Access to general practice: a qualitative study of appointment making in general practice

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Abstract

The aim of this thesis was to observe appointment negotiations in general practice, and investigate patients' and receptionists' experiences of appointment making. Improving access to health care is a National Health Service priority. These priorities are manifest when patients' request an appointment to see their GP.

This study was conducted in three general practices on Tyneside: a single-handed practice; a three doctor practice; and a seven-doctor practice. Two methods were used, participant observation, consisting of observing and recording practice activities and observations with informal interviews, and long interviews with patients and professionals.

Activity recordings and observations were conducted in waiting rooms, behind reception counters, and in other settings. There were 35 activity recordings and 34 periods of observation. Thirty-eight patients and 15 professionals were interviewed. Participants were selected by theoretical sampling. These included 12 short interviews with patients attending an 'open access' surgery. Six groups of patients (23) and 15 professionals were selected for long interview. These included patients who complained about appointment making or who complimented the receptionists.

Transcripts of observations and interviews were analysed by theoretical coding and data display to identify concepts and categories of data. Several methods were used to enhance the research's quality.

Outcomes from appointment negotiations are influenced by patient's illness behaviour, the process of negotiation, and appointment availability.

Appointment requests are legitimised by receptionists enforcing practice rules and requesting clinical information. Receptionists also work outside 'official' practice rules to manage limited appointment availability. These strategies include 'fitting patients in,' reserving appointments, referring to other professionals and using advocates to support their actions. Patients volunteer

information to provide evidence that their complaint is appropriate, and employ strategies, such as assertiveness, and threats, to try and obtain appointments.

Receptionists have a crucial role in managing patient access that remains unacknowledged by policy makers.

CONTENTS

FIGURES

TABLES

Acknowledgements

I would like to thank the patients and professionals who contributed to this study. The practices made me welcome in observing their work.

My biggest thanks go to my wife Janet and my children Rosemary, Wendy, Peter and Joshua, for their support and tolerance, and my partners at Central Surgery for allowing me to spend time out of the practice. I also thank God and several members of the Kelvin Grove Fellowship for help and support during the conduct of the thesis.

My excellent supervisors Dr Pauline Pearson and Prof Chris Drinkwater, together with fellow postgraduates and researchers at the Department of Primary Care in Newcastle, gave invaluable advice and support.

I conceived and designed the study, conducted all activity recordings, most observations, and all interviews, analysed the data, and wrote the thesis. Dr Pauline Pearson advised on methodologies, analysed samples of the data, including comparing coding of three observations and three interviews, and contributed to the ideas in the thesis. Prof. Chris Drinkwater assisted me to develop the initial proposal, contributed to the analysis and interpretation of the results, and contributed to the ideas in the thesis. Mrs. Joy Guy conducted joint observations with me, coded and analysed these observations, and contributed to ideas in the thesis. Mrs. Val Elsey compared the coding of three initial observations and three interviews with me and Dr Pearson. Clare Tagg of Tagg Oram Partnership provided advice on early coding, data management and NUD*IST use. Clare Ward transcribed all field notes and interviews. Mrs. Maureen Duffy, Librarian at the Postgraduate Centre at South Tyneside Hospital Trust tracked down most of the obscure references. Several professionals and patients commented on ideas in the research and the research papers. Dr Angela Malone and Mr David Crellin proof-read the final draft, although any remaining mistakes are my own.

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Chapter 1 : Introduction

"In 10 years time, you will be as likely to use NHS Direct, the Internet or digital TV as your first port of call for entry into the NHS as to nip down to the local GP surgery." Alan Milburn, Secretary of State for Health (Grice 2000).

1.1 Aims

The aims of my thesis are rooted in observations I made as a patient while waiting to see my own GP. I realised that appointment negotiations were an important part of accessing general practice care. I also knew that very little research examined patient – receptionist negotiations and relations. The **main aim** of my thesis was therefore ***to explore the dynamics of the patient-receptionist negotiations when making an appointment*** to see the doctor or nurse. I also wanted to discover the influence of practice policy on appointment making.

As my fieldwork progressed I realised that it was impossible to treat the negotiation as an isolated phenomenon. I decided to investigate two related areas, illness behaviour and the practice culture, particularly as they relate to appointment making. This was essential to provide the context in which appointment making could be examined. The first of these new aims was to investigate the journey that patients make from having symptoms to contacting the general practice. The second of these additional aims was to explore practices' attitudes, rules and norms associated with appointment systems and service provision.

The rest of this chapter examines how my thesis began and evolved, I outline the principles behind the methods chosen, my conceptual framework, research objectives and summarise the research timetable.

1.2 Background to the thesis

A key process in accessing health care is obtaining an appointment to see the doctor. The purpose of this study was to observe and investigate patients' and receptionists' experiences of appointment negotiations in general practice.

1.2.1 Policy and cultural context of the research

The original purpose of the NHS was to make health services accessible (available) to the whole population on the basis of need and regardless of people's ability to pay (Campbell 1998). In the 1950's general practice was mainly a 'cottage industry' of isolated doctors working from their own homes supported by the doctor's wife (Arber and Sawyer 1981). Political and administrative changes such as the GP Charter of 1966 encouraged the employment of ancillary staff including receptionists (Cartwright and Anderson 1981). In the late 1960s and early 1970s the Government and British Medical Association (BMA) also encouraged and supported the growth of health centres and group practices (Arber and Sawyer 1981). It was assumed that these changes were good for doctors and patients, but the growth in partnerships had deleterious effects on accessibility of care and the doctor patient relationship (Arber and Sawyer 1981).

Improving patient access to health care and managing patient demand remain National Health Service (NHS) priorities (Mihill 2000). General practice is an important interface between self-care and care provided by health care professionals, such as general practitioners. As such it is influenced by patients' decisions about health and illness and accessing services (Rogers et al. 1999). Socio-economic factors such as distance of a surgery from the patient and availability of transport affects the ability of the patient to visit the doctor.

Recent debate and action in the NHS have embraced ideas of demand management and improving access. Examples of this include NHS Direct, the government's telephone advice line for patients, and 'advanced access,' which attempts to improve general practice access by matching general practice appointment demand with supply (Murray 2000).

1.2.2 Access by appointment

Alongside the growth of receptionists and group practices in the 1960s and early 1970s was an increase in appointment systems (Cartwright 1967; Cartwright and Anderson 1981). Cartwright showed that the majority of patients preferred these arrangements, although Arber found that an appointment system made it more difficult for a quarter of patients to be seen urgently (Arber and Sawyer 1982). There was also substantial

evidence that people from lower social classes and the elderly were less able to negotiate appointments by 'persuasive appeals' particularly for home visits or urgent requests (Arber and Sawyer 1981).

In the last decade research into general practice appointment systems continues to evaluate patient experiences, and professional attempts to improve access and flexibility. Patient satisfaction was shown to be related to practice list size and the number of patients seen as 'extras' (Campbell 1994). Several strategies have been used by general practices to provide more flexible appointment systems. These include 'open access' surgeries and reserving some un-booked appointments to cater for urgent patients or 'extras' (Kendrick and Kerry 1999; Smith 1997). Changing appointment length has also been shown to produce a better 'fit' between supply and demand, but with a loss of flexibility for 'extras' (Campbell 1992).

Receptionists are key personnel in managing appointment access and demand. In the late 1970s Arber examined a representative sample of interviews of 1,000 patients' experiences of the reception process (Arber and Sawyer 1985). She argued that receptionists have a powerful 'discretionary' role in determining patient access to care. They act as gatekeeper to care. The result of this discretionary use of power by receptionists is that nearly 40 per cent of patients experienced negative interactions with receptionists. This study is important because of the large sample of patients' experiences, and her conception of the receptionist as "a dragon behind the desk" which pervades public and professional consciousness about the receptionist role (Arber and Sawyer 1985).

The other large body of research into patients' views about accessing general practice is Cartwright's two studies of general practice (Cartwright 1967; Cartwright and Anderson 1981). In her second study, where 836 patients were interviewed, she presents a positive picture of patient-receptionist relations where the majority of patients found the receptionist helpful (Cartwright and Anderson 1981). She identified, however, that when the receptionist asked the patient why they wanted an appointment this resulted in patient anxiety and antagonism towards the receptionist, and seemed to discourage the patient from consulting their doctor. More recently, a survey of 119 receptionists showed that that they derive most satisfaction from their relationships with patients, rather than with professionals (Eisner and Britten 1999).

At the time this research was conceived (1997) little research had been conducted examining patient-receptionist interactions when making appointments, and using observation as a research method. There was also no debate about the role of receptionists in managing access and demand.

1.3 Definitions

I define **general practice** as the part of primary care characterised by doctors, nurses, managers, receptionists, administrators, and increasingly other professionals working in consort to plan and provide an initial health care response to patients.

A receptionist is a person employed by a general practitioner to act as a 'go between' for patients with medical and nursing staff. They have a role in making appointments, filing records and other administrative activities.

Primary care is formal care provided by organisations such as general practice, primary health care teams, pharmacists and other practitioners to patients. Other commentators include self-care and informal care under the heading of primary care on the basis that these are also 'first line' measures used by patients when responding to illness (Rogers et al. 1999).

Access is the process by which health care is obtained. It is directional and usually implies a person travelling to see a professional, but also describes patients accessing help from other patients, as in self-help groups, professionals accessing patients' views, and accessing information (Pencheon 1999).

Demand "is the expression of want" - for health care (Pencheon 1997).

Need is a related concept that can be defined as "a problem for which there is an intervention that is "effective" i.e. that works" (Pencheon 1997).

Informal and self-care is where "ordinary people become providers of health care" (Rogers et al. 1998). People use their experience of caring for themselves and their social networks to acquire health advice and support, as an alternative to professional health care or as a supplement to it.

1.4 Thesis beginnings

In 1998 I became the leader of a Northern and Yorkshire Research general practice, funded by the NHS and overseen by the Northern Primary Care Research Network (NoReN). This provided protected time over four years to plan and conduct my doctoral research. During this time I also completed research examining telephone access to general practice.

I am a general practitioner working in an urban practice of over 11,000 patients. My interest in managing general practice patient demand began in 1995 when one of my partners was ill. We could not find a locum doctor and felt stressed by patient demand. I suggested developing nurse telephone triage. This halved doctor workload for patients wishing to see the doctor the same day (Gallagher 1998; Gallagher et al. 1998a; Gallagher et al. 1998b; Gallagher et al. 1998c). It won the NatWest/Doctor award for innovation in general practice in 1997. I also became responsible in my practice for examining tactics for managing workload.

A more general interest in managing need and demand in general practice was stimulated by subscribing to the GP-UK Internet discussion site in 1996 and 1997. A search of comments posted to the site archive using the key words, *consultations, extras, urgent and same day consultations*, showed that general practitioners had negative attitudes to managing patient demand, especially 'extras.' This unpublished research convinced me that demand management was an important issue for general practitioners.

I developed several potential ideas for my research. For example, I became interested in the characteristics of the 'extra patient', and also thought about doing a survey of local practices examining methods used to manage patient demand. Eventually I settled on what I felt was a neglected area of demand management, the interaction between patients and receptionists when negotiating an appointment. I was interested in whether things had changed since the seminal works of Cartwright and Arber.

My ideas were developed in discussion with my supervisors Prof Chris Drinkwater, Professor of Primary Care Development, University of Northumbria, and Dr Pauline Pearson, Head of Department, Department of Primary Care, University of Newcastle upon Tyne. Prof Drinkwater has considerable experience in developing and evaluating primary care services. Dr Pearson is an experienced nursing and primary care

researcher, with a particular interest in qualitative research methods. Their support and direction was crucial in the planning and conduct of the research.

1.5 Methods - principles and choices

Several methods have been used to examine appointment making and the role of receptionists. These include using structured interview schedules, and surveys of patients and professionals. A new departure in researching receptionist work in a general practice setting came in 1989 when Freeman observed receptionists making appointments (Freeman 1989). The focus of the observations was on how receptionists maintained continuity of doctor care. This involved the use of observation and counting as a research method, rather than trusting only to patient and professional accounts. Freeman did not, however, observe *patients*.

All research operates within assumed or explicit principles about the nature of reality (ontology), the relationship between the researcher and the observed (epistemology), and methods. Historically in medicine the emphasis has been on quantification. This is exemplified by research to prove or disprove a hypothesis by using mathematical formulations. This is seen as 'hard' research which is more valid and truthful than 'soft' research, such as qualitative research, which is viewed as personal, intuitive and lacking in rigor.

There are three main paradigms that influence research; positivism, constructivism, and critical theory or inquiry. The first is concerned with verifying or disproving hypotheses to establish facts or probable facts, where knowledge is cumulative and quality is judged by notions such as internal and external validity, reliability and objectivity (Guba and Lincoln 1998). The constructivist philosophy assumes that what is real is constructed in the minds of individuals (Lincoln and Guba 1985). There are multiple potential constructions, all of which are meaningful, and "truth is a matter of the best informed and most sophisticated construction on which there is consensus at a given time" (Schwandt 1998). Constructivists judge quality in terms of concepts such as trustworthiness and authenticity (Guba and Lincoln 1998). Critical enquiry focuses on issues of domination, distribution of power, and inequalities (Crabtree and Miller 1999).

In this climate of conflicting views about the nature of research it is possible to conclude, particularly in a post-modern world, that it is impossible to determine the truth with any certainty (Hodgkin 1996). Some practitioners, however, strongly defend the 'scientific medical heritage' (Harrison 1997). Seale advocates a pragmatic 'middle-way' between the extremes of positivism and constructivism (Seale 1999). His approach accepts that social research is a "collection of craft skills driven by practical and local concerns," where competing philosophical debates are used as resources for creative research enquiry (Seale 1999).

Like Huberman and Miles, I think that, "...social phenomena exist not only in the mind but also in the objective world - and some lawful, reasonably stable relationships are to be found among them." (Huberman and Miles 1998). This lawfulness is demonstrated in the sequences and regularity that we identify in social phenomena. It is these regularities that allow different researchers to view and judge research when these regularities, and the concepts that are derived from them, are detailed.

I use ideas from positivistic traditions and more contemporary research where I believe they provide useful insights into planning, conducting and interpreting my research. For example, I have used the positivistic notion of reliability as a technique to improve and monitor the quality of data analysis. Elsewhere, I have used so called, "thick descriptions" of the research findings so that the reader can better understand and judge the research (Seale 1999).

Some researchers argue that positivistic and constructivist ontology's are irreconcilable. Other researchers view them as complementary as they are both concerned with examining social worlds where reality is constructed in the research process (Cupchik 2001; Silverman 1993). I see no conflict in collecting qualitative and quantitative data. An example of the latter is my structured observations where activities were counted as well as described.

An important issue in qualitative research is the balance between flexibility and systematisation. Qualitative methods encourage experiment and flexibility, but have been accused of offering little protection against 'self-delusion,' and the production of invalid and unreliable conclusions (Huberman and Miles 1998). Today, theory and processes have evolved that foster quality and rigour in conducting, analysing and publishing qualitative research (Lincoln and Guba 1985; Seale 1999). My view is that

it is essential to start research with, "some ideas of what one is looking for, and foolish not to make that quest explicit" (Wolcott 1982). I had an initial conceptual framework, a set of general aims and ideas about sampling and data gathering.

Participant observation appeared to be the method that was most appropriate to exploring the complex activity of appointment making in a general practice social setting. It avoids some of the problems of interviews where 'interviewers construct data' within the artificial setting of an interview, but 'observers find it (data)' in natural settings (Dingwall 1997). Observation may also help overcome the discrepancy between what people say and what they do in practice (Mays and Pope 1996). Participant observation, like ethnography, has its roots in anthropology. Ethnography involves spending a prolonged period, perhaps years, in a culture before starting to collect data (Gribich 1999). Participant observation developed as a shortened and organised data gathering technique by Mead and others (Mead 1971). Both approaches allow the researcher to study the meanings of behaviour, language, and interactions of a particular culture or social group (Creswell 1998). I was particularly attracted to the systematic approach to data collection with observation, informal interviewing, document analysis, respondent interviewing, and participation with self-analysis as complementary methods (McCall and Simmons 1969). It also allowed for other forms of research enquiry such as surveys or long interviews, which some researchers would also put under the umbrella of participant observation.

1.6 Conceptual framework

A conceptual framework is the collection of ideas that inform and direct the research. It should be explicit and mature and develop as the research does. It is a dynamic process (Miles and Huberman 1994).

There are five elements to my framework: my professional experience; my personal experiences; ideas from my literature review; knowledge and understanding of relevant theories; and awareness of the policy and cultural context of my research. I will describe the orientating ideas in these areas, and then show how these elements changed as the research progressed.

1.6.1 Initial framework

The first element of my conceptual framework is my professional and research experience. I have already described my experiences as a 47-year-old male full-time general practitioner working in an urban practice in South Shields that led to my interest in researching access and demand. For most of my professional life as a general practitioner I have been interested in research and in 1987 was appointed as one of the first Royal College of General Practitioners (RCGP) research-training fellows. I initiated and conducted a survey of 3,500 GPs attitudes to AIDS and HIV. Between 1992 and 1995, while a member of South Tyneside Medical Audit Advisory Group, I examined patients' experiences of diabetes care using a novel group method called Nominal Group Technique. A report of this work was distributed to decision-makers in the form of a Delphic survey. Experience in using these qualitative group methods showed me that qualitative methods were powerful tools for exploring patients' and professionals' behaviour particularly in areas that were ill understood. In the late 1990s I also conducted several studies exploring telephone working and telephone triage to improve patient access.

The second element to my conceptual framework has been my own illness consulting behaviour. Prior to the research I developed two chronic health problems and now take long-term medication. It was a novelty for me to spend anxious times in the waiting room to see the doctor or nurse. I was surprised at how easy it was to hear intimate negotiations at the reception desk. I was also struck afresh that receptionists are the main interface between the patient and the doctor and nurse, and that their job was more complex than I had imagined. I also realised that an observational study of patient-receptionist interactions would be practically possible.

The third element has been a reading of the literature. Particularly influential initially was literature on access to health care (Arber and Sawyer 1982; Stewart et al. 1995) and observational research of receptionists (Freeman 1989).

The fourth element of my initial conceptual framework was an examination of theory and research methods. I looked at some organisational theory (Blau 1972; Hall 1974), literature on patient satisfaction (Baker 1996) and lay concepts of illness (Stewart et al. 1995; Tuckett et al. 1985). Strauss and Corbin, and Miles and Huberman provided

ideas on sampling and data analysis (Miles and Huberman 1994; Strauss and Corbin 1998).

The final element to my framework was an awareness of the policy and cultural context of the research. This meant keeping abreast of political changes in the media and health literature.

These ideas led to aims for my project, ideas about sampling and methods, and a list of preliminary questions.

1.6.2 Personal opinions

Before starting the research I summarised my beliefs and opinions about appointment making and receptionists in general practice. These opinions changed as the research progressed, and can be compared with a summary of my main findings in Chapter 11.2.

- Receptionists are undervalued by doctors, other health care professionals, and by health care planners.
- Patients and some professionals have negative views about receptionists. They see them as obstacles to obtaining health care.
- Receptionists have difficulty reconciling patient demand with appointment availability
- Receptionists take the blame for practice's inability to provide sufficient appointments
- There is a culture in the practice that affects appointment availability.
- It may be more difficult to obtain an appointment in a large practice compared to a small or single-handed practice.
- Making an appointment is an important part of the process of accessing health care.
- People in work are more likely to have difficulty obtaining an appointment compared to children and the elderly.
- Patients do not like having to persuade the receptionist to obtain an appointment.
- Professionals have most difficulties managing requests for 'extra' appointments.

1.6.3 Framework development

When I entered 'the field' it became clear what issues I needed to focus on. My original impression that urgent appointments most tested the ability of the patient and receptionist to negotiate appointments was confirmed in my first practice, Practice A (my three research practices are called Practice A, B and C). In Practice A I observed all appointment requests, but in my second practice (Practice B), I tried to observe more urgent requests and interview these patients. These patient interviews elicited reasons why patients make appointments and explored the reasons for conflict between patient and receptionist. At this stage I examined theory and publications about lay concepts of health (Mechanic 1978).

During the research my practice became a Personal Medical Services (PMS) pilot with the main aim of improving access by employing a salaried doctor and an extra nurse. This approach was successful in managing demand and improving access.

The original research, most of which was conducted by me, took more time than I imagined. I decided to concentrate on trying to do one piece of research well. I also initiated and managed a focus group study of my practice's patients' views about access to the practice and their views of PMS. That research is not included here.

My personal circumstances changed in the autumn of 2000. I became ill and between September 2000 and September 2001 I took a year off from this project, although I kept up with developments in the literature.

Throughout the study I reviewed the literature. For example, as I collected and analysed data on interactions between receptionists and patients I searched for examples in the literature. At the start of my study the focus in the literature was on theories and models on analysing and managing access in primary care (Pencheon 1999a; Rogers and Elliott 1997; Rogers et al. 1999). My awareness of the impact of health service policy and the cultural context of my research grew throughout the study.

1.7 Objectives

Observations

- I decided to systematically observe and record *all* waiting room interactions and activities, not simply appointment making, to provide a context in which appointment making occurred.

