'preparing myself for what I might be facing'. Twenty per cent of calls entered into the logbook resulted in a home visit.

**Test results.** Telephone calls relating to test results also represented varying proportions of telephone contacts: 16 of the 49 doctors interviewed estimated no more than one call a day; none estimated three or more. Few practices had blanket policies for either types of tests or their results. As expressed by one general practitioner:

'The same test with the same result could be dealt with in three different ways, depending on the patient, their condition and their likely reaction'

Three general practitioners had a firm policy of no test results being given by anyone over the telephone. A further 10 instructed reception staff not to do so, but did so themselves when appropriate. However, their views on appropriateness varied. The remaining 36 allowed reception staff to give some results, but held differing opinions on which results receptionists could give. Eleven per cent of calls entered in the logbook related to test results.

**Prescribing by telephone.** A series of questions was asked about the relative frequency and circumstances in which new prescriptions for antibiotic, analgesic and tranquillizer drugs were issued by telephone. Recurrent problems in known patients were most

frequently cited as instances where antibiotic drugs might be prescribed. Of 105 examples given, 63 contained the word 'recurrent'. Only 10 of the general practitioners interviewed said that they prescribed antibiotic drugs by telephone 'very frequently' or 'fairly frequently'.

A similar pattern was evident in prescribing analgesic drugs, although the range of examples cited was more circumscribed and the word 'recurrent' less prominent. Musculoskeletal complaints, particularly back pain, and trauma including musculoskeletal injuries accounted for 49 of 71 specific examples given. Several doctors stressed that only mild analgesic drugs in small quantities would be prescribed by telephone.

Prescribing tranquillizer drugs by telephone was rare. Twenty six general practitioners said they would 'never' do it, 19 did so 'only in exceptional circumstances' and the remaining four 'fairly infrequently'. Comments indicated some discomfort, for example, 'I would like to say never, but...' and 'We all know we shouldn't, but...'

The majority of those interviewed (36) did not consider prescribing played an important part in telephone consultations with patients. Only three saw themselves as 'very frequent' prescribers over the telephone overall. Eight said prescribing happened 'only in exceptional circumstances' or 'never'. Sixteen per cent of calls recorded in the logbook resulted in a prescription.

### *Doctors telephoning patients*

Calls initiated by the doctor to a patient were relatively rare. Only nine general practitioners estimated that they made in excess of three calls a day to patients; conversely, 20 said they made, on average, less than one. The main reason doctors telephoned patients was to convey a test result (particularly where it was unexpected), where immediate follow up was indicated, or where they could alleviate a patient's anxiety. There was disagreement about whether the telephone was a suitable medium for bad news. Two comments were indicative of opposing views:

'I'd rather phone than write..., letters have an air of doom, however carefully worded'

'It's nearly always reassurance..., I wouldn't ever telephone with bad news.'

Calls to patients prompted concerns among half of the respondents about confidentiality, unnecessarily alarming patients and increasing workload. However, the great majority believed that patients reacted favourably to receiving a telephone call.

### *Characteristics of callers*

It was widely believed that women and young adult patients were more likely to telephone than men and patients in other age groups. These two characteristics were linked by the role of younger women as family carers. Women were recognized as more frequent users of all services. Three doctors believed that elderly people called more frequently than other groups. Slightly more than half of the general practitioners saw no difference between patients of different social classes, but 19 of the 22 who did thought that patients in higher social classes were more frequent telephone callers. These patients were thought to be more confident, more articulate and more anxious about health problems.

The entries in the logbooks revealed that 52% of calls involved a third party. These 'surrogate' consultations included parents, spouses or other carers calling on behalf of the patient. Many doctors had not previously recognized the extent of these sur-

rogate contacts. Twenty per cent of all calls entered in the logbooks related to children of 16 years or younger and 27% to patients aged 65 years or more.

### *Timing and organization of telephone calls*

Two thirds of the doctors interviewed said that they did not generally accept calls while consulting in the surgery. Patients who telephoned would normally be asked to telephone again after surgery had finished. Only five respondents regularly returned patients' calls themselves.

On the postal questionnaire, 14 respondents had reported routinely setting aside time for patients' telephone calls. At interview, 17 claimed to do so. Since time set aside was usually at the end of a surgery, the distinction between reserving time and deferring inconvenient calls was not clear-cut. Doctors who claimed to reserve time variously estimated that less than a quarter and more than three quarters of telephone calls fell within that period, dependent in part upon what efforts were made to dissuade callers at other times.

Six of the doctors who did not reserve time for patients' telephone calls were considering doing so, but the remainder thought it impractical. They foresaw problems in predicting surgery length, potential congestion of telephone lines, possible time wasted if too few patients called then, and patients' unwillingness to accept restrictions on timing. Several suggested that restricting access might endanger patients.

