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Patient burden during appointment-making telephone calls to GP practices

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ABSTRACT

Objective: This study addresses, for the first time, the effectiveness of receptionists handling incoming calls from patients to access General Practice services.
Methods: It is a large-scale qualitative study of three services in the UK. Using conversation analysis, we identified the issue of 'patient burden', which we defined based on the trouble patients display pursuing service. We quantified instances of 'patient burden' using a coding scheme.
Results: We demonstrate how 'patient burden' unfolds in two phases of the telephone calls: (i) following an initial rejection of a patient's request; and (ii) following a receptionist's initiation of call closing. Our quantitative analysis shows that the three GP services differ in the frequency of 'patient burden' and reveals a correlation between the proportion of 'patient burden' and independent national satisfaction scores for these surgeries.
Conclusion: Unlike post-hoc surveys, our analysis of live calls identifies the communicative practices which may constitute patient (dis)satisfaction.
Practice implications: Through establishing what receptionists handle well or less well in encounters with patients, we propose ways of improving such encounters through training or other forms of intervention.
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1. Introduction

The proportion of patients for whom the appointment-making process is satisfactory varies considerably between General Practice (GP) services. For example, the UK GP Patient Survey (of January 2015; https://gp-patient.co.uk) shows that the proportion of patients rating their experience of making an appointment as either 'fairly good' or 'very good' ranges from 22% to 100%, with a national average of 74%. One risk for GP services with low scores is that patients remove themselves from GP lists and register elsewhere. Poor experiences of appointment-making can also result in costly, or even dangerous, health outcomes, such as patients visiting Accident and Emergency rather than their GP [1,2]. It is for these reasons that building an understanding of how patient access works is a pressing issue in primary care. But while some GP services perform better than others on patient surveys, we know little about *what* makes the difference between these services, and *how* these differences might affect patients' access to, experience of, and satisfaction with, their GP service.

The paper analyses phone-calls from patients to their GP service, to make an appointment or an enquiry (e.g., regarding test results). We focus on the way receptionists meet patients' requests, and how the interaction progresses when something stands in the way of meeting the request. Given the importance of GP receptionists in facilitating patients' access to primary care, there is surprisingly little research on their interactions with patients [3–7]. Studies on patient-receptionist encounters are often reflective of, or responding to, the stereotype of receptionists as 'dragons' or as 'gatekeepers' that is prominent in media discourse. Some academic research supports this notion by highlighting receptionists' strong intermediary role in their everyday dealing with patients [8,9]. But most studies draw a more nuanced picture, suggesting that particular complexities and constraints in the receptionists' job affect their ability to facilitate patient access [3,6,10]. While such complexities may affect patient outcomes, in this paper we are interested in such factors only in as far as they become relevant for meeting requests. For example, if a requested doctor is not available, an account and/or alternative action might be relevant *for the patient*, and the primary question in this report is *how* this is done, in order to identify *what* makes some interactions

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(and GP services) more effective than others in dealing with patient access.

Hewitt et al. [7,11,12] explored discourse practices that influence the quality of service received by patients at the front desk from GP surgeries in the UK. They found that receptionists who maintain a narrow focus on the task at hand, while ignoring patient comments and apologies, were less effective in meeting the patients' needs than receptionists with more patient-centred orientations. Hewitt et al.'s [7,11,12] work is, to the best of our knowledge, the only study of patient care that also analyses real-time interaction, but in face-to-face encounters rather than in initial telephone calls (see also [13,14]). The majority of quality-of-service studies within patient care are based on surveys, self-reports and/or focus groups [9,15]. The disadvantage of such methods is that they fail to explain how and when problems occur in encounters, and therefore we do not know *what* needs improving or *how* to improve. We also know that practice staff struggle to identify and action changes based on survey feedback alone [16]. This paper follows a growing body of research that demonstrates how evidence *endogenous* to interactions provides novel insights into how communication works, which can then inform training and interventions [17,18], which has been reported as near absent for GP receptionists [3]. The paper therefore identifies some key indicators of (in)effective patient care, and provides an evidence base from which to develop interventions that are relatively cheap and do not require large-scale organisational changes.

2. Methods

The dataset comprises recorded incoming telephone calls from patients to three General Practice surgeries in the UK, totalling 2780 calls. The recordings were anonymized digitally, in line with standard ethical practice when using recorded conversational data [19]. Consent was granted by the NHS for our evaluation of the data. 1555 of the calls were transcribed verbatim and 447 of these were coded by the authors for numerous nominal categories. All of the transcripts containing target sequences were transcribed using the Jefferson [20] system for conversation analysis, which encodes prosodic, pacing and other phonetic information about the way talk is delivered. A glossary of transcription conventions is included in Appendix A. The data were analysed using conversation analysis (CA [21,22]). CA starts by repeatedly viewing or listening to recorded data, with the technical transcript. It proceeds to analyse systematically the activities that comprise the complete interaction; the way those activities are designed and how different designs lead to different outcomes. CA proceeds by exposing participants' tacit understanding of each preceding turn and of the action it comprised, rather than from analysts' a priori interpretations of what is happening [23].

We focused on instances where patients pursue service/call progress. In some cases, patients display trouble by (i) demonstrably awaiting a relevant next action from the receptionist, and (ii) in its absence pursue the relevant next action themselves. Patients display a struggle in pursuing the relevant next action themselves, through, for example, self-repair or hesitation. We labelled these cases as instances of 'patient burden'; that is, it is the patient that has to push for service, rather than the receptionist offering it to them. We excluded cases where, although one might judge a relevant next action from the receptionist as absent, the patient did not demonstrably struggle to deal with this absence. We illustrate this distinction through our examples of successful (no burden) and less successful (burden) practice below.

We calculated the inter-rate reliability score using the Kappa score for nominal scores [24]. With Kappa scores varying between 0.69 and 0.95 and an overall score of 0.78, which is near the 'perfect agreement score' of 0.81–1 [24], we regarded our coding as reliable. We compared our quantification of 'patient burden' with satisfactions scores from the same three surgeries found in the GP Patient Survey run on behalf of NHS England (https://gp-patient.co.uk). We used the January 2015 survey because of its temporal proximity to the data collection. We chose "X% describe their experience of making an appointment as good" and "X% find the receptionist at this surgery helpful" as the most relevant for comparison in our study.

3. Results

The analysis is divided into four sections: in Sections 3.1 and 3.2 we summarise the phenomenon of patient burden in two phases of the calls; in Section 3.3 we summarise our quantitative findings, and in Section 3.4 we provide instances of successful practice,

Table 1a
GP3-14: receptionist offers no alternative after non-granting.

GP3-14: Receptionist offers no alternative after non-granting

```
1     R:    >Good< mornin:g, surgery: Cath speaking,
2               (1.6)
3     P:    Hello have you got an appointment for
4           Frida:y afternoon or teatime please.
5               (0.4)
6     R:    ↑This Friday.
7               (1.1)
8     P:    Yeah,
9     R:    Uh I'm sorry we're fully booked on Friday.
10              (1.6)
11    P:    Right.
12              (0.3)
13    R:    (°(     ) fully booked.°)
14    P:    Okay,
15              (0.3)
16    R:    Okay.
17              (0.4)
18    P:    Yeah, #uh:-#=o↑kay, [uhm,]
19    R:                        [Than]k yo[u:]
20    P:                                  [Is] it worth me
21          ringing Flaxton.
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