- I extended my observations and informal conversations to administrative areas and coffee areas. The aim of this was to solicit 'backstage' comments on the practice and its workings.

- I sought 'routine' interactions, as well as 'discordant' and 'successful' interactions.

- I collected details on different appointment types, such as routine, urgent, return appointments, home visit requests, either face to face or on the telephone.

Short interviews

These occurred in Practice B. Initial analysis of observational data confirmed that urgency of appointment making was a key issue for patients and professionals. The aims of interviewing a sample of patients in Practice B were:

- To ascertain why and how the patient had decided to consult urgently.

- To examine family and work influences, the organisation of the practice, and patients' understanding of the terms 'urgent,' 'emergency' and 'routine' appointments.

Long interviews

Patient interviews

- To understand the reasons that led them to consult the doctor or nurse at their last appointment.

- To understand their experiences of appointment making.

- To understand the process of negotiating an appointment, including volunteering or being asked for clinical information, and their understanding of appointment systems and practice policies.

- To establish patients' understanding of appointment types and personal definitions of appointment types
- To identify attitudes to receptionists and other practice staff, and to explore patients' dissatisfaction and satisfaction with care.
- To ascertain the importance of seeing the same doctor (personal care), and its relation to urgency.

Receptionist interviews

- How the practice develops and monitors appointment making policy.
- Receptionists' concerns about appointment making and receptionists' working.
- Opinions on requesting information from patients.
- Tactics used in appointment making.
- Personal definitions of appointment types: routine, urgent, emergency, and home visits.

Interviews with other professionals (doctors, nurses and managers)

- How the practice develops and monitors appointment making policy.
- Opinions on requesting information from patients.
- Tactics used in appointment making.
- Personal definitions of appointment types: routine, urgent, emergency, and home visits.

1.8 Organisation of the thesis

The rest of the thesis is organised into three interconnected sections. The following four chapters contain the literature review and methods. The next four chapters consist of the results. The final two chapters examine the quality of my research and the discussion, and are followed by the bibliography, appendices and publications. The research and data collection timetables are displayed in Figure 1-1 and Figure 1-2.

1.8.1 Writing in the first person

Most of my thesis is written in the first person because that was how I collected most of my data. It would have been inappropriate for me to use the third person, such as "the researcher observed," to describe what I have seen, experienced, or deduced from my data (Webb 1992). The use of the third person implies objectivity and separation from the subject. As this is a qualitative study there is a much greater connection between researcher and subject. The researcher tries to articulate the effects which they may have on the subject, and the effects which the subject may have on the researcher.

Writing in the first person is also a way of 'owning' or taking responsibility for the data. Becker's comments about writing in the third person are illuminating "...many people use such expressions *[writing in the third person]* to hint at stronger assertions they just don't want to take the rap for. They want to discover causes, because causes are scientifically interesting, but don't want the philosophical responsibility" (Becker 1986). I have interpreted this comment to mean that it is intellectually dishonest not to use the first person. I use the first person plural for activities such as observing with another researcher and conclusions made with others, but sometimes use the third person when, for example, writing about the role of the researcher in an abstract sense (see last sentence in preceding paragraph).

1.9 Research timetables

Figure 1-1: Overview of research timetable

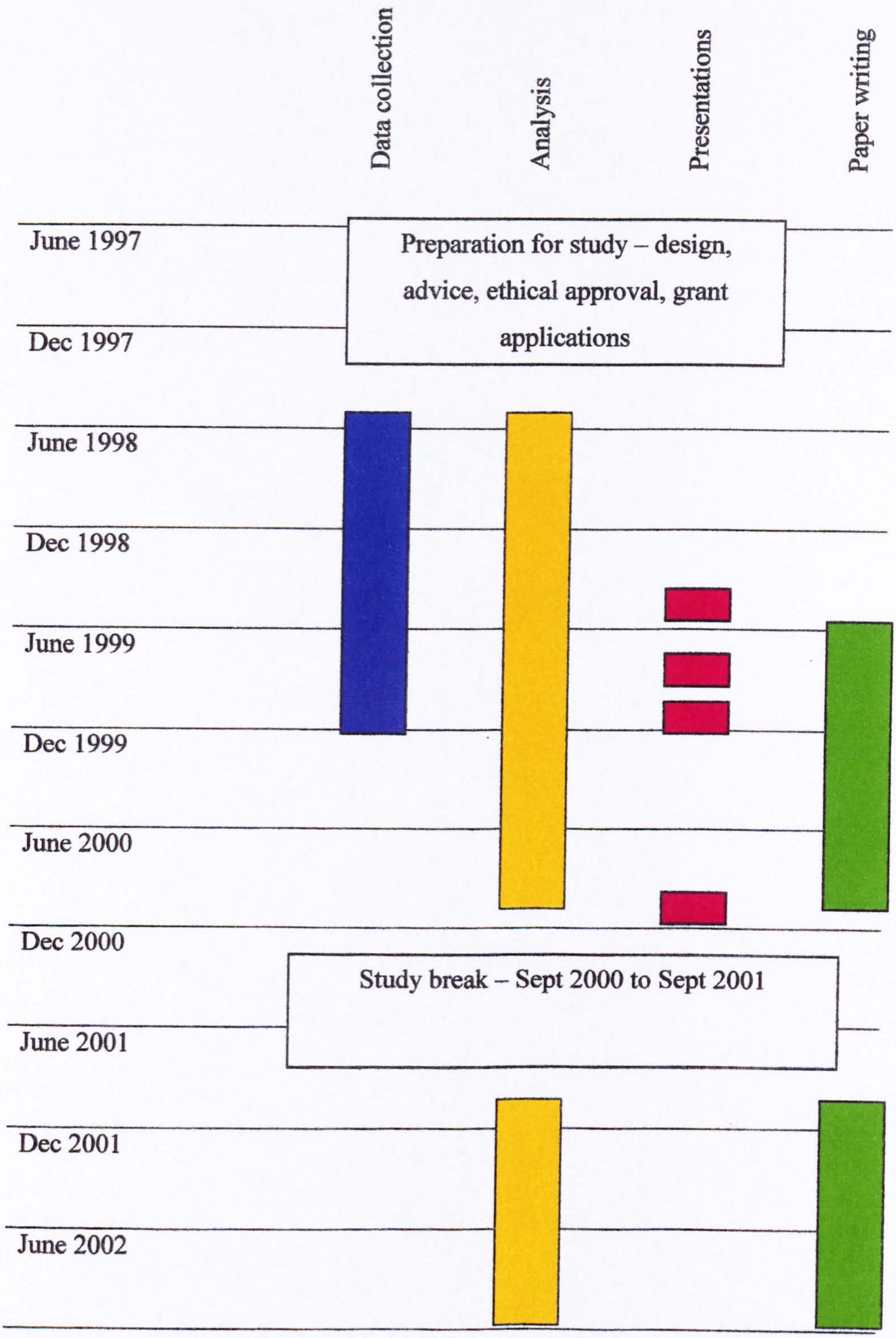
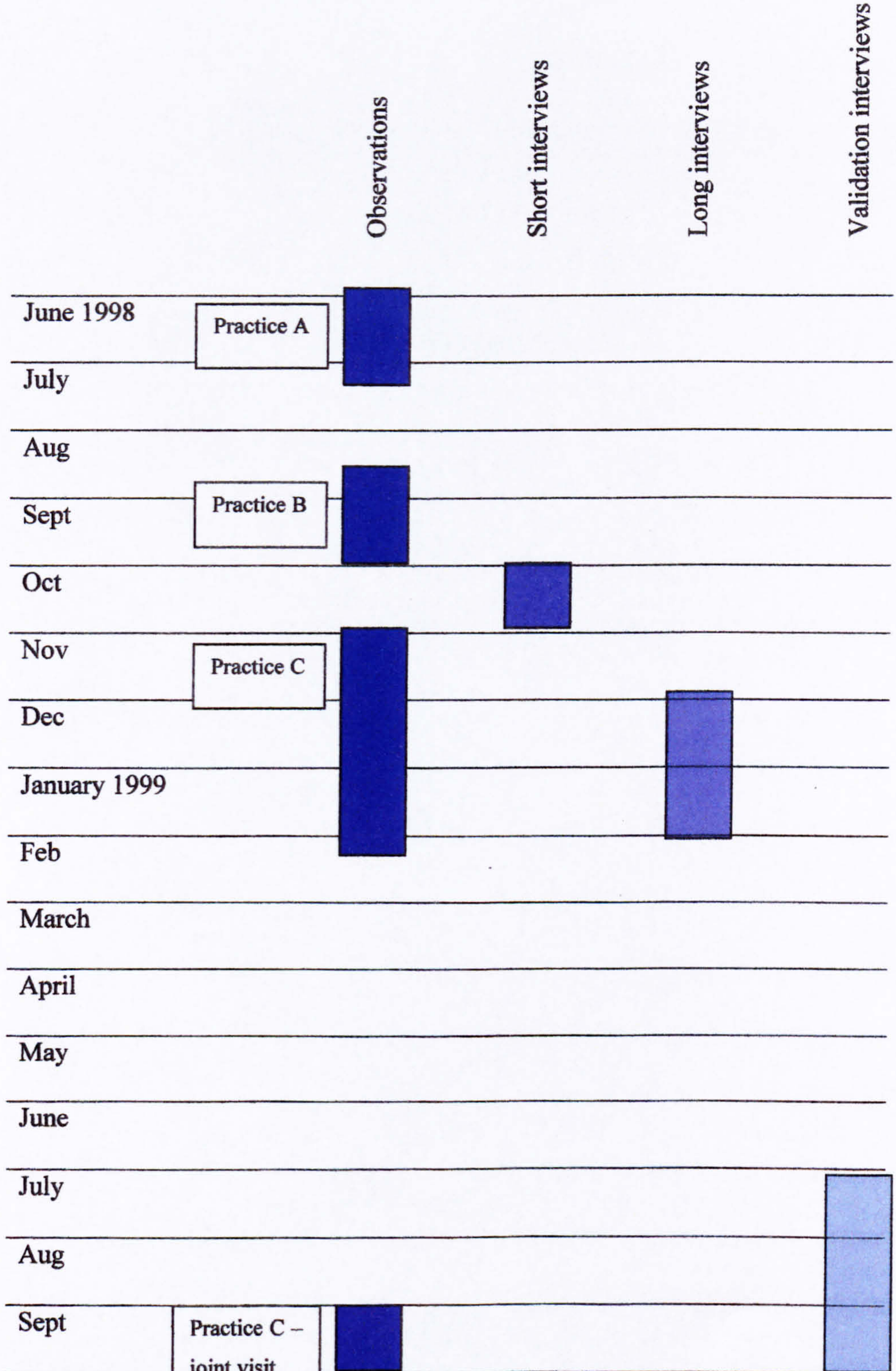


Figure 1-2: Data collection timetable



Chapter 2 : Literature review

> "But I think their appointment system stinks. The whole system. It is not just the doctor's appointment system; it is all over, when you go to the hospital and that." Patient interview, No 3.5

2.1 Introduction

This literature review is in two parts. The first part examines past and current thinking about access, need and demand, illness behaviour and use of primary care services. The second part considers the development of health service policy and primary care services to improve patient access and meet patient demand. The focus of the review is appointment making in general practice and the role of receptionists as gatekeepers.

2.2 Thinking about access, need and demand

2.2.1 Introduction

The purpose of the fledgling NHS was to make health services accessible (available) to the whole population on the basis of need and regardless of peoples ability to pay (Campbell 1998; Loudon and Horder 1998). Ensuring equitable and rapid access to health services and managing patient demand remain key challenges for health professionals and policy makers. The NHS Plan of July 2000 promised improved access to many NHS services including GP appointments (within 48 hours), outpatient appointments, and operations (DOH 2000). Patients are also increasingly vocal in wanting better access to health care. The interface between self-care and care provided by primary health care professionals, such as general practitioners, practice and district nurses, pharmacists, and accident and emergency doctors and nurses, is the point in the NHS where patients have the most choice about who to consult for help and advice. It is most influenced by patients' decisions about accessing services (Rogers et al. 1999). Primary care is also important because of its gatekeeping role in limiting access to secondary care. But what *is* access? And what about these related concepts of need and demand?

2.2.2 Conceptualising access

There is no consensus about the concept of access in the literature. At it's simplest I would define it as the process by which care is obtained. For example, The Collins

Concise Dictionary gives three meanings of the word access: "the act of approaching"; "the condition of allowing entry"; and "the right to make use of something" (Collins 1989). These meanings reflect three aspects of access in primary care: care is sought; requests for care are rationed; a service is appropriated. The aspect of rationing care, as we shall see later, is relevant when we examine the gatekeeping role of receptionists.

Two researchers, Penchansky and Thomas, provide a theoretical framework for understanding access. They define it as "a concept representing the 'fit' between the clients and the system" (Penchansky and Thomas 1981). Their concept is divided into several dimensions that are summarised in Table 2-1.

Table 2-1: Dimensions and attributes of the concept 'Access' – after Penchansky and Thomas

Dimension	Attributes
Availability	The relationship between volume and type of services to clients and volume and type of need
Accessibility	The relationship between the location of the supply and the client – transport, distance and cost
Accommodation	The relationship between how supply resources are organised (such as appointment systems) to accept clients
Affordability	The relationship of price of services and ability of clients to pay
Acceptability	Attitudes of providers and clients to each other. For example, providers may be less willing to accommodate some types of clients

Their model integrates variables describing need, predisposing factors and enabling factors. One of the most important features of this research is that the authors tested out the validity of their proposed dimensions of access on a sample of 287 people from New York. This produced data to confirm the existence and validity of the five dimensions. There are limitations to the data, as the number of questions given to respondents to test each dimension was small; they would have benefited from more positive and negative questions. Specific findings were as expected by the authors. For

example, travel time is a strong predictor of accessibility, time to get an appointment was predictive of satisfaction with accommodation, and a long relationship with the doctor was associated with greater satisfaction with availability and acceptability. The authors also conclude that while there is overlap between these five dimensions, patients can and do discriminate between them when accessing care.

The context in which Penchansky's and Thomas's research was conducted was the health care in the United States of America, where the dominant notion of access is ability to pay. Without this dimension other authors argue that access is a more subtle concept (Goddard and Smith 2001). Goddard and Smith take an economic approach to access seeing it as a "supply side problem." Within their concept of access they identify four dimensions which explain variations in access: availability; quality; costs; information (Table 2-2).

Table 2-2: Dimensions of access after Goddard and Smith

Dimension of access	Attributes of these dimensions
Availability	The ability to secure a specific service
Quality	The quality of the service
Costs	Acquiring the service at a specified maximum level of personal inconvenience and cost
Information	Having a specific level of information about the availability of services

In their analysis 'cost' is seen as personal inconvenience, such as having to travel to the surgery, which may vary between population groups, rather than just a financial matter. The dimension of 'availability,' like Penchansky's and Thomas's, refers to whether a service is available to some population groups, and the propensity for some clinicians to offer treatment to one group of patients over another where both groups have identical needs.

Accessibility and socio-economic factors

We have seen with the dimension of accessibility a relationship between the location of the supply (e.g. GP surgery) and the client (patient). This involves issues of transport, distance and cost (Penchansky and Thomas 1981). The organisation of services and patients' decisions about care influence access to primary care (Rogers et al. 1998). For example, some patients consult accident and emergency departments and out of hours services because of a perceived inability to obtain appointments with their general practitioner (Shipman et al. 1997). This appears to be the case particularly for patients from non-affluent areas compared to people from affluent areas (Drummond et al. 2000). Patients of single-handed general practitioners consult more frequently than those from group practices (Hopton and Dlugolecka 1995). This may be due to high levels of morbidity rather than an increase in 'minor' illnesses.

Distance of the surgery from the patient's home affects equity of access to care (Parkin 1979; Robson 1995). In a study of four low income areas on Merseyside there was dependence on relatives and neighbours for transport to the doctor, access to the telephone, organising substitute care for dependants and collecting urgent prescriptions (Pearson et al. 1993). It is recognised that higher rates of GP consultation are associated with greater deprivation and with lower socio-economic groups (Goddard and Smith 2001). As this group consult frequently and have more difficulty getting to see the doctor they are doubly disadvantaged compared to people in higher socio-economic groups. The likelihood of missing an appointment is associated with living in a deprived area (Neal et al. 2001). Advances in health care access which make use of the telephone and computer are also likely to disadvantage low-income families with poor access to these resources. Financial resources to purchase over the counter medicines have also been shown to influence access to care (Hassell et al. 1997).

Access to self-care

In addition to the dimensions of access described by Penchansky and Thomas and Goddard and Smith, Pencheon and Rogers give new emphases. Their concept of access includes patients accessing help from other patients as in self-help groups, patients accessing information as well as care, and professionals accessing patients' views (Pencheon 1999; Rogers et al. 1999a). There is the notion of access being impersonal rather than face to face, as in accessing care by telephone or advice from the World

Wide Web (Pencheon 1999). Rogers also emphasises patient access to self-care (Rogers et al. 1999a). She suggests that self-care is important because "Relatively small decreases in these self-care behaviours or increases in the accessibility of services could produce large changes in the demand for formal care" (Rogers et al. 1998).

Self-care is the chief source of care for people who are sick. Two surveys of patients attending doctors' surgeries showed that self-treatment was practised by 52 per cent in 1970 and 55 per cent in 1985 (Elliott-Binns 1973; Elliott-Binns 1986). Before coming to the general practitioner's the patient will have received care from on average two sources, especially spouse, relative or friend, with home doctor books, chemists, nurses, and television making lesser contributions (Elliott-Binns 1986). A review of the literature by Rogers suggests that people "do what is pragmatic" and choose multiple treatments, conventional and alternative, in dealing with episodes of illness (Rogers and Elliott 1997). As Tuckett points out, "Many individuals (also) consult friends, relatives and others in a lay referral system where a doctor is only one of many specialists" (Tuckett 1976). Supportive networks have been shown to reduce isolation and provide help with health when needed (Dean 1986). Women have also been recognised as having a major role in providing and supporting self-care (Elliott-Binns 1986; Pearson et al. 1993; Stacey 1984). People who self-medicate have been shown to have the psychosocial characteristics of self-reliance (Rogers and Elliott 1997).

Factors which trigger consultations with a doctor appear to be related to the disruption of work, home and other people, and the interpretation of bodily symptoms (Punamaki 1995). These triggers are similar to those described by Zola who includes disruption of family, work and social life, pressure from others to consult, and setting of deadlines by which time the problem should be resolved (Zola 1973). Mechanic suggests that it is the response to disease rather than just the illness itself that determines whether people consult a health care professional (Mechanic 1978). Other research suggests that self-care is a substitute for formal medical services rather than a supplement to seeking formal care (Fleming et al. 1984). If this is so, promoting or supporting self-care has the potential to reduce demand for formal medical services.

Rogers and Elliott, in their review of health need and demand suggest that future research should incorporate lay understandings and past experiences of services with subsequent primary care use (Rogers and Elliott 1997).

2.2.3 Conceptualising need and demand

The language used to describe the relationship between need and demand for health care, and supply of health care services, is also borrowed from economic theory. Most research in this area has been conducted in North America, but since 1997 two United Kingdom academics, David Pencheon and Ann Rogers, have contributed new analyses of need and demand for primary health care (Pencheon 1997; Pencheon 1998; Pencheon 1999; Rogers and Elliott 1997; Rogers et al. 1999). They have also been influential in affecting and reflecting government policy, particularly Pencheon who is credited with having the original idea for NHS Direct (personal communication, D. Pencheon, 2000).

The concept of need is contested. The dominant notion in health service policy and practice is of 'clinically defined need'. This means that need is defined in terms of a symptom, signs or condition where there is an 'effective' ameliorative or curative intervention (Rogers et al. 1999). Support for this concept is reflected in the growth and popularity of evidence based medicine. In contrast, the social sciences approach to analysing need has been to see it in social, economic and political terms (Bradshaw 1972). Bradshaw divides need into four types. 'Normative need' is that which is defined by professionals, and is analogous to the concept of clinical need. 'Felt need' defines people's subjective wants or desires. 'Expressed need' is that which translates into action such as seeking an appointment with a general practitioner. 'Comparative need' relates to equity and the impact of disadvantage and inequalities on need (Bradshaw 1972). Bradshaw's analysis is useful as it presents need as a multifaceted concept that includes professional, patient, social and economic factors.

Demand is the expression of need among population groups (Rogers et al. 1999). Related to demand is the concept of supply, which in health care refers to the quantity of a service that providers are willing and able to offer (Rogers et al. 1999). Pencheon identifies three types of demand: demand for technological interventions; demand for quality and convenience (consumerism); and demand for 'meaningful involvement' by individuals and groups of patients (Pencheon 1997).