Respondents who reserved time for patients' telephone calls either did not view these issues as problematic or had developed strategies to overcome them. These included selectively accepting calls outside reserved periods, referring calls to partners when surgeries ran late and, in one practice, referring all calls during morning surgeries to the previous night's on-call doctor who had no morning surgery. In another practice partners rotated responsibility for handling calls received after the reserved time. Two doctors described systems which combined flexibility in timing with convenience to patients and reduced telephone congestion. One doctor had bookable telephone appointments at the end of each regular surgery; another returned all patients' calls at an approximate, prearranged time on a line used for outgoing calls only.

Doctors who reserved time for patients' telephone calls were more likely than those who did not to publicize the availability of this service in practice leaflets. Despite references to the medico-legal aspects of telephone communication, few of the general practitioners interviewed routinely recorded telephone contacts with patients. Only three kept a personal log of all calls, and a further 12 had systems for routinely entering the call in a patient's records.

### *Perceived frustrations and rewards of telephone contacts with patients*

Over half (26) of the general practitioners interviewed felt that disruptions to surgery consultations from telephone calls were a source of frustration. The ringing tone of the telephone was intrusive and took priority over attending patients, who were occasionally required to leave the room for reasons of confidentiality. Although nearly all respondents reported that a few patients abused telephone access, patients telephoning frequently about 'trivial problems which don't warrant a doctor's attention' were not seen as a major problem, and most doctors adopted a philosophical attitude:

'You grin and bear it. They also make unnecessary surgery appointments.'

Thirty respondents described the rewards of telephone calls with patients in terms of relationships and their own feelings, exemplified by one quote:

'I like to feel I'm available. I think I have a good relationship with my patients and I think that part of it is they know I'm available at the end of the phone.'

Five doctors adopted a neutral stance, as expressed by one doctor:

'...it's just a tool, like pen and ink. We couldn't cope without it, but it's not rewarding or frustrating, just necessary.'

Opinions about the impact of telephone work on stress levels and overall workload were divided: perceived reductions in some aspects of workload and reassurance that situations were under control reduced stress while it was increased by disruption to surgeries and doubts about telephone assessments. While most believed that telephone work reduced home visiting rates, particularly where they screened all requests, only half believed it reduced the number of surgery consultations. General practitioners found it difficult to assess the overall effect of telephone access on workload. While only eight doctors stated that it increased workload and 10 that it reduced it, the remainder were either unable to form an opinion or believed that it had no effect.

## Discussion

Telephone communication as a substitute for face-to-face consultation is a contentious issue. However, not all transactions between patient and doctor require personal attendance and telephone conversations do not preclude later face-to-face contact. The majority of incoming calls represent a conscious decision by the patient to at least begin an interaction at that level. If they and the doctor are also happy to terminate it at that level, there may be little cause for concern.

Interviews with doctors who already use the telephone extensively (more than nine telephone calls with patients each day) suggest that net savings in consultation time may be less than supposed. Telephone conversations which result in a face-to-face contact represent a net increase in contact time. If telephone access also encourages contacts which would not otherwise have taken place at all, this too will increase time spent. Both situations offset time saved on unnecessary home visits and surgery appointments.

Doctor time is not, of course, the only or necessarily the main criterion by which telephone use should be judged. The majority of those interviewed felt that being accessible by telephone led to a closer relationship with patients. It provided the opportunity to respond rapidly to problems, and represented an important management tool.

Disruptions to surgeries caused by incoming calls are a problem. Reserving a specific period of time for non-emergency calls can reduce interruptions, but greater publicity and patient education will be needed to achieve maximum benefit. Bookable telephone appointments demand considerable commitment on the doctor's part. The practice of doctors returning patients' calls offers greater flexibility, but has cost implications for the practice. A rota of telephone duty for doctors (with or without reduced surgery commitments) may be feasible only in larger partnerships.

The degree of consensus which exists on the type of patients and problems normally suitable for telephone advice alone suggests that guidelines on safe practices could be drawn. Immutable rules could not be laid down since too many factors determine appropriate responses. The importance attached to prior per-

sonal knowledge of the caller suggests that doctors new to a practice or practices with high patient turnover will experience greater difficulty in handling symptom-related calls.

It would be naive to suggest that every telephone contact merits a full or even partial entry in the patient's medical records, but greater emphasis on documentation may be indicated.<sup>16</sup> Finally, while policies on handling test results by telephone are often deliberately flexible, differences between practices may be wide enough to warrant further attention.

In summary, practices contemplating extending telephone access to patients should first consider their motives for doing so. If the prime objective is to save surgery consultation time, this strategy may be less effective than supposed. Permitting ad hoc access may lead to unacceptably frequent interruptions to surgery consultations. An organized, well-publicized system of access will minimize these. Prudence dictates that any such system includes a convenient method of documenting calls when appropriate. In the absence of more widely agreed criteria, practices may wish to consider drawing up their own guidelines.

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