Inappropriate demand and frequent attenders

The concept of inappropriate use of services emerged in the 1960s and 1970s as 'trivial' or 'rubbish' consultation; the latter concept referring to accident and emergency departments (Jeffrey 1979). It developed later into ideas of 'difficult' or 'heartsink' patients (O'Dowd 1988). Ideal types of patients were presented as 'good' or 'bad,' particularly in the work of Stimson and Webb (Stimson and Webb 1975). Good patients were seen as middle class, with easily identifiable problems amenable to treatment. Similar research identified different groups as consulting 'appropriately' or 'inappropriately.' More recently, patients who consult frequently and who are perceived as having a disproportionate impact on workload have been labelled as 'frequent attenders' (Neal et al. 1998). Rogers identifies 'patient blaming' as the underlying thread in these analyses. This patient defect model contrasts with holistic models of care which recognise that psychosocial factors are relevant and important in patient relations (Rogers et al. 1999). Rogers concludes (Rogers et al. 1999)

> "Heartsink patients may signify a projection of doctors' own difficulties in coming up with an appropriate response in terms of diagnosis and management. A label of 'heartsink' may provide a convenient evasion for the GP – 'if in doubt, blame the patient'."

Managing demand

In recent years attention has focussed on demand management. Pencheon defines this as (Pencheon 1997)

> "The process of identifying where, how, why, and by whom, demand for health care is made; and the best methods for curtailing, coping with or creating this demand such that the most cost-effective, appropriate, and equitable health care system can be developed."

This new emphasis reflects a pragmatic attempt to manage health resources, and contrasts with previous approaches of trying to define need and continually increase service provision. Elements of this new approach include curtailing demand for ineffective services, coping better with demand for effective services, and creating demand for services which are known to be effective but are under-used (Pencheon 1997). This analysis suggests methods for affecting demand such as reducing services,

introducing new services, and altering service use. The relationship, however, between need, supply and demand is complex. Reasons for this complexity include lack of a clear relationship between need and demand, patients and professionals not being well informed about some illnesses and responses to them, and increasing supply of services can stimulate demand rather than meet it. An example of this latter idea has been the government waiting list initiative of the late 1990s. A modest increase in resources failed to improve waiting lists and may have led to increased demand for referrals and operations (Pencheon 1997).

Is demand increasing?

Demand for general practice care appears to be increasing (Pencheon 1998). Most of the evidence for this is anecdotal (Pederson and Leese 1997), but increasing workload has been cited as the cause of increased anxiety and depression in general practitioners (Caplan 1994; Sutherland and Cooper 1992). The strongest evidence for an increase in workload comes from data on out-of-hours care where consultations increased dramatically due to changes in GP contractual arrangements (Hallam 1994). Further evidence comes from a general practice where consultations from children in each of the first five years of life increased from an average of 3.73 per child in 1960 to 17.2 in 1990 (Del Mar 1996). Evidence, however, of static and possibly even declining consultation rates comes from research in 17 practices in Sheffield (Waller and Hodgkin 2000).

Several reasons have been suggested for an increase in demand. These include population changes, increasing public expectation and life expectancy, and changes in clinical practice such as improved detection of illness, better and more treatment, and professional desire to provide best treatment. There is, however, little or no evidence that the incidence of diseases has changed markedly. Older people account for only two per cent of the increase in hospital admissions, and demand appears to be increasing in all age and diagnostic groups, except perhaps the socially deprived (Rogers et al. 1999). Another postulated cause for increasing workload is the transfer of patients and work from hospital to primary care by earlier discharge, sometimes called 'dumping.' A review, however, of 'shifting' services from secondary to primary care concluded that this did not increase general practitioners' workload (Pederson and Leese 1997). There is little evidence to support the contention that general practitioner

workload is increasing. The perception by general practitioners that workload is increasing may be related to increased patients' expectations, where the doctor has to provide more within a single consultation.

2.2.4 Is there a problem with access?

When I started this research in 1998 the main emphasis in the research literature was on demand management. Since then, the issue of improving access has gained greater prominence. This is probably due to the influence of government policy. Delays in access are important as they cause patient and staff dissatisfaction, and may lead to poor clinical outcomes (Murray 2000). Patients may consume scarce resources while waiting, for example, for joint surgery, and there is the risk that the delay in surgery may mean more costly surgery or time in hospital. In primary care, the longer the wait the higher the 'Did not attend' (DNA) rate, that represents unused capacity. The National Patient Survey of general practice in 1998 showed that the highest levels of patient discord were related to accessing services and waiting times (Airey et al. 1999). One in four patients had to wait four or more days for a GP appointment. Patients with less favourable views included the under 45s, those in full time work or education and people from ethnic minorities (Airey et al. 1999). In the 1990s a number of government initiatives stimulated discussion and action on improving access to health care. The 'New NHS' white paper and the green paper 'Our Healthier Nation,' recognised the role that patients have in accessing services, and advocated an approach to managing health needs across health and social boundaries (Stationary Office 1998; Rogers et al. 1999). The most important practical initiative was the arrival of NHS Direct in July 1998. For the first time an alternative point of access to the doctor was provided that was available from the patient's sitting room. The government also launched six Modernisation Action Teams in 2000 to develop a National Plan for the NHS. One of these teams, as we shall see later, aimed to improve access to general practice appointments.

2.3 Models of appointment making and illness behaviour

Most research that examines the relationship between need, demand and health care utilisation concentrates on the work of professionals to the exclusion of patient perspectives (Rogers et al. 1999a). A number of models have been developed to

understand factors relevant to health care. These include economic models, appointment making models, those that examine the relationship between symptoms and consulting, and models that integrate social, psychological and economic factors, and view help seeking as a social process.

2.3.1 Economic models

We have already seen that the language of economics pervades analyses of need, demand, and health care use. One of the most influential analyses was provided by Donabedian, and includes notions of health care as a complex market with definable needs, and variable supply, but, importantly, influenced by consumer and governments' behaviour (Donabedian 1973). This notion of health care as a market is exemplified by the idea of introducing the 'internal market model' to the NHS. Alain Enthoven, a visiting American academic, proposed this in 1985 (Klein 1999). His idea did not appear in the 'Working for Patients' government white paper that introduced the 1991 reforms, but seems to have stimulated government thinking about organising health care (DOH, 1989). This led to two key and controversial innovations, the purchaser-provider split and general practitioner fundholding (Klein 1999). As we have seen, Penchansky and Thomas conceptualise access in terms of availability, accessibility, accommodation, affordability, and acceptability (Penchansky and Thomas 1981). More recent analyses of demand and supply embrace this traditional language of economic theory to present a new explanation and theory of demand management (Pencheon 1997).

2.3.2 Appointment making models

Since the introduction of appointment systems in the 1970s (Cartwright and Anderson 1981) most practices have a system of urgent and non-urgent appointments available, sometimes in combination with a system of 'open access', where people attend and wait their turn (Oldham 2001). A variety of systems exist for managing same day appointment requests. These commonly include pre-booked appointments for part of the surgery and some emergency slots (61 per cent of 79 practices in Devon), extras shared by GPs (57 per cent) and practice nurses seeing some extras (41 per cent) (Luthra and Marshall 2001). This traditional model of appointment making may not be good at meeting fluctuating demand, unless the practice has contingency plans for

temporary increases in demand, and can cause battles between receptionists and patients. It is associated with high DNA rates and long waiting times. A new model of appointment access developed in the United States of America (USA) called 'advanced access' asserts that it can improve access to general practice appointments by clearing deferred demand or 'backlog' and by doing 'today's work today' (Murray 2000). The essential elements of 'advanced access' are summarised in Table 2-3 (NHS 2002).

Table 2-3: Elements of 'Advanced access.'

- Understanding the demand for access to a specific practice
- Shaping that demand
- Matching the capacity of the practice to meet the demand
- Having contingency plans to sustain the system

This approach may reduce patient and staff dissatisfaction because waiting times are short with greater equality of access by patients and less DNAs. Advocates of this model assert that when the backlog of appointments is cleared then capacity and demand remain in equilibrium. This model does not take account of another element of economic theory that improving a service can also stimulate demand for it. Patients who could not get an appointment might seek advice from family, friends, and pharmacists rather than their general practitioner. But if access to the general practitioner is improved they may consult the doctor instead. Advanced access also assumes that there is sufficient supply (or capacity) in the system to meet demand, and that the dynamics of health care are the same in the UK as they are in the USA.

2.3.3 The iceberg of symptoms

The concept of the iceberg of illness (Hannay 1979) is useful in understanding the relationship between health and illness (Jones 2000). Like a pyramid, at its base the iceberg has healthy people who ascend through self-care, professionally provided primary care, and secondary care. The movement of patients from self-care to primary care determines workload, and small changes lower down can significantly affect demand higher up the pyramid (Jones 2000). There are problems with this metaphor as it relates to reported (above water) and unreported (below water) symptoms. The most important of these problems is that the type and severity of symptoms does not

adequately explain how individuals seek help and care (Rogers and Elliott 1997). Mechanic suggests that symptom reporting reflects a pattern of illness behaviour which is largely influenced by the individual's affective state (Mechanic 1979).

2.3.4 Social process and other models of health care use

Three models of health care use have dominated theories of health care use over the last 30 years (Rogers and Elliott 1997). These are the health belief model (HBM), the rational choice model (RCM) and socio-behavioural models (SBM).

The focus of the HBM is individual patient decisions. High users of health services see themselves as ill and vulnerable, whereas low users of primary care are less anxious and less concerned about symptoms (Rogers and Elliott 1997). The RCM views lay decisions as 'purposive' where individuals weigh up the costs and benefits of a particular action in situations with variable characteristics, constraints and opportunities (Pescosolido 1992). The socio-behavioural model of health care utilisation sees this as a 'pathway' with predisposing, enabling and need factors that influence health service use (Anderson 1995).

Rogers and Elliott note several limitations of these models (Rogers and Elliott 1997). They overemphasise patient choice, ignore habitual behaviour and the influence of social networks on patients' decisions, cater more for acute rather than chronic problems, and don't explore social variables.

Social Process Models (SPM) provides a new dynamic to understanding health care use. These models concentrate on the *interaction* of the patient with others, rather than concentrating on motivation and determination of decision making as fixed attributes of individuals. A number of approaches are included in the SPM. These include health utilisation as an *illness career*, where patients' roles are negotiated. They also include ideas about how people react to and categorise illness, concepts of self and identity, and stages of the medical consultation (Rogers and Elliott 1997). Decisions made at an earlier stage are known to shape later decisions (Pescosolido 1992). Zola highlighted variables that act as 'triggers' for the patient to consult (Zola 1973). The role of social support on health maintenance and illness behaviour has also been emphasised (Dean 1986). Collectively, these models highlight social and other factors, outside the control of individuals, which affect patient decision-making (Rogers and Elliott 1997).

2.4 Health policy and access to primary care services

Health service policy and the organisation of health care affects access to it and delivery of health care. For example, the advent of the NHS has affected the way in which people use health care. Also, distance of a surgery from patients, and availability of transport affects the ability of patients to visit the doctor. This section concentrates on health service policy in the post-war period and the organisation of formal services such as general practice, accident and emergency, pharmacists, and NHS Direct.

2.4.1 Health service policy

In the 1950s general practice was mainly a 'cottage industry' of isolated doctors' working from their own homes and supported by family members, usually the doctor's wife (Arber and Sawyer 1981; Loudon and Horder 1998). Several political and organisational changes boosted the development of general practice as a discipline, and encouraged ancillary staff recruitment. The new NHS developed a contract where general practitioners were paid by the state to provide patient care. The GP Charter in 1966, in particular, encouraged employment of ancillary staff, and the creation of the General Practice Finance Corporation in 1967 provided loans to finance new and improved premises. The Health Services and Public Health Act in 1968 extended the work of nurses, midwives and health visitors in the community to support general practitioners. Further changes included mandatory vocational training and fundholding.

Ham classifies development of the NHS in the postwar era into three periods or 'ways.' These are summarised in Table 2-4. (Ham 1999)

Table 2-4: The development of health service policy since the postwar period.

Policy approaches	Period	Characteristics of approach
'The first way'	Postwar to 1980's	"Centralised bureaucratic organisation." Control by central directives and **planning**
'The second way'	'The Thatcher years' 80s to 1997	Central control, but emphasis on delegation and **competition** in the "politically managed market"
'The "third way"'	'New Labour.' 1997 to date	**Pragmatism.** "Central control and staff empowerment." "A complex cocktail of ...planning and competition"

Ham supports the "third way" but feels that politicians do not appreciate the size of the problem and alienate health care workers, by making jibes about their resistance to embrace the modernisation agenda (Ham 1999). He is also concerned about the lack of capacity within the NHS (Ham 1999a). Frankel challenges this and other pessimistic analyses of the NHS (Frankel et al. 2000). He asserts that "conventional assumptions of an imbalance between demand and supply are not supported by evidence," and projections about demand increasing due, for example, to an ageing population are also unsupported by good evidence. His thesis is that there are limits to demand, and a properly resourced NHS should be tested explicitly. This chimes with the current government's promise of a modern and better NHS, with lower waiting times for hospital and GP services. Frankel's optimism about the ability of the NHS is criticised by Maynard and others as misplaced (Maynard and Sheldon 2001). They assert that demand is infinite and needs to be rationed. The original architects of the NHS believed that by meeting the backlog of unmet needs demand for the service would plateau in the 1950s. The reality was and has continued to be that demand continues to grow. Maynard attributes this growth to changing treatment criteria, technological advances, and socially determined needs and wants (Maynard and Sheldon 2001).

Ham and Alberti summarise the changes in social and health policy that will affect the provision of services and the work of doctors and patients (Ham and Alberti 2002). They argue that we need a new contract spelling out the responsibilities of the government, patient and profession. They state that from 1997 there has been more change than in the previous 49 years. They detail these as: a more demanding and knowledgeable public; an increasingly litigious culture with prominent failures such as Bristol and Alder Hey hospital; challenges to self regulation by GPs; greater involvement by government in issues of quality and standards; and increasing workloads and frustration about what can be done with restricted resources.

In this chapter a number of policy initiatives are described. These are summarised in Table 2-5, together with notes on my study activities at that time.

Table 2-5: Policy developments during my research

Date	Study activity	Policy development
1997	Preparation: choosing study subject, examining literature	**Government report: 'The New NHS: modern, dependable'**
July 1998	Just completed first period of fieldwork in Practice A, and preliminary analysis of observational data	**Introduction of NHS Direct** the patient telephone advice line
Oct 1999	Joint observing, Practice C Completed respondent validation interviews	**NHS report: 'National surveys of NHS patients: general practice 1998'**
Feb 2000	Study break	**BMA report: 'Shaping tomorrow'** discussion document by BMA prior to General Practitioners Committee's annual conference
July 2000	Study break	**Government report: 'The NHS Plan'** Modernisation Agency is established to promote best practice Target of "guaranteed access to a primary carte professional within 24 hrs and to primary care doctor within 48 hrs by 2004"
Sept 2000	Study break	**Modernisation Board established** – GP arm concerned with improving access by promoting 'advanced access' and demand management
Oct 2000	Analysis and writing of caring and uncaring receptionist paper begun	**Department of Health report: 'Raising standards for patients. New partnerships in out of hours care'**
April 2002	Writing of thesis	**BMA report: 'Your contract, Your future'**

A key question is how policy developments have influenced my research and me. Table 2-5 is incomplete because it does not detail ideas in the research literature that may have had an influence of government policy, and which have also affected my study. An example of policy developments affecting my research are those concerned with 'demand management' and 'access'. When I was planning my study in 1997 the dominant idea in the research literature about need, demand and use of primary care services was 'demand management' as exemplified by the work of Rogers and

Pencheon (Pencheon 1997; Rogers and Elliott 1997). During my study the concept of access came to the fore with the introduction of NHS Direct and the publication of a national report on access to general practice and the 'NHS Plan' which set an access target for general practice (DOH 1997; Airey et al. 1999; DOH 2000). The research literature reflects these policy developments (Oldham 2001; Pencheon 1999; Rogers et al. 1999). I realised that my research should embrace these policy changes; I spent more time examining the literature on access and thinking about my project from this perspective. I also became interested in applying the concept of 'advanced access' in my own general practice as a solution to our problems with patient access. We are due to become an 'advanced access' practice in January 2003.

2.4.2 Access to general practice

We will now focus on how health service policy since the inception of the NHS has affected general practice, with particular emphasis on access and the role of receptionists as gatekeepers. The dimension of access that is relevant is Penchansky's and Thomas's 'accommodation,' which explores the relationship between how supply resources are organised (such as appointment systems) to interact with clients (patients) (Penchansky and Thomas 1981).

The beginning of professionalism

Policy initiatives in the 1960s, such as the GP Charter, had a huge impact on general practice. By 1977, 90 per cent of general practitioners employed receptionists, 35 per cent employed nurses, and 67 per cent had attached nurses (Cartwright and Anderson 1981). In the late 60s and early 70s the government and BMA encouraged and supported the growth of health centres and group practices (Arber and Sawyer 1981). By 1977, 17 per cent of practitioners were working from health centres, and 64 per cent of practices were in groups of three or more practitioners. These figures contrast with 17 per cent working in group practices in 1951 and 38 per cent in 1961. It was assumed that these changes were good for doctors and patients, however, the growth in partnerships had deleterious effects on accessibility of care and the doctor patient relationship (Arber and Sawyer 1981). For example, patients had greater distances to travel to fewer and larger surgeries, which particularly affected the elderly and poor. In 1981 patients also experienced more difficulty in getting an appointment to see their

own doctor in larger practices (Arber and Sawyer 1981). Research in 1996 showed that patients reported worse access to non-urgent and urgent appointments in practices with larger list sizes (Campbell 1996).

By appointment only

Alongside the growth of group practices was an increase in appointment systems. In 1964 only 15 per cent of practices had appointment systems (Cartwright 1967). By 1977 this had risen to 75 per cent of practices (Cartwright and Anderson 1981). Larger practices used appointment systems more than smaller practices. For example, by 1977, 90 per cent of practices with three or more doctors had appointment systems, compared to only 38 per cent of single-handed doctors (Arber and Sawyer 1982). At this time most patients made appointments by telephone (53 per cent), 36 per cent called at the surgery, and 11 per cent made them whilst visiting the surgery for an existing appointment.

Cartwright showed that the majority (72 per cent) of patients preferred these arrangements although 21 per cent preferred to wait their turn. There was some indication that doctors with an appointment system helped patients to feel more relaxed and able to discuss things more fully. Arber, however, found that an appointment system made it more difficult for a quarter of patients to be seen urgently (Arber and Sawyer 1982). There was also substantial evidence that people from lower social classes and the elderly were less able to negotiate appointment by "persuasive appeals" particularly for home visits or urgent requests (Arber and Sawyer 1981). These concerns about inequalities of access were echoed by other researchers, who noted that appointment systems encouraged patients to make appointments for chronic and preventative care rather than for acute care, and that they disadvantaged lower social classes who had limited telephone access and were less able to navigate practice bureaucracy (Morrell and Kasap 1972).

In the last decade research accepts that appointment systems are valuable, but continues to evaluate patients' experiences and professionals' attempts to improve access and flexibility. Patient satisfaction has been shown to be related to practice list size and the number of patients in the practice seen as 'extras' (Campbell 1994). Several strategies are used by general practices to provide more flexible appointment systems. These include open access surgeries and reserving some un-booked

appointments to cater for urgent patients or 'extras' (Kendrick and Kerry 1999; Smith 1997). Changing appointment length has also been shown to improve the match between supply and demand, but with a loss of flexibility for extras (Campbell 1992). Other research shows patient dissatisfaction with practices with increasing total list size, the absence of a personal list system and being a training practice (Baker 1996). 'Bigger is not necessarily better' is a recurring response in research into patients' views about accessing general practice care. Other recent research has emphasised the benefits of having longer appointments, and the practical problems of implementing these in general practice (Freeman 1989).

Receptionist gatekeepers

Today medical receptionists' and practice managers' roles are seen as a health care speciality with its own professional and training body. In the 1970s and 1980s the picture of this workforce was of married women over the age of 35 working part time alongside their family commitments (Mulroy 1974; Williams and Dajda 1979). General practitioners believed that this group of women had the personal qualities to steer a course between the needs and wishes of the patient and the availability and capabilities of the doctor (Copeman and Van Zwanenberg 1988; Mulroy 1974).

A key function of reception work is sorting patients' requests to see the doctor. A general practitioner writing in 1978 makes an unapologetic case for the receptionist's role of prioritising who should be seen, "It is indeed the maligned receptionist who creates order out of the chaos of limitless demand" (Brierly 1978). An analysis of letters, however, to the Patients Association in 1975 revealed that 17 per cent were writing because they were unhappy with receptionists, and 10 per cent felt that they were intruding between the doctor and patient (White 1973). In the late 1970s Arber and colleagues examined patients' experiences of the reception process (Arber and Sawyer 1985). They used a representative sample of interviews of 1,000 adults in London and the South-east of England. They argue that receptionists have a powerful 'discretionary' role in determining patient access to care. They act as gatekeepers to care. This power exists because they receive communications and control scheduling procedures. This was most evident in requests for urgent care, which usually involves the receptionist 'making a medical assessment based on a brief verbal exchange.' Over half of her patients who tried to make an appointment for the same day had to negotiate

one. Seventeen per cent said they were always or almost always asked for information and 15 per cent were sometimes asked for this information. Parents with children under the age of five were more likely to experience the discretionary power of receptionists as nearly half were asked about why they wanted to make a surgery appointment. In addition, patients offered information about their condition as part of the negotiating process of trying to obtain an appointment, but this was not quantified (Arber and Sawyer 1985). The result of this discretionary use of power by receptionists is that nearly 40 per cent of patients experienced negative interactions with receptionists; particularly adults aged 25-44 yrs., and patients attending health centres.

Arber states that it is inevitable when the receptionists are cast in a filtering role, especially in large practices, that they are more likely to be regarded with hostility. They act as the doctors' agents in carrying out the doctors' rules: "...antagonism over a doctor's policy is deflected from the doctor to the receptionist and...she becomes the doctor's scapegoat" (Arber and Sawyer 1985). While receptionists are gatekeepers they are also seen as barriers to accessing care. This study is important because it is a large sample of patients' experiences and their conception of the receptionist as "a dragon behind the desk" pervades public and professional consciousness about the receptionist role (Arber and Sawyer 1985).

The other large body of research into patients' views about accessing general practice comes from Cartwright's two studies of general practice (Cartwright 1967; Cartwright and Anderson 1981). In her second study she presents a positive picture of patient-receptionist relations where the majority of patients found the receptionist helpful (Cartwright and Anderson 1981). Eight hundred and thirty six of 1,000 patients interviewed (84 per cent) in England and Wales constituted a random sample of 50 people from the electoral registers in 20 parliamentary constituencies. She identified that when the receptionist asked the patient why they wanted an appointment this provoked some anxiety and antagonism and seemed to discourage the patient from consulting their doctor. In a separate postal questionnaire survey of 543 GPs with 365 (67 per cent) responding, 15 per cent of practitioners asked their receptionists to ask for patient information routinely, 23 per cent occasionally, 40 per cent for emergencies only, and 22 per cent did not like them to do this. This evidence suggests that asking for information about the patient's problem creates a barrier between patient and

doctor and discourages consulting (Cartwright and Anderson 1981). Inevitably, this approach also creates a barrier between patient and receptionist.

In 1989 Freeman observed 22 receptionists making 543 appointments (Freeman 1989). The focus of this research was how receptionists maintained continuity of doctor care. The influence of receptionists on personal care was small compared to what was expressed in practice policies. Only practices providing personal lists were able to offer personal care, although only for 60 per cent of requests to see a particular doctor. Organisational factors such as reserving appointments for same day consultations and emergencies, and availability of doctors who were working in branch surgeries limited choice of doctor. Like Arber he concluded that it was the rationing function of appointment systems that made life difficult for patients (Freeman 1989). An important feature of this research is the use of observation and counting as a research method rather than, as Cartwright and Arber did, trusting in patients' accounts. The weakness of Freeman's research is that it observed only one dimension of the receptionist-patient interaction, by recording receptionist and not *patient* behaviour.

More recently, a survey of 119 receptionists that included interviews with 20 of these receptionists showed that they felt unsupported by doctors and derived most satisfaction from their relationships with patients, rather than professionals (Eisner and Britten 1999). This study is important because it explored in a structured way receptionist feelings about their work. Receptionists work is acknowledged to be complex, demanding and stressful. Receptionists also said that their training was very limited, with virtually none in handling relationships. I will argue in this thesis that access by appointment making is a dynamic event that is defined by several dimensions that include how patients and receptionists interact.

Nurses as co-workers

The number of nurses working in general practice has increased dramatically in the past 30 years. The Health services and Public Health Act in 1968 extended the work of nurses, midwives and health visitors in the community to support general practitioners. By 1977, 35 per cent of general practitioners employed nurses and 67 per cent had attached nurses (Cartwright and Anderson 1981). Their biggest period of growth resulted from the health promotion demands of the new contract in 1990. Between 1986 and 1991 the number of practice nurses in England and Wales increased from

3,700 to 18,000 (Sheppard 1992). Nurses were seen as able do tasks such as taking blood pressures (Jeffreys et al. 1995), but in need of more and better training to support their health promotion activities (Peter 1993). In the last decade the focus has been on delegating doctor work to practice nurses to release extra doctor time (Iliffe 2000; Jeffreys et al. 1995; Marsh and Dawes 1995). Increasingly nurses are seen as able to manage minor illnesses; this was acceptable and even preferred by patients (Shum et al. 2000). Nurses had longer consultations with patients during which they were given more information and patients were more satisfied with the care that they received (Kinnersley et al. 2000). Nursing care was also shown to be as cost effective as general practitioner care (Venning et al. 2000). In parallel with the recognition that nurses could do more doctor work has been the growth of nurse practitioners who are able to work autonomously (Stilwell et al. 1987).

2.4.3 The last 10 years – innovation, politics and the patient as consumer

During the 1990s there was awareness of growing patient demand and of potential solutions to counter it (Davis 1996). Key solutions were the growth of telephone working and triage, particularly NHS Direct, and changes in attitudes to providing primary care in accident and emergency departments.

Re-discovering the telephone

The telephone has always been an important tool in accessing health care and responding to patient demand. Ninety per cent of UK households have a telephone and there are over a quarter of a million public pay phones (Williams et al. 1995). In 1993 the General Household study showed that telephone consultations accounted for nine per cent of patient consultations (OPCS, 1995). This lags behind estimates of 12 to 28 per cent of primary medical care conducted on the telephone in the USA, Sweden and Canada (Williams et al. 1995). General practitioners expressed a willingness to work on the telephone but this was not borne out in practice (Hallam 1991). Patients were satisfied with the quality of help received from the doctor, but were not pleased with receptionists' questioning about their problems (Hallam 1993). There are also concerns about increased telephone access stimulating rather than curtailing workload. One piece of research showed that telephone consultations were used as an alternative to appointment making (Brown and Armstrong 1995), although Hallam, an experienced

researcher into telephone working in primary care, is sceptical of the time savings purported by this research (Hallam 1992).

Until the mid 1990s telephone working in general practice was largely practiced by doctors, especially out of hours (Marsh et al. 1987). From 1995 the interest and practice of telephone working and triage by nurses and doctors has grown rapidly. Triage is the process of "assessment to determine the urgency of a problem and to designate appropriate resources" (Gallagher et al. 1998c). Currently, nurses define it with appropriate training working to explicit protocols: it is a formal rather than an ad-hoc activity. By 1997, 30 per cent of out of hours services employed nurses to triage calls, and all offered telephone advice from either a doctor or nurse (SWOOP 1997). Practice nurses also used the telephone to successfully triage daytime requests to see the doctor (Crouch et al. 1996; Gallagher et al. 1998a). Jones and I also showed that nurse telephone triage could reduce doctor home visits by 59 per cent and 14 per cent respectively (Gallagher et al. 1998b; Jones et al. 1998). The difference in experience in two practices in neighbouring health authorities and with similar practice size and experienced triage nurses, may be explained by natural variations in visiting rates, the experience and attitudes of triage nurses, and the practice-patient culture about triage and home visiting.

Nurses see telephone working as appropriate use of their knowledge, skills and time (Edwards 1994; Hallam 1992a; Williams et al. 1995). Telephone triage is now an accepted way of graduating access to general practice care, as it has been shown to reduce doctor work, and provide a more accessible and appropriate service to patients. This positive view of nurse triage contrasts with negative initial views, "Imparting nursing information over the telephone is analogous to nursing with your eyes closed and your hands tied behind your back" (Glasper 1993).

'Modernising' access

A key feature of the NHS Plan was to improve patient access to primary care and hospital services (DOH 2000). This included the targets of 24 hours to see any health professional in a practice, and 48 hours to see a GP. The governmental vehicle for improving access is the Modernisation Agency and its five teams (DOH 2001). The National Patients' Access Team concentrated on reducing inpatient, day case and outpatient waiting times by identifying and disseminating good practice in waiting list

and booking management. The National Primary Care Development Team was formally established in February 2000 to manage a national improvement programme called the Primary Care Collaborative. The collaborative focused on improving access for patients to primary care, "establishing systems in primary care to improve access to routine secondary care by addressing capacity and demand across the whole patient journey," and reducing mortality of people with Coronary Heart Disease (DOH 2001). A controversial American idea called 'advanced access' has been adopted by the Collaborative (Murray 2000; Smith 2001). The rationale of this new idea is that most waiting systems distinguish between urgent and routine appointments and so maintain two queues. Abolishing these queues and only having one short queue solves the problem. The short waiting time is achieved by several tactics: gaining capacity by smart working; clearing backlog of work; reducing the number of queues and types of visit; developing contingency plans to predict and manage fluctuations in demand; reducing demand for care by doing "one more thing" in the consultation; and matching demand and supply without delay (Murray 2000). The claimed benefits of this approach are improvements in patient access in America and in some 20 per cent of English practices (Smith 2001). This approach has been criticised on several fronts. First, this American concept is not transferable to health care in the UK which is culturally quite different. Second, advanced access assumes that a steady state can easily be reached because of removing waiting times, but removing them might stimulate rather than control or reduce demand. Third, there is not enough evidence of benefit without increasing doctor workload (Cave 2001; Craighead 2001; Meadows 2001). In one practice that introduced advanced practice, each doctor experienced an increased in patient appointments from 168 to 250 per week four months into the scheme, a temporary improvement in access was not maintained, and the doctors were "on their knees" (Dakin 2000). Advanced access is an exciting approach to managing demand and improving access. It may not be applicable to every practice; this may not be surprising as there are limitations to any model based on concepts of demand and supply. It is too early to see which practices will benefit long term from initiatives such as this. Evidence in the UK of sustained improvements from advanced access is not available.

Out of hours – access all hours

Out of hours care is important in itself and because it impacts on daytime care. Contractual changes and government support in the mid 1990s stimulated the growth of GP co-operatives. Increasingly GPs were less likely to provide night care personally choosing to delegate work to a commercial deputising service or belonging to a local co-operative of GPs where they would be on call during the night less frequently. By October 2000 only a third of GPs employed a deputising services and the majority of the remaining two-thirds belonged to GP co-operatives (DOH 2000).

A Department of health review that set out to develop standards for out of hours access advocated simplifying access by only one telephone call to out of hours care via NHS Direct, and more flexibility and co-operation in delivering services (DOH 2000).

Home visits – falling demand

Home visits account for 10 per cent of general practitioner contacts in the United Kingdom (Aylin et al. 1996). They are an important feature of general practice in Britain and in other European countries (Marshall 1996; Oreskovic et al. 1997). Analysis of data from the fourth national morbidity survey by Aylin showed that 1.3 per cent of patients accounted for 39 per cent of home visits, and home-visiting ratios for the 60 practices contributing data varied nearly eight-fold (Aylin et al. 1996). This study is important because of its size, and overcomes many of the limitations of previous studies that were based in one practice or on small samples.

Since the 1960s there has been a decline in home visits. For example, the General Household Survey showed a decline in home visits from 22 per cent in 1971 to 16 per cent in 1977 (OPCS, 1995). Cartwright attributed this to social changes such as better transport and increased telephone access (Cartwright 1967; Cartwright and Anderson 1981). Others confirmed this, notably Marsh (Marsh et al. 1972; Whewell et al. 1983). Whewell suggests several reasons for these differences including flexible appointment systems, improved efficiency and better organisation of the surgery (Whewell et al. 1983).

Patients' experiences of home visiting are first described by Arber in her interview survey of 1000 adults in 1977 (Arber and Sawyer 1985; Sawyer and Arber 1982). Much of this data concentrates on patients' relationships with receptionists as

mediators of home visits. For example, nearly a fifth of patients who asked for a home visit were asked by the receptionist to come to the surgery instead. Over 60 per cent of parents who requested a home visit brought their child to the surgery, but two-thirds of them were unhappy about doing so. Those without cars and with young children were adversely affected. Older people had less difficulty. Generally people were unhappy when they thought that "urgency" or "need" was being assessed by a receptionist (Sawyer and Arber 1982).

One qualitative paper investigates patients' accounts of calling the doctor out of hours. (Hopton et al. 1996). Although respondents described symptoms as the main reason for the call, they also described a range of other factors that led to the call, including their feelings, concerns about specific illnesses, their responsibility for others, and their previous attempts to manage the problem themselves. They also described past experiences with health services that were important in explaining the current out of hours call or explaining their general approach to using services. This work supports much of the research looking at illness behaviour.

2.4.4 Primary care access

Alternatives to general practice include NHS Direct, accident and emergency departments and pharmacists.

NHS Direct – from the surgery to the sitting room

The introduction of NHS Direct, the 24-hour health telephone line in July 1998 was a key feature of the government health reforms (DOH 2000a). The Health secretary, Alan Milburn, stated (Grice 2000)

> "In 10 years time, you will be as likely to use NHS Direct, the Internet or digital TV as your first port of call for entry into the NHS as to nip down to the local GP surgery."

NHS Direct reflected the growth of consumerism and technology by offering a more convenient, accessible and interactive gateway for patients to primary health care (Pencheon 1998b). Pencheon recognises that NHS Direct moves the gateway to the NHS "from the surgery to the sitting room" with much more public participation in health care (Pencheon 1998a). It is important because it challenges the traditional

model of requesting and waiting for a general practitioner appointment. An alternative is provided on the telephone (Pencheon 1998a).

There are a number of criticisms about NHS Direct. There are questions of safety and effectiveness, about the quality of the service provided, concerns about lack of integration with other services, concerns that it stimulates demand for all services rather than curtailing them, and that it may disadvantage sections of society (Florin and Rosen 1999; Pencheon 1998b). Initial results evaluating NHS Direct showed that 95 per cent of callers found the advice from the nurse helpful or very helpful (Munro et al. 1998; O'Caithain et al. 2000). This evidence is weak as it reflects the views of only those that have accessed the service and patient satisfaction can be high even if there are inadequacies in the service (Florin and Rosen 1999). Research, however, from the USA suggests that it is possible to provide a quality telephone advice service that does effectively manage demand (McKenna 1999). The future is likely to see more and better integration with general practice, particularly co-operatives (Reynolds 1999).

Walk-in centres have also been seen as a supplement to general practitioners' care by giving speedy access to care. It is likely that these centres will only have a peripheral impact on primary care as there are only a handful of them, in contrast to the biggest 'walk-in' providers of health care - general practice and accident and emergency departments. They are likely to attract young working people who are not prepared to wait or travel to see their usual GP. It has been suggested that they may reduce GP appointment requests and visits to accident and emergency departments (Clews 2000).

In addition to NHS Direct the government introduced the World Wide Web service NHS Direct online (Carnall 2000). While it is popular with patients, little research exists into its impact on supporting patients in self-care, or reducing demand for other services.

Accident and emergency – a primary care provider

Until the late 1990s accident and emergency workers blamed their increasing workload on "inappropriate attenders", particularly people who could have seen their general practitioner (Driscoll et al. 1987). The British Association of Accident and Emergency Medicine in 1998 estimated that between 10 and 40 per cent of accident and emergency patients needed primary care (Robertson-Steel 1998).

There are several explanations for patients choosing to visit accident and emergency departments rather than their general practitioner for primary care. The predominant reason is difficulty in getting an appointment quickly enough (Campbell 1994; Green and Dale 1992; Shipman et al. 1997), although dissatisfaction with previous general practitioner care (Green and Dale 1992) and distance from the practice are also factors (Campbell 1994). There is a growing acceptance that many of these patients need and should have primary care delivered within accident and emergency departments. Dale, working at King's College Hospital, showed that employing general practitioners to work in these departments was a cost-effective way of providing this care (Dale et al. 1996). Many of these patients could also be triaged by nurses to identify those needing primary care (Dale et al. 1995).

Underused pharmacists

Pharmacists are seen as an underutilised resource in primary care. In 1979 the Royal Commission on the NHS promoted the development of pharmacies in health centres as a way of fostering interaction between pharmacists and general practitioners. By 1991, however, only 10 per cent of the total numbers of pharmacists in England were integrated with general practices (Bond and Bradley 1996). There is a growing recognition of their place in giving health advice (Bond and Bradley 1996); 16 per cent of patients had consulted a pharmacist before seeing the doctor in 1985 compared with 11 per cent in 1970 (Elliott-Binns 1986).

2.5 Summary

Improving patient access to health care and managing patient demand are important NHS priorities. The relationship between need, demand and access is complex and contested.

Access is a broad concept which includes notions of seeking a doctor or nurse, rationing, the availability of a service, and issues of cost, time and convenience. It also has the dimensions of accessing information from relatives, friends and other professionals such as pharmacists. Access to general practice and other primary care services such as out of hours services, accident and emergency departments and pharmacists, is affected by social class, distance from the surgery, and perceived ease of getting a doctor's appointment.

The dominant notion in health service policy and practice is of 'clinically defined need'. This means that need is defined in terms of a symptom, signs or condition where there is an 'effective' ameliorative or curative intervention.

Demand is the expression of need in a population group. Demand management is concerned with curtailing demand for ineffective services, and coping better with demand for effective services. An example of this latter approach is nurse telephone triage.

The economic model dominates past and present health service policy about access, managing health demand, and use of hospital and primary care services. Other models, such as the iceberg of symptoms and social process models, attempt to integrate self-care and lay care, the use of social networks and organisational factors in understanding health need and demand.

The organisation of primary care affects access to care and how demand is managed. General practice has evolved from a 'cottage industry' in the 1950s to a professional service where doctors, nurses, managers, receptionists and other professionals work together to provide care. Between 1964 and 1977 the GP Charter stimulated receptionist employment and growth of health centres and appointment systems. Receptionists became recognised as gatekeepers to appointments to see or speak to the doctor or nurse. The conception by Arber that they were 'dragons behind the desk' still pervades public and professional consciousness about the receptionist role. A weakness of the research by Arber and Cartwright is that patients were asked their views of receptionists rather than observing receptionist-patient relationships. A recent survey of receptionists showed that they derive most satisfaction from their relationships with patients, rather than professionals.

The 1990s saw a number of government and general practice initiatives to manage demand better and improve access. GPs in out of hours co-operatives discovered the value of doctor and nurse triage to cope with a rising number of out of hours calls. The nurse advice telephone service NHS Direct was established in 1998. Research suggests that telephone triage is safe and effective. There is debate about whether it has reduced or stimulated demand for primary care services. The government introduced a contentious target of access to see a GP within 48 hours. The government's Modernisation Agency has promoted the concept of 'advance access' where

eliminating a backlog of waiting time for general practice appointments would lead to eliminating waiting times.

It is increasingly recognised that accident and emergency departments and pharmacists have roles as primary care providers.

2.6 Conclusions

There are several conclusions that I draw from my literature review that I will apply in my research.

1. The relationship between access, need, and demand is complex and unclear
2. Economic models dominate our understanding of access, need, and demand.
3. In recent years there has been an emphasis on pragmatic solutions to managing demand and improving access.
4. Access and demand management are influenced not only by what patients do, and how professionals respond, but also by health service policy.
5. Research on the formulation of demand and use of services should include the use of a social process model rather than being based solely on economic or medical models. This takes account of patients' conceptions of illness, and the use of social networks and other social factors in accessing health care.
6. The seminal research into patient-receptionist relations by Arber and Cartwright is based on large samples of structured interviews with patients, not on observation. Only one study has observed appointment making in general practice. This examined receptionist attempts to maintain continuity of doctor care, but did not observe patients.
7. Little research examines the *interaction* between patients and receptionists, particularly when making appointments.

Chapter 3 : Methods

"Armado: How hast thou purchased this experience? Moth: By my penny of observation."
Love's Labours Lost, William Shakespeare.

3.1 Introduction

This chapter examines the methods I have used in my research. This includes the thinking behind the study, ethical issues such as consent and confidentiality, and issues of quality. Several theories that contributed to planning and conducting my research are also discussed. The main method used is participant observation which can be seen as a collection of methods that includes observation, informal interviews, examination of documents and self analysis. The theoretical and practical problems in planning and doing observations and interviews are discussed.

3.2 Theory and research

3.2.1 The place of theory

A theory is a collection of ideas that "make things that were hidden visible, to define some patterns and give some meanings to observations that social researchers make when investigating society" (Gilbert 1993). Theories are important because they influence all stages of research, including planning and understanding results (Alderson 1998). In practical terms, theories should provide explanations for the phenomenon under study and make predictions (Howie 1996). Howie suggests that using more and better theories is needed to advance general practice research (Howie 1996).

A review of some of the literature predated my research. Particularly influential was literature on access to health care (Arber and Sawyer 1982; Cartwright and Anderson 1981; Stewart et al. 1995), and observational research involving receptionists (Freeman 1989). Initial theories and models which I studied included organisational theory (Blau 1972; Hall 1974), lay concepts of illness (Stewart et al. 1995; Tuckett et al. 1985), and theories and models about managing need and demand (Rogers and Elliott 1997).

Searching and reading of the literature continued during my research. I later examined research into general practice and hospital organisations such as the work of Stimson and Strong (Stimson and Webb 1975; Strong 1979). Their ideas were particularly

helpful in analysing the observational data. Another example where theory informed my research occurred after a preliminary analysis of caring and uncaring interactions between patients and receptionists. Two examples of phenomenological analyses of nurse caring provided useful insights into classifying caring and uncaring patient-receptionist interactions (Halldorsdottir 1996; Riemen 1998). I came across the first of these examples in the appendix of a book I was reading, the second research was suggested by my supervisor Pauline Pearson who had heard the author speak in Iceland.

3.2.2 Grounded theory approach

Two sociologists, Glaser and Strauss, originally described grounded theory in 1979 in their seminal book, 'The discovery of grounded theory' (Glaser and Strauss 1979). The book and method were a response to previous research that set out to verify so called 'grand theories' by the great men of sociology, and to now root theory in the experience of the researched. Grounded theory has developed since then, particularly by Strauss after a falling out with Glaser (Strauss and Corbin 1990; Strauss and Corbin 1998). Strauss and his co-worker Corbin define grounded theory as "Theory derived from data systematically gathered and analysed through the research process," with "data collection, analysis, and eventual theory standing in close relation to each other" (Strauss and Corbin 1998). Grounded theory is not simply a set of procedures, as Strauss states, "We are offering a way of thinking about and viewing the world that can enrich the research of those who choose to use this methodology" (Strauss and Corbin 1998).

Grounded theory has been accused of being unnecessarily strict in its application to a research subject. On being asked about the 'outer limits' of what Strauss would continue to call 'grounded theory,' he replied (Strauss and Corbin 1998);

> "The features of this method that we would consider so central that their abandonment would signify a great departure are the grounding of theory upon data through data-theory interplay, the making of constant comparisons, and the asking of theoretically orientated questions, the theoretical coding, and the development of theory."

Elsewhere Strauss emphasises flexibility in using grounded theory, "We know that readers ...will treat the material in this book as items on a smorgasbord table from which they can choose, reject, and ignore according to their own 'tastes' – and rightly so" (Strauss and Corbin 1998). They also recognise that it may not be used for theory generation, but for describing, classifying and elaborating.

The elements of grounded theory that I have used in my project are theoretical sampling, making comparisons, grounding the work in people's lived experiences and theoretical coding. Some people call this 'grounded theory approach' where not all elements of grounded theory are used, particularly the element of theory development.

Where I depart from traditional grounded theory as espoused by Strauss, Glaser and Corbin is the place of theory, and particularly prior theory. Glaser and Strauss assert that prior theory has no place in directing the research planning or conduct, as it might prejudice the research conduct. This approach can be criticised on two major grounds (Layder 1998). First, "by rejecting the contribution of general theory it impoverishes its explanatory potential" (Layder 1998). Layder emphasises that the contribution of a piece of grounded theory research should be seen as cumulative rather than being isolated. Ignoring previous theory and work ignores good ideas that may help inform the project. The second criticism of grounded theory is that, "although grounded theory is good at depicting the lived experience and subjective experiences of people, it does not have an adequate appreciation of social – structural or systemic aspects of society, because it is committed epistemologically and ontologically to denying the existence of phenomena that are not only or simply behavioural." Layder advocates a new approach to research where theory is used at all stages of the research to inform planning, data collection, etc. He calls this 'adaptive theory'. I have used this approach because it is impossible to ignore the contribution that theory and literature make to a research project. The best one can do is to be explicit about the conceptual theory and ideas and influences that have the potential to affect the project.

3.2.3 Dramaturgy

I was aware of some of the writings of Erving Goffman early on in my research. It was only while writing my thesis that I realised that dramaturgical sociology, and particularly the work of Erving Goffman (Goffman 1971; Hunt and Benford 1997), would be a useful concept for describing my analysis of waiting room behaviour

(Chapter 7.1). Dramaturgy is a perspective that uses a theatrical metaphor to understand social interaction. Its central concept is that people in a social context *act* to create meaning and demonstrate purpose. Goffman called such action 'impression management' where people develop and present particular images of themselves or fronts (Goffman 1959).

3.3 Methods

Methods can be defined as "a way of thinking about and studying social reality" (Strauss and Corbin 1998). I have already commented in my Chapter 1.5 that all research operates within assumed or explicit principles about the nature of reality (ontology), the relationship between the researcher and the observed (epistemology). I have also described three paradigms that influence research; positivism, constructivism, and critical theory. These paradigms produce conflicting views about the nature of research and questions about whether it is possible to determine the truth with any certainty (Hodgkin 1996). Seale advocates a pragmatic 'middle-way' between the extremes of the deductive and inductive approaches (Seale 1999). His approach accepts that social research is a "collection of craft skills driven by practical and local concerns," where competing philosophical debates are used as resources for creative research enquiry (Seale 1999). I embrace ideas from positivistic traditions and more contemporary research where I believe they provide useful insights into planning, conducting and interpreting my research. For example, I have used the positivistic notion of reliability as a tool to improve and monitor the quality of my qualitative data analysis. This is described in detail in Chapter 10.2 where I examine the quality of my research. In Chapter 10.2.3 I emphasise the contemporary notion of trustworthiness of my account to demonstrate the quality of my research (Lincoln and Guba 1985).

The main methods used were participant observation and long structured interviews.

3.3.1 Participant observation

Observational methods in social science involve "the systematic, detailed observation of behaviour and talk" (Mays and Pope 1996). These observations occur in natural rather than experimental settings. Two forms of observational methods have their roots in anthropology; ethnography and participant observation. Ethnography involves spending a prolonged period, perhaps years, in a culture before starting to collect data

(Gribich 1999). It could be argued that I had already spent a great deal of time as a GP working in the culture of general practice. I consider this to be an advantage, although my previous exposure to general practice was *not* as a researcher, and will have biases about working in a general practice setting. Participant observation developed as a shortened form of organised data gathering technique by Mead and others (Mead 1971). It was later used by sociologists, particularly the 'Chicago school' and others, in works such as a study of Italian slums in Street Corner Society by Whyte, and in Becker's study of medical student culture (Becker et al. 1961; Whyte 1981).

In health care research observation has been underused. Notable exceptions include Bloor's exploration of decision making by ENT surgeons for tonsillectomy (Bloor 1976), studies of patient consultations in hospital clinics (Strong 1979), and Stimson's study of general practice (Stimson and Webb 1975). More recently, Freeman observed how receptionists try to ensure continuity of doctor care in appointment making (Freeman 1989).

Participant observation can be defined as a "style of research which makes use of a number of methods and techniques – observation, informant interviewing, document analysis, respondent interviewing, and participation with self-analysis" (McCall and Simmons 1969). I have adopted this approach in my study. It can be thought of as self-triangulating.

There are a number of benefits of using participant observation as a research method. First, it can ameliorate the problem that people do not always do what they say (Mays and Pope 1996). This is particularly true of interviews where observers can present themselves in a good light and recall of events may be selective. Second, it avoids some of the problems of interviewer bias, where in the artificial setting of an interview the interviewer constructs an account. Dingwall argues that while observations are not free of bias the interview influences are less as "interviewers construct data whereas observers find it" in a natural setting (Dingwall 1997). Third, it is useful in examining natural settings, such as organisations, where important findings can be observed that respondents could not have revealed in interviews. One example of this is research of inappropriate attender in accident and emergency wards where patients were seen as 'normal rubbish' (Jeffrey 1979). This was an institutionalised response that respondents were largely unaware of, but which was visible to the new observer. Fourth, it provides a flexible approach with informal interviewing, counting,

observation and examination of documents or artefacts, and where there is genuine social interaction with subjects in the field and open-endedness in the direction that the study takes. Finally, getting close to participants allows the observer to access personal knowledge and direct experience as resources to aid understanding and interpretation of what is being studied. Reflections and introspection are also part of the data (Patton 1990).

There are, however, a number of problems with observation. These are considered next.

Observation

Observation can be divided into stages such as entry into the field, getting along with participants, and making decisions about the degree of participation or distance from the researched. There are also issues about recording data, bias and validity, and the degree of emotional involvement.

Entry into the field

A key strategy to gain entry to the practices was to secure the consent of general practitioners and practice managers. I telephoned one GP and the practice manager from each practice, and followed this up with a faxed summary of my research plans (Appendix 1). My approach was discussed at a practice meeting. All agreed to me conducting research in their practices. I then visited the practice to meet my telephone contacts and other practice personnel. I explained the objectives of the research and emphasised my research credentials and role. Two practices expressed concerns that I would generate extra work and affect the running of the practices. During that first visit I also looked for suitable areas for observing. In subsequent visits to the practice I was at pains to emphasise my independence from the approving authorities, particularly the doctors, and that my role in the practice was as a researcher not a general practitioner.

I usually dressed in jeans and jacket, a T-shirt, casual shoes and carried a rucksack containing all my equipment. No patient in any practice ever asked me what I was doing, despite their being a notice at the reception counter stating that I was observing in the waiting room. On my first day of observation at Practice A the practice manager (who I had met previously when dressed in a suit) mistook me for a patient.

"I was waiting outside the practice at 8.45 a.m. this morning. I was dressed in black Levi jeans, a grey T-shirt and blue corduroy Levi jacket. I was also carrying a green rucksack and pacing up and down the pavement at the side of the house [*surgery*]. I made eye contact with her as she removed her overfull carrier bag from the rear of her car. As she walked from the rear of the car she said to me, "If it's a prescription you want then you can come round the front (of the practice building)." I told her who I was. She then realised. I take it as a compliment - perhaps I look like a patient?"

Observation No 1, Practice A

Some staff were initially suspicious of me and tried to treat me as a doctor. I always insisted that they call me by my first name and that I was there as a researcher. Usually there was some testing out of my role in the practice. For example, two professionals joked that I was "a spy for the doctors," and "I suppose you're here spying on us." The following encounter occurred in the Practice B's coffee room with five receptionists present.

"The eldest receptionist gives me twenty questions about why I am visiting the surgery and what I am doing. Everyone else is listening. I answer her questions...On the way out she calls me Dr Gallagher. I suggest that she call me Morris - "After all, I'm not here as a doctor, but as a researcher." "All right," she says, "I'll break the habit of a lifetime and call a doctor by his first name." And she does thereafter. I know that I have been 'vetted' by the most 'senior' receptionist working in the surgery. And seem to have passed."

Observation No 12, coffee room, Practice B

Getting along

Playing and modelling the role of a researcher was an important strategy in all practices. Initially, in Practice A, I tried to remain detached from the practice staff to maintain 'objectivity', but this stilted my instinct to listen and share personal concerns, which occurred during informal questioning and during quieter moments in the surgery. My experience reflects Gold's comments on the subject, "success in both role-taking and role-playing requires success in blending the demands of self-expression with the demands of the role" (Gold 1958). I tried not to gossip with doctors and

receptionists and cast myself as a listener. I also found that making the tea when the receptionists were busy was a way of becoming involved in the practice. Initially, it was usually me who initiated conversations, usually to clarify observations. After a time, the receptionists involved me in conversations or banter, or asked my opinion. The more time that I spent in the practices, the more I knew about the home and family lives of the practice staff, particularly the receptionists. This was particularly so in Practices A and C.

> "Behind the reception desk I am accepted, but occasionally they make comments about the doctor, "All doctors are the same." They are taking a dig at me, but probably because I am a safe person and accepted by the practice."
>
> Observation No 5, Practice A.

Participating or not?

The extent to which the observer is a participant in the setting is best seen as a continuum from complete immersion to acting as a spectator (Patton 1990). Gold presents a typology of researcher involvement from complete participant with covert observation, to participant as observer with overt observation, to observer as participant with no enduring relationship based on lengthy observation, to complete observer with no participation; see Figure 3-1 on next page (Gold 1958). This typology was the starting point for thinking about my involvement. My approach, however, does not fall easily within this typology. It is closest to the participant as observer where my observations were overt with mutual awareness of the research. The problem with Gold's typology is that it invites you to commit to a limited number of choices. For example, it does not include variables such as how the purpose of the observation is presented to others.

Figure 3-1: Researcher roles in observation (Gold)

Complete participant	Covert observation
Participant as observer	Overt observation – mutual awareness of research
Observer as participant	A 'one shot' interview with no enduring relationship based on lengthy observations
Complete observer	Experimental design, no participation

I prefer the approach of Patton who describes five dimensions to thinking about observational fieldwork (Patton 1990). These are shown in Figure 3-2. The attraction of Patton's typology is that all of these dimensions, including the researcher roles, are thought of as continuums and other variables are considered.

Figure 3-2: Five dimensions of variations in approaches to observations (Patton)

Dimension	Range of dimensions
Role of observer	Full participant observer << Partial observation >> Onlooker
Portrayal of observer role to others	Overt, everyone knows observations are being made and who observer is << Observer known by some and not others >> Covert, no one knows observations are being made and who observer is
Portrayal of purpose of observations to others	Full explanation << Partial explanations >> No explanations to staff or participants >>- False explanations; staff deceived
Duration of observations	Single, of limited durations << >> Long-term, multiple observations
Focus of observation	Narrow focus; single element of setting << >> Broad focus; holistic view of research setting

If I apply the first of Patton's dimensions to my research, my role and participation varied from time to time and situation to situation. Initially I behaved solely as an observer in the waiting room and did not become involved with patients or professionals. I was concerned about maintaining distance from the observed and the concept of objectivity. When observing with the receptionist behind reception counters I would have more participation with receptionists, especially if I solicited their ideas

about events that I had just witnessed (informal interviewing). I recorded only one episode, in Practice A, where I consciously stepped out of my role as a researcher. I spoke to a distressed pregnant woman on the telephone when the receptionists could not contact the general practitioner. My role changed from researcher to GP and from observer with participation to full participant. I believe that it was appropriate for me to express the 'caring' and 'helping' aspects of my personality and professional training. There were many other situations where I could have asserted my role as a doctor but did not. My full participation in this setting was limited and temporary. The staff appeared relieved that I had intervened. Interestingly, this period of observation continued with me returning to my established role as researcher and the receptionists treating me as before. There was an unspoken understanding that this was an exceptional event. In retrospect I did not consider the potential negative implications for the project. In other settings and with different people stepping out of my role as a researcher and returning to it again might not have been possible. In my situation I trusted the reception staff to be sensitive to my dilemma, and they were.

The observer is in the social world, but not of it. This inevitably produces anxieties and uneasiness (Fielding 1993), that are never quite removed by physical and emotional involvements in the setting. At the start of my observations I felt isolated from the people in the practice because I consistently tried to play my research role. Later on I became more relaxed and informal in my relations with staff, but still treated all comments and confidences as sources of data. This sense of marginality is probably essential to the success of the research. If I were to be completely involved in the practice, rather than at some distance, it would affect what I see and record, and my interpretation of events. The consequences of not being sufficiently involved with participants are that it would adversely affect my data collection, and impair my understanding of the social world of the practices. There is a fine line between under involvement and over involvement, both of which could prejudice the research. It is likely that I have strayed either side of this line throughout the research, perhaps erring on the side of being too involved with individuals.

The second of Patton's dimensions is concerned with the degree of overtness or covertness of observations. The waiting room observations could be classed as covert observation or overt observation with mutual awareness of the research as I had put a notice at the reception counter stating that "a researcher from Newcastle University is

in the waiting room...doing research..." Some patients would have been aware of my presence from the notice or might have 'guessed' that I was a researcher. Other patients would not have seen the notice or 'noticed' me. To them my observations would have been covert. Even though all the professionals were aware of my research into appointment making I do not think that most were initially aware that I was interested in the wider workings and culture of their practices. I recorded coffee room and corridor comments in my fieldnotes. These observations could be thought of as covert in nature, as the professionals had not overtly agreed to this aspect of the study.

Patton's third dimension is the continuum of explanation of the purpose of observations to others. I tried to give as much explanation to staff as I could on entering the field. I gave a handout to all doctors and receptionists and discussed my research with them when asking if I could observe them at work. I have already mentioned coffee room and corridor observations. It could be argued that I deceived the professionals in the practices by recording coffee-time chats. In fact, it was only once I had entered the field that I realised that it was important to absorb and record the life and culture of the practice, and not simply focus on appointment making and practice policy. Recording 'backstage' comments were important to understanding the difference between public and private behaviour. I doubt that people would have been quite so open and honest if I had 'flagged up' that these where settings where they would be observed, and worse still recorded.

Patton's fourth and fifth dimensions in thinking about observations are concerned with the duration and focus of observations. These are considered in detail in Chapter 4.3.2 which is about choosing when and what to observe.

Recording and analysis

Observations are by their nature selective. It is not possible to observe or record everything. The purpose of my first observations was to identify the nature and range of interactions seen in the waiting room. I recorded all activities in the waiting room and reception areas for periods of 30 minutes. Usually, this was at the beginning of my observational period. I chose to sample periods when the practice was at its busiest, and when demand was 'more normal'. The receptionists recommended these periods. Invariably the busiest period was a Monday morning, and a 'more normal' period was

a Wednesday or Thursday morning. Sometimes other periods of observation were chosen to fit in with my work and social commitments.

The purpose of activity recording was to identify the nature, frequency and range of observable practice activities. Initially a list was made of all activities or tasks occurring in the waiting room or reception. From these, two Excel spreadsheets were constructed; one for the waiting room, and one for the reception area. Each activity was described and defined on the spreadsheet. These were refined, over several observation periods, to be as inclusive as possible. Printouts of the spreadsheet were used as proforma for recording activity data. The spreadsheets changed as the observations progressed and very quickly became 'saturated' for new events. Activity recording was conducted in the waiting room and behind the reception counter. The results of activity recording are in Chapter 7.3.1.

A recurring theme in my early field notes is that the practices are "bustling" that it is impossible to observe everything and that my observations need more focus. At Practice B it was too difficult to observe all receptionists' activities, because there were too many happening at the same time. I concentrated on those that were visible from the waiting room. I wanted the staff of Practice B to collect additional data to describe the full range of receptionist and administrative activities, such as telephone calls and requests for prescriptions. They did not want to do this as they felt that it was extra work when they were already overworked. There are fewer observations from behind the reception counter at Practice B than in the other two practices because of a lack of space behind the reception desk for me to sit.

In the waiting room I usually sat opposite the reception hatch or counter (see Chapter 5). I would have a file on my lap and open exercise book in which I would write my field notes. My activity spreadsheet would also rest on a hard-backed book. Chapter 5.4.1 details how observations and interviews were transcribed.

Bias and validity

The disadvantage of identifying me to the observed is that it may provoke changes in patient and receptionist behaviour – the so-called "Hawthorne effect" (Roethlisberger and Dickson 1939). Whyte and I experienced this while observing (Whyte 1981);

"Doc (one of the street gang members) found the experience of working with me interesting and enjoyable, and yet the relationship had its drawbacks. He once commented: "You've slowed me up plenty since you've been down here. Now, when I do something, I have to think what Bill Whyte would want to know about it and how I can explain it. Before, I used to do things by instinct."

"Initially *[name of receptionist]* would chat to me - about my family about triage. It is part of the 'checking out' procedure that I have experienced before. She then says, "Normally I would be busy doing other things if you were not here." I encourage her to do what she normally does - this is about 40 minutes into our time together. She is giving me a running commentary on what is happening."

Observation No 27, reception counter, Practice C

In practice A and C there are examples of receptionists saving incidents to narrate to me or directing me to patients or interesting incidents. The first of these was a patient who tried to bypass the system for obtaining appointments by involving someone outside the practice as an advocate; the second was a patient who the receptionist disliked who had just come into the waiting room. Another problem is 'going native' where you become so much a part of the culture under study that you lose any sense of objectivity or distance from it. This danger was particularly evident after I had been in the practice for some time.

"Comment: A lot of discussion about *[a named health care professional's]* high cholesterol level (8.3). The discussion is more interesting than the observation. My observations are coming to an end - it's quite a discipline, the focus is now on the interviews."

Observation No 7, reception counter, Practice A

Documentary analysis

Documents about appointment-making and policy were sought during my time in the surgeries and afterwards. At the end of my time in the surgeries I requested workload figures and copies of practice meeting minutes from all three practices. I obtained the former, but not the latter. I did not have sight of the workload data, but the practices

did complete a proforma on which they put details about the practice population and staff.

Practice A showed me a manual, which included three documents about making appointments none of which covered tactics to use. All detailed the process of making appointments using the computer. Practice B had a two-page document stating how appointment making was organised. It did not cover the implementation of these approaches, which were invariably passed on verbally as the practice rules. Practice C did not show me any documents describing the role of receptionists.

Reflective diary

Comments on the nature of the research were entered into my fieldnotes. I also kept a reflective diary of my reading, ideas, and personal feelings as a Word file. Later on it was imported in to NUD*IST to be coded. Examples from this appear in Chapter 5.3.2.

3.3.2 Patients and professionals interviews

There were three sets of patient interviews: developmental, short and long. All the interviews with professionals were long interviews. The interviews are summarised below.

Table 3-1: Summary of type and number of interviews conducted

Type of interview	Patient interviews (No)	Professional interviews (No)	Practice(s)
Developmental – to develop questionnaire	(3)	None	A
Short interviews 10-30 min	(12) people attending 'open access' clinic.	None	B
Long interviews – 30-90 mins	***Six groups of interview:***		
	Parents of children < 16 (3)	Receptionists (10)	A, B and C
	Patients aged 16-65 (6)	GPs (2)	
	Patients aged > 65 (5)	Managers (2)	
	Complainers (3)	Practice nurse (1)	
	Complimentors (3)		
	Waiters (3)		

A key issue in tackling the reliability of interviews is standardisation of questions in the interview guides. There is a danger that if identical questions are asked then the interview can become stilted and that this is "a retrogressive move that seeks quixotic reliability at the expense of validity" (Kirk and Miller 1986). The other danger is that there is a lack of consistency in questioning so that one loses focus. My strategy was to develop a question *guide* which mapped out in some detail some of the areas that I was interested in. Within, for example, four long interviews there was consistency about the issues raised, although each individual interview highlighted additional items raised by the interviewee or me.

The selection of patients for interview is considered in Chapter 4.2 and 4.3.3. Some of those chosen for interview had already been observed or discussed. An example of this was three patients from the waiting room selected for long interviews who had waited more than an hour to see the doctor or nurse. There were three sets of data pertaining to these people: what the patient and receptionist said and did together, the receptionist's reaction to the patient, and the patient's account of the interaction with the receptionist and visit to the surgery.

All but one of the long interviews were conducted in people's homes. I usually parked my new Volvo estate car some distance from the house. I thought that if the patients saw the car then it might prejudice them against me, particularly when visiting socially deprived areas. On one occasion when I interviewed a patient I took with me my black leather briefcase. At the end to the interview I said to the patient that "I am also a part-time GP." I was interested in what their reaction would be. The interviewee, a 22-year-old woman, said, "I knew that you must be. I saw your stethoscope dangling from your bag and thought you probably were." It is not always possible to eliminate all the cues that one gives or appropriates.

There was some tension about being covert in identifying myself to patient interviewees. I always introduced myself as, 'A researcher from the University of Newcastle upon Tyne.' All patients were offered sight of my University student card which has my photograph on it, together with an information and consent sheet to sign. I always explained the nature of the research.

After my second long patient interview I decided to tell some people at the close of the interview that I was also a part-time general practitioner, and whether they thought that

it made any difference to the interview or might have done so. A number said that they felt that they thought that I was a health worker. Two patients went on to ask oblique questions about the confidentiality of the interview. In all cases I re-emphasised that I did not know the practice and my data would not be available to it. Only one patient asked me if I was a general practitioner. I replied that I was.

Several patients were interviewed jointly with another patient. This included a husband and wife who had both consulted their doctors with whiplash injuries and a teenage girl and her mother whom I had met in their doctors' waiting room. Most joint interviews occurred fortuitously when I visited the house and the other person in the room, usually the spouse or partner, was invited to take part. Some partners agreed to take part, some remained in the room during the interview and said nothing, and some left the room. When two people were interviewed together I tried to ensure that I had both of their views on the main issues, although it was usually the woman who made appointments. It is difficult to quantify the impact of a 'passive' party in an interview. I could have insisted that I interviewed all participants alone, but this seemed an artificial thing to do when interviewing in people's homes: I wanted to make people comfortable and at ease. Only if there was substantial contribution from the other person in the room were they included in my sample. Table 4-4 in Chapter 4.3.3 details the patient long interview sample and Appendices 2 and 3 contain the patient and professional interview guides.

3.4 Ethics

Ethical issues and problems are an integral part of research in naturalistic settings. Debate in the literature about ethics in health care did not help me to resolve these problems except to emphasise the importance of patients' rights and the principle of informed consent (Doyal 1997). It was one thing to read about ethics, but another to apply these principles to my research.

Lofland and Lofland in their guide to qualitative observation suggest two ethical questions that researchers should address when planning observational research. They are, 'Should this setting be researched by *anyone*?' and, 'Should this setting be researched by *me*? (Lofland and Lofland 1995). Both questions are ways of assessing the potential negative consequences of the research. I thought that observing a general

practice environment was a legitimate subject for research as previous research had avoided direct observation of patients. A criticism of observational research is that all (or almost all) covert observation is unethical as it involves deception. The concern here is to seek consent and prevent exploitation of individuals or groups. I sought the consent of the professionals in the practices through a formal approach to the decision-making doctors and managers, and later, informally, to individual professionals while observing. The decision-makers and observed professionals were given a summary of the research plan. Obtaining the consent of individual patients was problematic. This was the major concern of my local ethics committee (South Tyneside). It would be impossible to seek every person's informed consent, and if I did it would probably affect the behaviour of patients. I agreed with the ethics committee to put a notice at the reception desk informing patients that there was a researcher in the waiting room (Appendix 4). The notice stated that if they were unhappy with the researcher's presence then they should speak to the receptionist. I had doubts that patients would see and remember the notice, but to my surprise most of the patients interviewed for the long interviews had read it and noticed my presence.

The issue of whether it is right for me, as a general practitioner, to research general practice is problematic. There are concerns about status and bias. In primary care, GPs have a high status compared to receptionists and patients. This can affect the dynamics of these relationships. The danger in the field would be that I would be seen and treated as a GP rather than as a researcher. This would affect the quality of my observations and successful integration into the practices. We have already seen how some of these concerns were addressed in the field. There are also advantages to me, as opposed to somebody else, doing this research. I already had insight into how primary care 'works' from working in a general practice environment, and had developed personal and research skills that enabled me to get on with patients and professionals.

Confidentiality.

Throughout my research I assured patients that I would not discuss my observations of their behaviour or their interviews with anyone else except my supervisors, although I made it clear that unidentified comments would appear in a final report and research papers. I also promised not to use real names of people or any other details that would identify them in a report or paper. The confidentiality of the interview contribution was

always discussed before interviews (Appendix 5). Some patients and professionals questioned my reassurances about confidentiality. Two of these professionals were influential people within their practices and gave revealing accounts of their practice's organisation. Four patients asked questions about the confidential nature of the interviews. Their main concerns were that I was not working for the practice or that their comments would "get back to the doctors." I had concerns that someone would divulge information that was of a criminal or harmful nature, where the issue of breaking confidentiality might arise. In practice this did not happen. I did however interview someone who felt that the practice was negligent in the death of his or her parent who had died a few days before. They intended to submit a written complaint. I thought that in my role as a researcher I should not comment, only listen. In retrospect I should have had a discussion with potential interviewees that included discussion about when I would feel is essential to break the promise of confidentiality. For example, I could have explained that if they gave information about people who were being harmed or damaged, then it would be my duty to act on that information to prevent further harm, and that this would override the promise of confidentiality. It is possible that after hearing an extended discussion of confidentiality, as above, some potential participants might have decided not to be interviewed.

3.5 Quality in research

There is a debate about what criteria should be used to assess the quality of *qualitative* research in primary care (Carter et al. 1999). Published guidelines contain ideas derived from assessing quantitative research, such as the notion of the reliability of data and ideas derived from contemporary social sciences, such as trustworthiness (BMJ April 26th 2002; Lincoln and Guba 1985; Mays and Pope 1996a; Murphy et al. 1998). The question is, therefore, what criteria *are* applicable in judging the quality of qualitative research in primary care?

A thorough analysis of the nature and value of criteria in judging research is provided by Seale (Seale 1999). His overview divides these criteria into positivistic and interpretivistic. The former is concerned with criteria originating within the positivistic tradition, and evaluates concepts such as objectivity, validity and reliability. The interpretivistic tradition espouses relatively new ideas such as trustworthiness, and

criteria such as credibility and transferability (Lincoln and Guba 1985). These concepts are summarised in Table 3-2, which is an adaptated from Lincoln and Guba.

Table 3-2: Lincoln and Guba's schemata of criterion (adapted by me)

Criteria	Positivistic criteria	Interpretivistic criteria
Main idea(s) connected with criteria.	Ideas of **validity, reliability, and objectivity**	Idea of **trustworthiness**
Components of main idea(s).	Truth value – **internal validity** Applicability – **external validity** Consistency – **reliability** Neutrality - **objectivity**	**Credibility** **Transferability** **Dependability** **Confirmability**

3.5.1 Positivistic criteria

Objectivity, validity and reliability are key ideas within the positivistic tradition.

Objectivity

Objectivity is traditionally concerned with producing facts that are not influenced by the personal biography of the researcher. The main objection to this view is that facts can never be neutrally produced, and that scientific facts are no more value free than those that arise in daily life. Other threats to objectivity are the effects of the observer's presence on the phenomenon being studied and limitations of the observer's ability to witness all aspects of the phenomenon (McCall and Simmons 1969). The Hawthorne experiments showed that inserting an experimental situation into an environment or being part of the experimental team affected the performance of those observed (Gribich 1999; Roethlisberger and Dickson 1939). In the experiments the observed factory workers increased their performance; this could not be explained by independent or extraneous variables. Despite these objections the concept of objectivity still has value. Researchers can employ procedures to collect and analyse data that to a greater or lesser extent reduce the influence of the researcher (Seale 1999).

Detailing these procedures in the research account allows the reader to judge the degree of objectivity of the research, rather than committing the researcher and reader to an unrealistic belief that knowledge is fixed and true for all time.

Validity

Validity is concerned with whether something is true or not. Internal validity is the "extent to which causal propositions are supported in a study of a particular setting" (Seale 1999). Integral to this concept is the idea and practice of fallibility, where the researcher has to consider and overcome 'threats' to these propositions. This encourages methodological awareness to counteract these 'threats' and pre-empt critics of the research. A qualitative corollary of this is the search for negative cases that try to falsify emerging causal propositions (see Chapter 3.5.2). External validity is concerned with "whether causal propositions hold true in other settings" – are the findings generalisable? (Seale 1999). I used ideas on triangulation to enhance the validity of my findings.

Triangulation

The concept of triangulation is drawn from military, navigational and surveying contexts, however Campbell and Fisk are credited with introducing the concept into qualitative research (Campbell and Fisk 1957). They state that, "When a hypotheses can survive the confrontation of a series of complementary methods of testing, it contains a degree of validity unattainable by one tested within ...a single method." Using two or more methods to analyse a single phenomenon – triangulation - is seen as a way of eliminating the biases of a single method. The idea was further developed by Denzin who identified four types of triangulation: of method; of data; of investigator; of theoretical model (Denzin 1970). Participant observation, by its emphasis on using several methods to collect data, can be thought of as inherently supporting the concept of triangulation. My experiments detailed in Chapter 10.2.2, using different investigator to observe the same phenomenon, are an example of investigator triangulation.

There are two main arguments for triangulation (Murphy et al. 1998). First, that triangulation is a way of increasing the comprehensiveness of the research by providing a more complete understanding of the phenomenon than could be achieved

by using only one method. The emphasis here is not that different data sources confirm one view, but that divergent findings from different sources may produce a more complete or sophisticated understanding of the phenomenon under study (Murphy et al. 1998). The second argument for triangulation is that it is a test of validity. Bloor summarises it as "findings may be judged valid when different and contrasting methods of data collection yield identical findings ...a case of replication in the same setting" (Bloor 1997). This assumes that the weakness of one method is compensated by the strengths of another (Bloor 1997), but this may not be the case as all methods have different strengths and weaknesses. Bloor argues that there is no problem if data from different methods agree, but if they do not then one is left with a choice between setting aside data from one method over another method. He argues that triangulation "cannot be a test of validity when only the findings are corroborated and not when the findings are confounded." Silverman views the main problem with triangulation as being that in juxtaposing data from different methods, it denudes the data of the context in which the data was produced (Silverman 1993). This is important because analysis in context is a crucial feature of qualitative research. A further criticism of triangulation is that it forces people to search for a single 'master reality' at the expense of other realities. This is problematic for those with a post-modern world view who assume that there are multiple realities. Murphy et al illustrate the limitations of using data from one source to validate that from another in the work of Stimson and Webb (Murphy et al. 1998; Stimson and Webb 1975). They discovered inconsistencies between their observations of patient-doctor interactions and what patients said at interview. Rather than reject one these accounts they treated the interviews as situated accounts where patients had the opportunity to redress the power balance of the doctor-patient relationship.

Reliability

Reliability in quantitative research is concerned with the search for a single external reality where different researchers find and measure the same reality. If, however, you adopt a constructivist view that there are multiple realities that can be researched and described, then logically it becomes a fruitless task to pursue a single reality, and attempts to do so may simply produce an artificial consensus.

There are several ways of thinking about reliability and replicability. LeCompte and Goetz usefully divide it into internal and external reliability (LeCompte and Goetz 1982). Internal reliability refers to the extent to which researchers applying similar constructs would match these to the data in the same way as the original researchers. External reliability concerns the capacity of other researchers studying the same area to produce the same findings.

Internal reliability

LeCompte and Goetz list five features that enhance internal reliability (LeCompte and Goetz 1982).

- The use of low inference descriptors. This involves recording observations as verbatim accounts of what people say, rather than researchers' reconstructions of what people say and do.
- Using multiple researchers. Using more than one researcher who communicates with each other during the process of the research may enhance internal reliability. One aspect of this is experiments of inter-rater reliability as suggested by Armstrong (Armstrong et al. 1997).
- The use of participant researchers. These are people recruited by the researcher to check the researcher's views are correct. This is similar to respondent validation.
- Peer examination. These are checks by supervisors on the research progress and analysis and findings. Peer auditors examine research transcripts and assess the adequacy of data reduction and analysis.
- Recording of data manually. This refers to the use of audio and video tapes for capturing data in its 'raw' forms.

Another contribution to the quest for reliability is in the approach by Armstrong (Armstrong et al. 1997). Armstrong and others reported the results of six experienced analysts of qualitative data asked to identify five main themes in interview transcripts of people with cystic fibrosis. There was concordance of analysis in the first three themes, the analysts tackled the fourth in different ways, and there was considerable divergence in the fifth theme.

They conclude (Armstrong et al. 1997);

> "...in spite of debate about the philosophical assumptions that underlie exercises in inter-rater reliability, in practice data do appear to speak in similar ways to different people, although each analyst might have used the themes to construct a different narrative about the people interviewed."

Indeed, Armstrong argues that as things have not been resolved at an ontological level, replication exercises are still useful as they help to generate trust in the research and subject the research to some testing circumstances. Three replication experiments are reproduced in Chapter 10.2.2.

External reliability

External reliability concerns the capacity of other researchers studying the same area to produce the same findings.

The ability to replicate a study as a value has been questioned. The most celebrated example of this is Margaret Mead's work on Samoan adolescents. Subsequent attempts were made to replicate this research several years later. Similarly, Whyte's research on Italian youth culture has also been repeated (Whyte 1981). The more recent studies came to contrary conclusions that differed considerably from the original researchers.

LeCompte and Goetz suggest five tactics for enhancing external reliability (LeCompte and Goetz 1982). The following should be addressed by the researcher:

- Their operational status during the research
- Sources of data, and
- The social situations in which this was collected
- A full account of the theories involved in the research, and particularly those that influenced coding
- Attention to methodological reporting

How I have applied these criteria during my research is considered in Chapter 12.

3.5.2 Interpretivistic criteria

Many new criteria for judging qualitative research vie for consideration. Particularly influential are Lincoln and Guba who argue that establishing the **trustworthiness** of a research account should be the prime objective in judging qualitative research, and should be a substitute for reliability and validity (Lincoln and Guba 1985).

They propose four criteria for qualitative researchers: credibility, transferability, dependability, and confirmability. Credibility is proposed as a replacement for internal validity. Transferability is advocated as a replacement for external validity where ideas such as random sampling are replaced by providing detailed description to allow the reader to judge the applicability of the research findings. Dependability replaces reliability and is achieved by auditing the decisions made by the researcher in producing their research. Confirmability is suggested as an alternative to objectivity. Here the researcher is obliged to provide a reflective account of how the research was undertaken and of triangulation exercises.

Credibility

Credibility asserts that through persistent observation, triangulation, showing interview transcripts and research reports to participants, respondent validation, the search for negative cases, prolonged time in the field, and exposing the research report to peer criticism the credibility of the research is established.

Negative cases

An analytical issue is the thoroughness with which the researcher examines the data for "negative" or "deviant" cases; those where the researchers explanations appear to be contradicted by the evidence (Mays and Pope 1995). Three uses of negative cases have been proposed: to provide additional support to the researchers conclusions; to modify the analyst's emerging view; to identify situations or behaviour that are exceptional for good explainable reasons (Perakyla 1997).

The commonest search for negative cases in my research was in judging the relevance of concepts in the data that did not 'fit' or that challenged other findings. Examples of these are detailed in Chapter 10.2.3.

Respondent validation

'Respondent validation' is a term used to denote techniques that purport to validate findings by demonstrating a correspondence between the researcher's analysis and participants' descriptions of their social worlds (Bloor 1997). The most popular way of doing this is to take an analysis back to respondents to see if they understand and recognise the researcher's description. My experiments in respondent validation are considered in Chapter 10.3.4.

Additional elements advocated by Lincoln and Guba are persistent observation, prolonged time in the field, and exposing the research report to peer criticism (Lincoln and Guba 1985). Persistent observation with a prolonged period in the field suggests that the observer is more likely to understand the context in which data is collected. This background information allows the observer to impose a broader perspective on the data and be more able to judge spurious finding and more reliable findings (McCall and Simmons 1969). Spending a prolonged period in the field is also more likely to have allowed participants to accept the role of the researcher. Indeed, all three practices were initially suspicious about the role of the researcher, but later accepted their presence in their practice. Throughout the research interim analyses were presented to my supervisors, at departmental meetings, to my partners and staff and at regional and national meetings. Some researchers readily accepted my ideas on the complex social process of making an appointment. Others were sceptical about my conception of receptionists as caring and uncaring.

Transferability, dependability, and confirmability

Transferability is advocated as a substitute for external validity. It is concerned with providing thick descriptions that allow the reader to judge the applicability of the research. Only after reading my report will you be able to do that. Dependability is concerned with auditing the decisions made by the researcher in producing this report. Within NUD*IST I kept a record of memos about important decisions made in thinking about the research. I copied complete versions of the NUD*IST research file which were later used as a basis for auditing the evolution of the range of coding. This is described in Chapter 5.3 in the chapter on analysis. I also kept a reflective diary of my research experiences. The main external resources for auditing my thinking and decisions were Pauline Pearson and Chris Drinkwater. On a monthly basis I would

present my findings and diagrams of my relationships between codes and groups of codes. NUD*IST allows an experienced user to explore the detail of coding and analysis. As none of my supervisors were experienced users this was not attempted. Clare Tagg, a NUD*IST consultant, did review the coding after three months for a whole day, and in particular encouraged me to move from descriptive coding to more conceptual coding to advance the study. In retrospect I could have involved an experienced user to audit the data collection and analysis.

Confirmability is suggested as an alternative to objectivity, but the emphasis is on reflection within the research account and with the triangulation exercises. These issues are discussed further in Chapter 10.

3.6 Summary

This chapter examines the methods I have used in my research. Methods can be defined as "a way of thinking about and studying social reality."

Several theories and models influenced my research including organisational theory, lay concepts of illness, appointment making models, theories about access and managing need and demand, and theories about the nature of nurse caring. Particularly influential was grounded theory. The elements of grounded theory that I have used in my project are theoretical sampling, making comparisons, grounding the work in people's lived experiences and theoretical coding. I refer to this as grounded theory approach where not all elements of grounded theory are used, particularly the emphasis on theory development.

The main method used in my research is participant observation which can be seen as a collection of methods that includes observations, informal interviews, examination of documents, and self analysis. Observation can be divided into stages such as entry into the field, getting along with participants, and making decisions about the degree of participation or distance from the researched. There issues about recording data, bias and validity, and the degree of emotional involvement. The ethical, theoretical and practical problems in planning and doing observations and interviews were discussed.

There is a debate about which criteria should be used to assess the quality of *qualitative* research in primary care. I have adopted the framework espoused by Seale in planning and doing my research (Seale 1999). He divides criteria for assessing the

quality of qualitative research into positivistic and interpretivistic. The former is concerned with criteria originating within the positivistic tradition, and evaluates concepts such as objectivity, validity, triangulation and reliability. The interpretivistic tradition espouses relatively new ideas such as trustworthiness, and criteria such as the search for negative cases, respondent validation, credibility, keeping an audit trial, and transferability (Lincoln and Guba 1985). I briefly discuss the applicability of these criteria to my research, although several experiments in applying quality criteria appear in Chapter 10 which bridges the results chapters with my discussion.

Chapter 4 : Sampling

> "As much as you want to, you cannot study everyone everywhere doing everything." (Miles and Huberman 1994)

4.1 Introduction

This chapter considers the principles and practice of sampling the general practices, observations and interviews.

4.2 Sampling principles

Sampling is the process of selecting settings, people, or phenomenon to study. My approach to sampling is as advocated by Patton, and Miles and Huberman (Miles and Huberman 1994; Patton 1990), and by theoretical sampling as described by Glaser and Strauss (Glaser and Strauss 1979; Strauss and Corbin 1990). The former researchers emphasise choosing cases and settings that illuminate the area of interest. The latter emphasises that these choices should be made on the basis of concepts generated during the research.

The key features of qualitative sampling are that *small* samples are involved, they are usually *purposive*, and are often *theory-driven* (Miles and Huberman 1994).

4.2.1 Samples are small

Quantitative samples are usually relatively large samples selected at random. The purpose of choosing this statistically representative sample is that it allows confident generalisation from the sample to the larger population (Patton 1990). Qualitative research focuses *in depth* on relatively small samples, even single cases (n=1). These are chosen purposely.

So how small can a qualitative research study be? This is not merely an academic question, especially when you are deciding how many practices, patients and professionals you want to observe and interview for a grant proposal. Again, Patton provides insight. He cites the work of Freud who established the field of psychoanalysis on ten patients, and other researchers who have studied one or three cases in depth which have led to significant contributions in other areas of research. He suggests that the validity of qualitative sampling has more to do with how information-

rich the cases are and the abilities of the researchers rather than just sample size (Patton 1990). Patton also suggests that 'how many' depends on what you want to know, the purpose of the enquiry, what's at stake, what will be useful, what will have credibility, and what can be done with available time and resources. Sample size is therefore negotiable, and like other areas of research depends upon personal judgement, peer review and consensus.

4.2.2 Purposeful sampling

The function of purposeful sampling is "to select information-rich cases whose study will illuminate the questions under study" (Patton 1990). Information-rich cases are those from which we can learn al lot about the issues that are of central concern to the purpose of the research. Table 4-1 summarises some of the elements of Patton's typology of sampling strategies that I have used (Patton 1990).

Table 4-1: Types of purposive sampling used in my research

Sample type	Purpose	Examples from my study
Typical case	Highlights what is normal or average	***Observations*** – 'normal' appointment making. ***Interviews*** – key informants to identify 'norms' of practice life.
Intensity sampling	Information-rich cases that manifest the phenomenon intensely, but not extremely	***Short interviews*** - 12 patients consulting 'urgently' at 'open access' surgery
Extreme or deviant sampling	Unusual cases that by contrast shed light on the normal.	***Long interviews*** - Patients who complained or complimented the reception staff.
Stratified purposeful	Illustrates subgroups; facilitates comparisons	***Long interviews*** – Three age groups selected; <16 yrs, 16-65 yrs, >65 yrs.
Confirming and disconfirming cases	Elaborating initial analysis, seeking exceptions, looking for variation.	***Observations*** – caring and uncaring interactions in later practices
Opportunistic sampling	Following new leads	***Long interviews*** – patients waiting more than 1 hour
Politically important cases	Attracts desired attention or avoids attracting undesired attention	***Observations and interviews*** – key informants: manager and senior receptionists

We can see from Table 4-1 that there can be considerable overlap in sampling types. My list of purposive sampling types and examples is not exhaustive.

4.2.3 Theoretical sampling

A further dimension to thinking about sampling is provided by choosing cases to examine theoretical constructs or concepts. Patton calls this 'theory-based' sampling and Strauss and Corbin call this 'theoretical sampling.' Strauss and Corbin define theoretical sampling as (Strauss and Corbin 1990);

> "...on the basis of concepts that have been shown to be significant during the research because they recur repeatedly or are notably absent when comparing incident after incident that have been examined."

Strauss and Corbin provide a great deal of advice (and nomenclature) about sampling most of which I did not find helpful. The sampling principles that I did find valuable also include searching for cases to verify the relationship between concepts and sets of concepts and the idea of theoretical saturation. This is where sufficient cases are chosen so that no new data on a particular category or the phenomenon under scrutiny are revealed (Strauss and Corbin 1990). An example of saturation is described in Chapter 5.3.1.

4.3 Applying sampling principles: idealism versus pragmatism

In the rest of this chapter I will apply the sampling principles that I have outlined and show how the exigencies of conducting the research affected sampling decisions.

4.3.1 The general practice surgeries

My initial approach to sampling the general practice surgeries, as detailed in my grant application, was to choose five general practices with features known to influence patient satisfaction with service provision (Baker 1996). For example, this would include a group training practice and a small group practice with personal doctor lists, where patients view the service provided as better than in a large practice or a practice with five minute appointments. I also thought that a single-handed practice might be easier to sample than a practice with personal lists and yet achieve the same objective of choosing a practice with 'personal care.' I also thought that a practice without an

appointment system might provide a valuable comparison to those with appointment systems. Strauss and Corbin, who have concerns about the use of the literature in grounded theory, recognise that it is essential to generate initial (and provisional) samples based on concepts identified in the literature (Strauss and Corbin 1990).

I started my research with a single-handed practice in Gateshead (Practice A) and left decisions about which practices to visit next until I had spent some time in the field. There were several reasons for choosing this practice. First, it was relatively near my home (10 miles away), in an adjacent health authority area. This would make it easier to visit frequently than if I lived at a distance. I also wanted the practice to be outside the area where I worked, so that I would not come across patients or professionals that I knew well. Second, I thought it more likely that I could gain the confidence of a small number of people – three receptionists, one manager, one doctor, and a nurse – than working with, for example, 39 people, as in my own practice. Third, I hoped that the relatively small number of appointments made by patients would give me plenty of time to learn to be a researcher. This included developing my observational and interviewing skills, developing the activity recording and manifesting the role of a researcher. Fourth, I expected to see more examples of routine appointment making, rather than problems with personal care – getting to see the same doctor. I also thought that there would be little tension about making urgent or emergency appointments, although this proved to be wrong.

I chose *this* single-handed practice because I had met the doctor and his practice manager at a conference, five years earlier. I did not know their staff. The previous contact was a sufficient base on which to approach the practice. This practice also had a waiting room where I could easily overhear what was said at the reception counter. I reconnoitred the surgery's waiting room before visiting the doctor and practice manager.

After Practice A I felt that I needed to visit a larger, more complex practice. Practice B was a group practice of three doctors in a deprived area of South Tyneside operating from a purpose built health centre. I was also interested in two services used to manage patient demand, a so called, 'open access' surgery for people who wanted to be seen urgently, and telephone triage of home visit requests by a district nurse, although I did not have time to investigate the latter service. I had spoken to one of the partners three times in the last 15 years, at postgraduate meetings. My practice manager belonged to

the same practice manager group as their manager. Again, I did not have a detailed knowledge of the practice, although I had visited it several months previously to observe the work of the home visit triage nurse. I expected to find more dissatisfaction with appointment making. I hoped that there would also be more consultations to record and observe, because of the increased size of the practice. Personal care – care provided by the same doctor – was a major issue and benefit at Practice A. I was interested in how much this would be an issue at Practice B with three doctors.

While observing in Practice B I thought about which practice to visit next. I tried to identify a practice on Tyneside without an appointment system via the local Family Health Service Authorities (FHSAs). Two practices were identified, both of which had changed to an appointment system within the last two years. Rather than insisting on the strict list of practices that were suitable to visit, I felt the most information-rich practice would be a large group practice with a large practice team. I had become more aware of the practices as cultures to sample rather than simply reservoirs of appointment making episodes.

Practice C was chosen because it was large with seven doctors and numerous other staff. I suspected that the organisation and relationships between people was complex. They had also recently started to share the employment of our practice business manager, and had adopted practice nurse telephone triage of same day requests to see the doctor. Some of the doctors had visited my own practice twice, but I had not visited their surgery. Like the two other practices, I felt that I needed to have some tentative history with the practice as a starting point for soliciting their involvement in the practices. I thought that the nature of the research might be threatening to the practices.

I realised two or three months after starting field work that it would be impossible to visit my intended five practices. The time taken to do this, and manage the associated analysis, would be prohibitive. I thought it better to observe three practices in some depth rather than several practices superficially. I also considered that other similar practices would provide little new information. With the increasing size of the practices it took proportionally longer to gain the confidence of the practice staff. I wanted to feel that I had in some measure got to know 'what makes the practices tick'.

4.3.2 The observations and interviews

Activity recording

My aim was to record patient-receptionist interactions, and appointments made at the reception counter and on the telephone, and anything else that seemed interesting. A starting point for thinking about examining workload was previous research on receptionist activities, much of which was quite old (Buchan and Richardson 1972; Copeman and Van Zwanenberg 1988), and .the observational work of Freeman (Freeman 1989). Events and behaviour recorded in the activity spreadsheets and field notes were those that seemed relevant to appointment making. These recordings are considered in detail in Chapter 7.5.

In Practice A it was relatively easy to record activities, but once I got to practice B and C it became more difficult. In these two practices some appointment working, especially on the telephone, was moved to locations distant from the waiting rooms and reception counters. In Practice B and C the filing was also separated from the reception area. I did not observe there. I did ask the receptionists and practice managers of Practices B and C if they would collect workload data, but they did not want to generate extra work. I decided at these two practices to focus more on the workload within the reception area that was visible to patients and me.

The dates, days, times and places of activity recordings are shown in Table 4-2.

Table 4-2: Dates, days, times and places of activity recording in the study practices

Date	Day	Time	Setting	Practice
08.06.98	**Mon**	**9.00 am**	Reception counter	A
11.06.98	**Thur**	**9.30 am**	Reception counter	A
19.06.98	**Fri**	**9.15 am**	Reception counter	A
29.06.98	**Mon**	**9.15 am**	Reception counter	A
02.07.98	**Thur**	**9.45 am**	Reception counter	A
06.07.98	**Mon**	**9.45 am**	Reception counter	A
04.06.98	**Thur**	**8.50 am**	Waiting room	A
04.06.98	**Thur**	**9.20 am**	Waiting room	A
04.06.98	**Thur**	**9.50 am**	Waiting room	A
05.06.98	**Fri**	**3.45 pm**	Waiting room	A
05.06.98	**Fri**	**4.15 pm**	Waiting room	A
05.06.98	**Fri**	**4.45 pm**	Waiting room	A
08.06.98	**Mon**	**10.45 am**	Waiting room	A
12.07.98	**Mon**	**10.50 am**	Waiting room	B
07.09.98	**Mon**	**10.15 am**	Waiting room	B
10.09.98	**Thur**	**3.30 pm**	Waiting room	B
14.09.98	**Mon**	**9.50 am**	Waiting room	B
11.11.98	**Wed**	**11.35 am**	Waiting room	C
11.01.99	**Mon**	**10.50 am**	Waiting room	C
11.01.99	**Mon**	**11.20 am**	Waiting room	C
12.01.99	**Tues**	**1.50 pm**	Waiting room	C
14.11.98	**Mon**	**8.35 am**	Reception counter	C
14.11.98	**Mon**	**9.05 am**	Reception counter	C

Note: each period of activity recording lasted 30 mins. The time given is the start of the period.

Waiting room and reception observations

The decisions about when and where to do waiting room observations with informal interviews are similar to those for activity recording although they are explained in more detail here. Initially, I intended to systematically observe mornings, afternoons, and evenings of the week, including Saturdays. As my observations at Practice A were characterised by little activity, and few demands for 'emergency' appointments, I decided that I needed to observe when there were more patients in the surgery. As the focus of my research was on observing patients and receptionists managing demand or making appointments, particularly when busy, it was crucial to change the observational times. A complete list of observations appears in Table 4-3.

Table 4-3: Table of observations

Observation Number	NUD*IST document code	Date	Day	Times	Hours and min of session	Site of observations: R= Reception W= Wait room C= Coffee room A= Admin area	Practice, A, B or C
1	AOR1	04.06.98	Thurs	1030-1200	1.30	R	A
2	AOR2	08.06.98	Mon	1715-1815	1.00	R	A
3	AOR3	11.06.98	Thurs	0915-1215	3.00	R	A
4	AOR4	27.06.98	Sat	0930-1200	2.30	R	A
5	AOR5	29.06.98	Mon	0900-1130	2.00	R	A
6	AOR6	02.07.98	Thurs	0930-1200	2.30	R	A
7	AOR7	06.07.98	Sat	0930-1100	1.30	R	A
8	AOW1	04.06.98	Thurs	0850-1020	1.30	W	A
9	AOW2	05.06.98	Fri	1545-1715	1.30	W	A
10	AOW3	08.06.98	Mon	1045-1145	1.00	W	A
11	AOW4	15.06.98	Mon	1045-1145	1.00	W	A
12	BOC1	07.09.98	Mon	1040-1120	0.40	C	B
13	BOC2	14.09.98	Mon	1100-1130	0.30	C	B
14	BOR1	07.09.98	Mon	0920-0950	0.30	R	B
15	BOR2	14.09.98	Mon	1330-1530	2.00	R	B
16	BOR3 (GP)	11.11.98	Wed	1345-1400	0.45	R	B
17	BOR4 (GP)	12.11.98	Thurs	1115-1145	0.30	R	B
18	BOW1	02.09.98	Wed	1045-1145	1.00	W	B
19	BOW2	10.09.98	Thurs	0930-1100	1.30	W	B
20	BOW3	10.09.98	Thurs	1530-1645	1.15	W	B
21	BOW4	14.09.98	Mon	0930-1030	1.00	W	B
22	BOW5	21.09.98	Mon	1030-1100	0.30	W	B
23	COAdmin1	14.12.98	Mon	1115-1215	1.00	A	C
24	COAdmin2	07.01.99	Thurs	1030-1100	0.30	A	C
25	COC1	14.12.98	Mon	1100-1200	1.00	C	C
26	COR1	16.11.98	Mon	1030-1130	1.00	R	C
27	COR2	14.12.98	Mon	0825-0940	1.15	R	C
28	COR3	07.01.99	Thurs	1200-1300	1.00	R	C
29	CORJoint	11.02.99	Thurs	1100-1200	1.00	R – Joy Guy	C
30	COWJoint	11.02.99	Thurs	1100-1200	1.00	W	C
31	COW1	05.11.98	Thurs	1730-1830	1.00	W	C
32	COW2	11.11.98	Wed	1130-1230	1.00	W	C
33	COW3	14.01.99	Tues	1355-1500	1.05	W	C
34	COW4	18.01.99	Mon	1145-1200	0.15	W	C
35	COR2Joint	03.09.99	Fri	1030-1130	1.00	R –Joy Guy	C
36	COR2Joint	03.09.99	Fri	1030-1130	1.00	W	C

Note: MG conducted all observations except where indicated (Joy Guy)

In Practices A and B the waiting room and reception areas were observed when the practice was at its busiest, and when demand was 'normal'. The receptionists recommend these periods. Invariably, the busiest period was a Monday morning, and a 'normal' period was a Wednesday or Thursday morning. Sometimes I observed at other times, to sample activities like the 'open access' surgery, or on Friday mornings or Tuesday afternoons, because of work and social commitments.

Usually I would observe in the waiting room for an hour and a half followed by a further hour and a half in the reception area, with a break in between. This gave me a rest from writing field notes. I also had the opportunity to discuss patients that I had observed in the waiting room. For example, I observed a distressed woman at the reception hatch, but it was only when I spoke to the receptionists about the conversation later that morning that I understood some of the reasons for this.

In practice B there was no space for me to sit behind the counter. I usually sat in the waiting room and would come to the reception desk or behind the counter to ask the receptionists to clarify what had just happened. In Practice B there were other areas, such as corridors, administrative areas and the coffee room, which became areas of observation and interaction that found their way into my field note diary.

In Practice C it was very easy to observe in the reception area and behind the reception counter. By that stage of the research I was more aware than at any other stage of the research that the dynamic of the whole practice was important in thinking about patient-receptionist-practice relations. I chose to spend time 'hanging around' in the coffee room and administrative areas. These sessions yielded useful insights into what was happening 'backstage;' some of these overheard comments were recorded.

The question of *what* to observe is important. Before starting my research I naively thought it was wrong to plan what to observe, and that the important behaviours would easily manifest themselves before me. After reading texts about observational research and talking to my supervisors I realised that you cannot observe everything and that "observation favours the prepared mind" (Attributed to Louis Pasteur in comment on QSR-Forum an Internet discussion group) For my first observations I decided to observe and record *all* waiting room interactions and activities, not simply appointment making, to provide a context in which appointment making occurred. I sought 'routine' interactions, as well as discordant, and 'successful' interactions. I collected details on

different appointment types, such as routine, urgent, return appointments, home visit requests, either face to face or on the telephone. During subsequent observations I became interested in finding examples of situations that had revealed themselves in the analysis. For example, I was interested in how 'good' and 'bad' receptionists behaved, and sought these out. I was also interested in episodes where receptionists asked patients for information about their problems.

4.3.3 The long and short interviews

There were three rounds of interviews: preparatory, short and long.

Preparatory interviews

Preparatory interviews were conducted in Practice A. My intention was to identify people who displayed emotions such as anger or sadness, and people with no overt emotional displays. The purpose of these interviews was to discuss their experience of appointment making, as a starting point for developing the questionnaire. Three patients were recruited from the waiting room. They were the parents of a young child, an elderly lady presenting for an emergency appointment and a woman whom I had observed a few weeks previously who was close to tears at the reception desk because she could not get an appointment with her usual nurse. These interviews were short, as I was not confident in my role as an interviewer.

Short interviews

The second round of interviews was in Practice B. Their open access surgery provided a 'captive' audience of a large group of patients and carers waiting, on a first come first served basis, to see the doctor. These appointments were all written by hand on the appointment book. Those who were lower down the list and therefore had the longest time to wait were chosen. Previous research literature and my work in the Practice A led me to sample parents of children, and middle-aged patients and the elderly. Discussion was needed to identify from the list (it could be as long as 30 people) who would be waiting a long time and therefore could be told that they would not miss their appointment while being interviewed. There were a total of 12 interviews. The focus of these 15-minute interviews was the reasons why they had come to see the doctor, together with their ideas about definitions of appointments. Early on in these

interviews I noted that employment and getting out of work to visit the doctor was an issue, and thereafter tried to choose middle aged men who appeared to be in paid employment. The two men were chosen as they looked as if they were dressed in work uniforms. I was interested in how work affected people's abilities to make an appointment and manage their illness.

In the next chapter (5.3.1 and Table 5-1) I detail how this sample became saturated so that no new data was obtained before the last of the 12 interviews were analysed.

Long interviews

Patient interviews

The third phase of 23 patient interviews was conducted between December 1998 and February 1999 in the three practices (Table 4-4 on page 90). The aim was to sample patients according to five interest groups that had been identified during conceptual coding: parents of children aged 16 and under, middle aged patients, and patients over the age of 65, patients who complained or who were thought of as complaining, and patients who complimented the receptionists or bought presents. After several of the long interviews I added a sixth category of patients who had been waiting in the waiting for an hour or more, because I was interested in their experience as an 'extreme' patient group.

The choice of how many people to choose for each of the six interest or 'extreme' groups was difficult. I initially decided on five people for each group as I thought that this would be yield sufficient data to allow comparisons between groups. It was more difficult to recruit parents of children < 16yrs where I recruited three parents, but I fortuitously sampled two further cases when selecting people for other groups. People who complained about or complimented the receptionist and people who had waited a long time in the waiting room were more difficult to recruit. There were three patients in each of these groups, but later reflection on the data and analysis, as for the other groups, suggested that sufficient patients had been chosen.

Recruitment of patients varied from practice to practice, but usually involved choosing them from that day's appointment written record or computer record. The records gave patient's details such as age and telephone number. I rang people to invite them to be interviewed. I also recruited some patients from the waiting room. Recruitment was

easiest at Practice C because of the large number of doctors working there and the practice had detailed patient information on the computer to which I had access. In contrast, in practice A it was difficult to identify certain groups for interview from the computer records. In Practice B some patients chosen from the appointment list did not have phone numbers. For convenience I chose patients with phone numbers. This discriminates against those without phone numbers recorded by the receptionists. The majority of patients were interviewed the same or the next day, so that their interactions at the surgery could be fresh in their minds. The interview usually started with an open question about why they came to see the doctor or nurse. This proved to be the most successful start for most interviews. Other approaches were less successful. For example, initial trials with an open question about how the practice managed the needs and demands of patients were abandoned. There were some questions that were asked of patients and professional, such as tactics used to negotiate appointments, and people's definitions of appointment types. This approach gave patient and professional perspectives on the same issue.

Table 4-4: Sampling frame for long patient interviews

	Group			Extremes			Interviewee						Practice details		Organisational issues				
Interview number	Children <16 yrs	Mid-age 16-65 yrs	Elderly >65 yrs	Complainers	Complimentors	Waiters	Age of interviewee	Employed	Joint interview	Sex of interviewee	Age children at home	Single parent	Date of interview	Practice	Recruited telephone	Recruited wait room	Home interview	Telephone interview	Hrs after consultation
3.1		Y					50	Y		F			14.12.98	C	Y			Y	3
3.2	Y	Fo					36	Y		F	2,6	Y	14.12.98	C		Y	Y		3
3.3	Fo	Fo			Y		27			F	10		14.12.98	C		Y	Y		8
3.4			Y				71			F			15.12.98	C	Y		Y		32
3.5		Fo		Y			53			M			16.12.98	C	Y		Y		48
3.6		Y					64			F			16.12.98	C	Y		Y		46
3.7		Y					42	Y		M			16.12.98	C	Y		Y		4
3.8a			Y				78		Y	M			07.01.99	C	Y		Y		2
3.8b			Y				76		Y	F			07.01.99	C	Y		Y		2
3.9a		Fo			Y		66		Y	M			07.01.99	C	Y		Y		5
3.9b		Fo			Y		72		Y	F			07.01.99	C	Y		Y		5
3.10a		Fo				Y	40	Y	Y	F	10,15		07.01.99	C	Y		Y		3
3.10b						Y	15		Y	F			07.01.99	C		Y	Y		3
3.11		Fo		Y			24			F			11.01.99	A	Y		Y		2
3.12	Y						26			F	1,3		12.01.99	B	Y		Y		26
3.13a		Y					42	Y	Y	M	5,13		12.01.99	B	Y		Y		27
3.13b		Y					37	Y	Y	F	5,13		12.01.99	B	Y		Y		27
3.14a			Y				72		Y	M			12.01.99	B	Y		Y		28
3.14b			Y				74		Y	F			12.01.99	B	Y		Y		28
3.15a	Y	Fo				Fo	22	Y	Y	F	1		15.01.99	A		Y	Y		3
3.15b		Y					54		Y	F			15.01.99	A		Y	Y		16
3.16	Fo					Y	33	Y		F	2,9,12	Y	20.01.99	A		Y	Y		*
3.17				Y		Fo	57			M			20.01.99	A	Y		Y		**

Key and comments to Table 4.1

Y = Yes

Fo = Fortuitous sampling of features of people from my 'interest' and 'extreme' groups.

M = Male

F = Female

* = 123 hours

** = 120 hours

Professional interviews

My first professional's interviews were in Practice A. I interviewed the practice manager who was an experienced receptionist, the practice nurse and the doctor. These interviews were to test out the areas that I though were interesting from the observations. For example, I observed that some receptionists asked for information from patients when they requested emergency appointments. I was interested in whether that was part of the practice policy and whether all were comfortable with this function. The repertoire of appointments available and the rules for getting them were complex. I wondered if staff felt that patients understood the apparent complexities of "the system" (the practice managers' words). I was interested in their views about discrimination as I had backstage conversations about people who they disliked and people who they liked.

Professional's interviews were conducted between June 1998 and July 1999. The timing of the professional interviews was usually after I had completed most of my observations in a particular practice. For example, in Practice B the practice manager and five receptionists were interviewed about a broad range of subject. The situation was similar in Practice C, but the three receptionists in surgery A were interviewed last. This was because I was keen to move on to observing in Practice B.

4.3.4 Extreme cases

Throughout my observations I was on the look out for unusual or special cases. This was not for novelty value, but because these may have illuminated features of 'the ordinary' in comparison with the extraordinary (Patton 1990). The extremes may also have lessons to tell of the service. As the fly leaf of a book of Goffman's essays on interaction rituals states (Goffman 1967);

> "For Goffman, as for Freud, the extreme cases are of interest because of the light they shed on the normal: the study of the trapeze artist is worthwhile because each of us is on the wire from time to time."

Examples of sampling extreme cases are my choice of patients who had complimented the receptionists or complained to the receptionist, and people who had been waiting for more than an hour in the waiting room in the long interviews (Table 4-4). This helped to shed light on the range of responses to patient-receptionists dealings.

4.4 Summary

This chapter has outlined the principles and practice of sampling my general practices, observations and people to interview.

The key features of qualitative sampling are that *small* samples are involved, it is usually *purposive*, and are often *theory-driven*. Qualitative research focuses *in depth* on relatively small samples. The function of purposeful sampling is "to select information-rich cases whose study will illuminate the questions under study." Information-rich cases are those from which we can learn a lot about the issues that are of central concern to the purpose of the research. A further dimension to sampling is 'theory based' sampling or 'theoretical sampling, which Strauss and Corbin define theoretical as sampling "...on the basis of concepts that have been shown to be significant during the research."

The rest of this chapter examined the choices I made in applying these sampling principles to choosing my general practices, the activity recordings, the observations, and the patient and professional interviewees. These choices are also judgements that I have made after talking with my supervisors and other experienced researchers.

Chapter 5 : Analysis

> "What methods of analysis can we use that are practical, communicable, and non self-deluding – in short, will get us knowledge that we and others can rely on?" (Miles and Huberman 1994)

5.1 Introduction

This chapter deals with how I analysed and organised my data. Data analysis consists of two main processes, data analysis and management. Analysis consists of the interplay between data, thinking and theory. Specific analytical approaches and techniques, such as grounded theory approach, matrices and visual maps are discussed. I will also demonstrate the process of my analysis by reviewing and auditing my data records. Data management is the process by which data is recorded, organised, and manipulated into other forms. This includes the use of the qualitative computer software's NUD*IST and Inspiration.

5.2 Definitions

Several terms are used to describe data analysis. The most important of these are defined below.

Codes are "tags or labels for assigning units of meaning to the descriptive or inferential information compiled in the study" (Miles and Huberman 1994). These can be words or phrases, or larger collections of data. They can either be descriptive labels such as 'age' and 'gender', or more complex labels such as 'racial stereotyping.'

Categories are groups of codes illustrating a particular concept or idea. These may have one or more subcategories related to the main category.

Themes are important categories or groups of categories that explain behaviour.

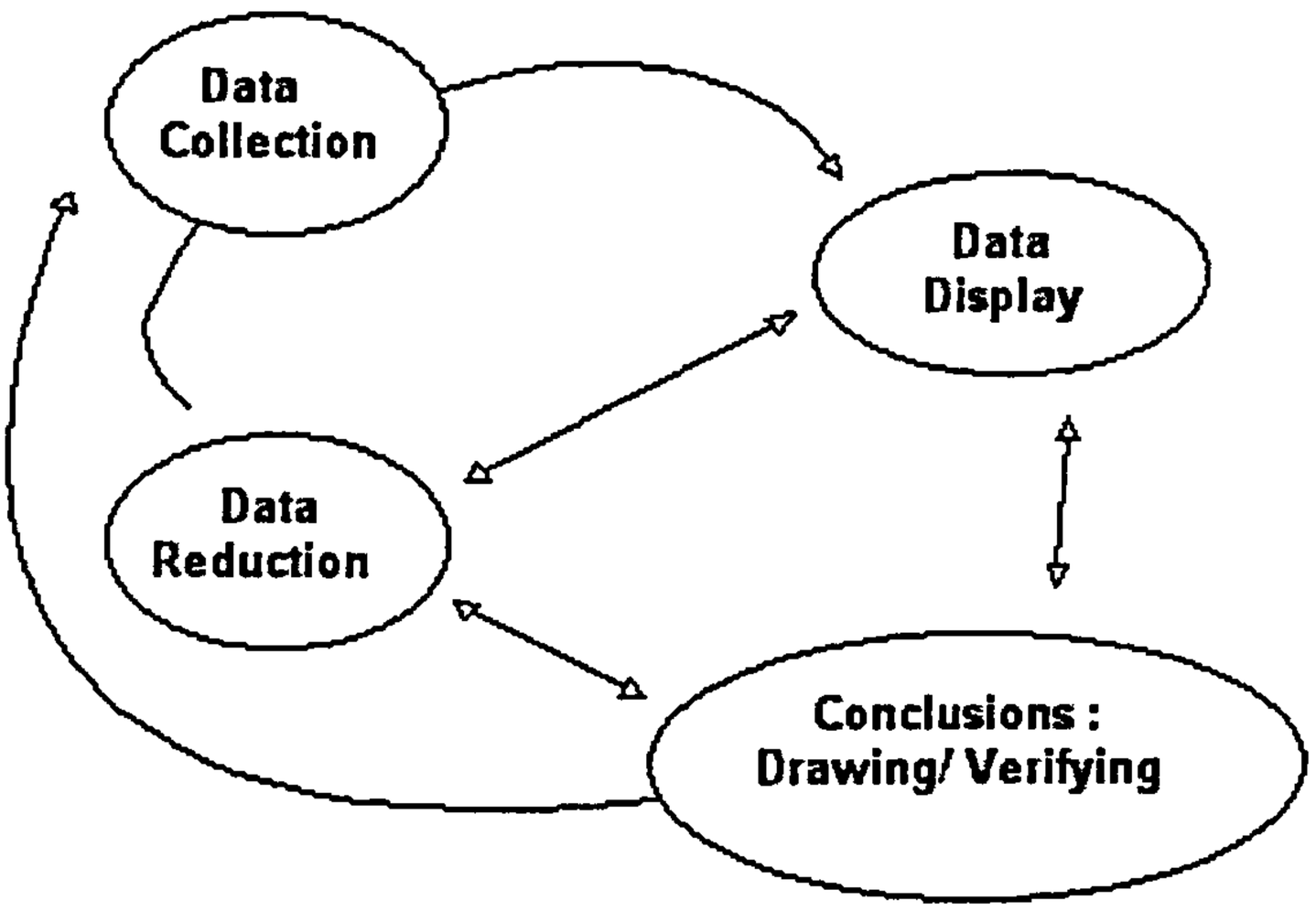
Memos are written records of analysis (Strauss and Corbin 1998). They also include theoretical notes about thinking, and ideas about sampling and analysis.

A theory is "The plausible set of relationships between concepts or sets of concepts" (Strauss and Corbin 1998).

5.3 Analysis

Analysis consists of the interplay between data, thinking and theory, and involves the processes of data reduction, data display, conclusion drawing and verification. Miles and Huberman see these three processes as interwoven before, during and after data collection to make up the general domain of "analysis" (Figure 5-1) (Miles and Huberman 1994). I have adapted the principles displayed in this model in my analysis.

Figure 5-1: Components of data analysis: interactive model



A number of authors suggest principles and guidelines for data analysis. I have drawn on the work of Strauss and Corbin, Miles and Huberman, Silverman, and the experience of my supervisors. Strauss and Corbin describe methods and techniques within an approach called 'grounded theory' for coding, developing concepts and making comparisons (Strauss and Corbin 1998). Miles and Huberman in their 'Qualitative research analysis: an expanded sourcebook,' champion the use of contact sheets, mapping and textual matrices to display data and conclusions (Miles and Huberman 1994). Silverman is an advocate of pragmatism in coding and analysing data and the use of counting in analysis (Silverman 1993).

5.3.1 Techniques

Grounded theory approach

I was attracted to grounded theory for two reasons. First, as a practitioner, it emphasised collecting and analysing the 'day to day' experience of people in their social environment. Second, it offered a structured approach to qualitative research, as in theoretical sampling and its techniques for facilitating analysis. This ordered approach appealed to my positivistic research experience.

The techniques that I used included open and axial coding, concept development, the constant comparative method and saturation of sampling. The latter is not a technique as such, but I shall argue that it is inextricably linked to analysis.

Strauss and Corbin suggest two types of coding, open and axial. The former are where "concepts are identified and their properties and dimensions are discovered in data" (Strauss and Corbin 1998). The latter are "the process of relating categories to their subcategories, termed 'axial' because coding occurs around the axis of a category, linking categories." This usefully defines two basic levels of coding, 'open' for early coding that is fluid and relatively unstructured, and axial where these early codes are in relationship to other related codes and ideas. I prefer to use the simpler labels of codes and categories (groups of codes) to define the two levels of coding. Strauss and Corbin also define a complex system for analysing data with strict definitions for concepts, categories, properties and dimensions of categories. I did not use this process because it lacked the clarity of the analytical processes described by Miles and Huberman (Figure 5-1).

Strauss and Corbin also espouse the 'constant comparative method' to analyse data (Strauss and Corbin 1998). The purpose of making comparisons is to identify *variations* in the data. These may be obvious, but may be made by manipulating the data or choosing samples that allow comparisons. For example, the samples for the long interviews were chosen to compare people who complained about the service with those who complimented the receptionists about the service. I made comparisons at several levels in the data. This could be comparing data line by line, or groups of data within tables or matrices.

Theoretical saturation of sampling data is a sampling method, but it is informed by the outcome of the analysis. The rule is to sample until theoretical saturation of each category is reached (Glaser and Strauss 1979; Strauss and Corbin 1998). In practice this means sampling until no new data emerges in a particular category. At this stage the data should provide sufficient explanation for the area under scrutiny and relationships between categories of data are well established and validated. To demonstrate this saturation of sampling (and analysis) I kept a detailed record on my sampling and analysis of 'the reasons why patient consulted urgently' (Table 5-1). The sample was a total of 12 short interviews (done in two batches of six) of patients waiting to see the doctor urgently in Practice B. The interviews explored reasons why patients attended then as opposed to by a routine appointment, and what factors, such as work, family, and social factors, led them to consult that day. I had identified these issues to be important after a preliminary analysis of observations from Practice A.

Table 5-1: Progress of coding of interviews on why patients consult urgently

Number of interviews analysed	**Date**	**Number of codes generated by analysis**	**Category and subsidiary coding labels. Category labels are in bold text *and* codes in plain text**
One	08.10.98	Seven	No categories. Seven codes: parental judgement, wait too long for an appointment, certainty seen, lack of routine appointment, work, high fever, child
Six	14.10.98	Twenty one	Five categories, and 21 subsidiary or unlinked codes: **Patients' judgements about illness:** previous knowledge of condition, lasted a long time, treatment failure, parental judgement, beyond self-care, feeling bad. **Organisational factors:** certainty of being seen, previous use of service, lack of routine appointments, wait too long for an appointment, anything, surgery not busy **Illness worries:** reassurance, worrying symptom **Child issues:** uncertainty about illness, deterioration **Social convenience** Unlinked codes: referred by other doc, employment concerns, sick note, doctor good reason, family advice
Nine	25.10.98	Nineteen	Categories reduced to three, **Patients judgements about illness, organisational factors, and employment concerns.** The two other categories not sustainable and absorbed into or relegated to plain coding. Some codes rejected as unimportant in the analysis No new codes or categories generated by the analysis
Twelve	30.10.98	Nineteen	Identical categories and coding to 25.10.98

The data for Table 5-1 was produced from four Inspiration maps of categories and codes saved on the dates shown. For ease of display the data is tabulated.

This table shows how quickly codes and concepts from the interviews became saturated. By the analysis of the sixth interview the range of codes and categories visible in the data was complete. This did not become clear until after the analysis of the ninth interview when no fresh codes or categories were identified. It was only then that it was clear that no more patients needed to be sampled about these particular issues. The table also show that there is a fluid relationship between category making and coding, as analysis and thinking changes. Categories and coding do not remain static as new data is collected and analysed.

Use of matrices

Matrices are often used in research involving numbers. They can also display textual data. Some of these were written in Word using the 'create table' option, others were generated in NUD*IST as a result of searching the database. A section of one of my earliest matrices was used to compare the appointments observed is shown in Table 5-2. The full matrix went to three pages. It included all appointment requests or queries observed in Practice A. The rules I used to develop the matrix were that at least one patient statement or observation must support each entry on the matrix, and that there was to be limited data reduction. The matrix made the elements of appointment making visible. Some of these ideas were kept, such as opening and closures. The matrix emphasised that the middle area was the area of complexity that needed further sampling and analysis.

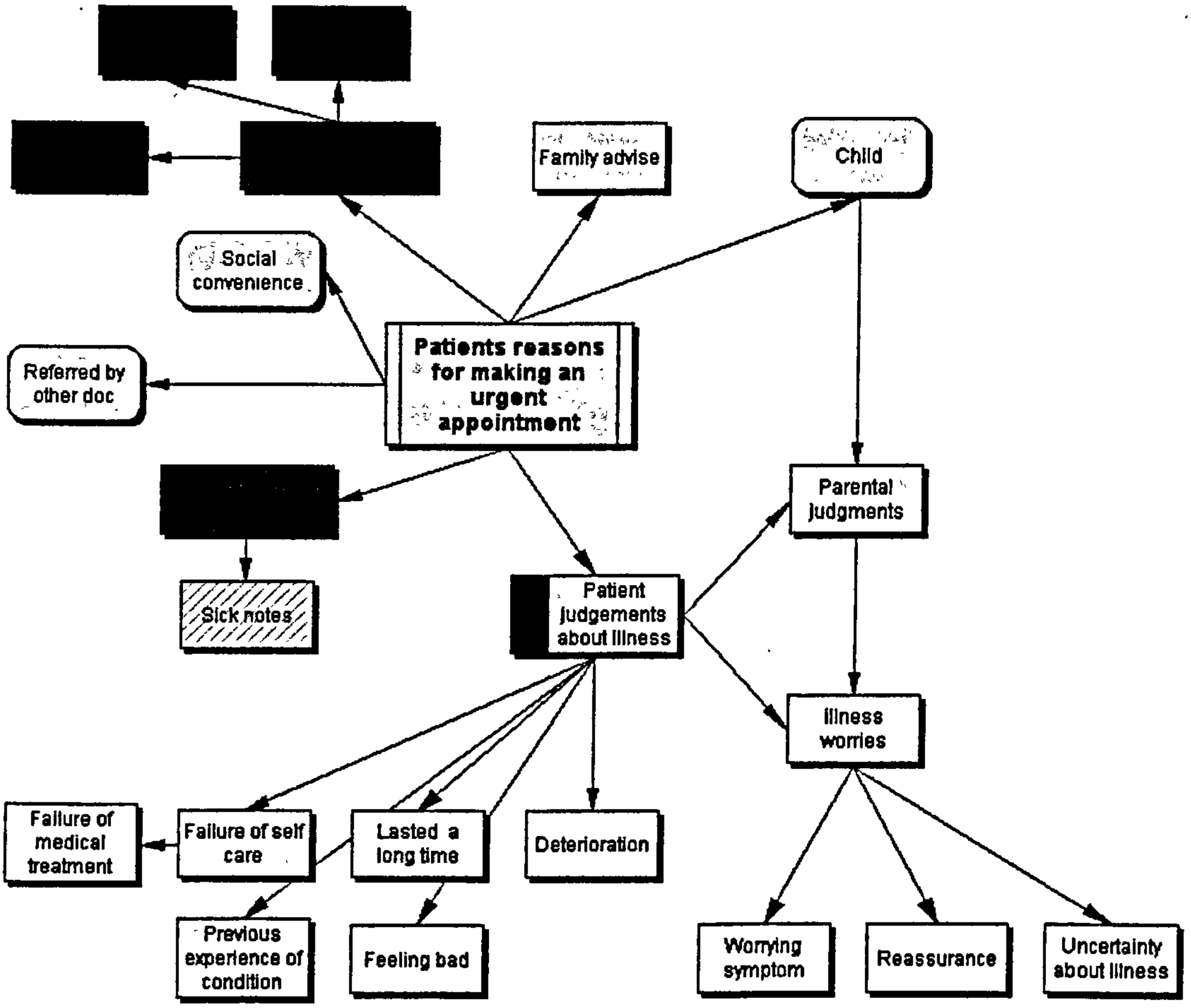
Table 5-2: Matrix of patient and appointment making phases

Patient and appointment	Beginning phase	Middle phase	Closure phase
M a 45 yr. old 'regular' with varicose ulcers that need regular dressing Return Waiting room	**Request** - "need to see the nurse" **Refusal and explanation** – "She's not in. She's on a course" **Disagreement about** availability – "she told me she was in" **Checking of availability** – "I'll have to check". Rings nurse.	**Disclosure about disappointment with unavailability** of nurse, and health problems – "I'm so disappointed" "I've got pains in my legs" **Display of emotion by patient** – "She had tears in her eyes when she talked about her pain" **Listening, empathy – receptionist**	**Acceptance** of offer **Reiterates disappointment** with nurse **Smiling, warmth – receptionist** (non-verbal communication)
50 yr. old man Checking in Reception	**Statement** – "I have an appointment for the doctor" **Refusal** – "I have no record of it" **Checking**	**Refusal** – "But I need to see the doctor" Offer with doctor at new time	Acceptance
Woman Repeat Reception	**Request** – "Can I have an appointment for next Friday" **Refusal** – "There aren't any"	**Asked to defer appointment request** –? offer "But you can ring in next Monday for the week after" (No more repeat appointments)	Acceptance (seems to understand the system)
Mrs S Emergency Waiting Room	**Request** – "To be seen tonight?" **Refusal** "Can't be seen"	**Offer** "We just have emergencies" **Offer of time** – "11.45 all right"	Acceptance

Mapping

Mapping is the process of displaying research data in diagrammatic from. Most of the maps were created in Inspiration after groups of categories and codes were imported from NUD*IST. The analysis of 12 short interviews on patient reasons for consulting urgently in Practice B, that were looked at under the subheading of grounded theory, was constructed in NUD*IST and then exported to Inspiration to view pictorially (Figure 5-2).

Figure 5-2: Patient reasons for making an urgent appointment



This version is similar to that produced early on in analysis prior to writing the thesis. The boxes can be re-orientated and changed to experiment with and display relationships between data. I used hundreds of them, keeping only the important ones.

Writing and presentations

Writing, as in memos, summaries of research, research papers, presentations and the thesis was a very important element of the analysis. Miles and Huberman in particular advocate the use of summaries of fieldnotes as a way of summarising and reducing data. Several of these were produced, usually for supervisors or departmental meetings. Usually these were presented as text with maps, matrices and extracts of data. The feedback from presenting data encouraged me that my analysis was valid, at least to those academics that responded to the data. Presenting summaries to respondents and key informants also suggested that my analysis was correct.

Paper writing was an important part of the analytical thinking, and in particular helped to hone the detailed description of the methods and develop conclusions. The interaction with authors, advisors, participants, referees and editors distilled the large volume of data into a form that was readable and understandable. Several ideas were generated by the authors about the significance of the research, some of these finding their way into print. Exposing the research to external scrutiny was also helpful to the interpretation of results. For example, the editor of the British Journal of General Practice commented on and identified a weakness of analysis and presentation of the long interview data in a submitted paper. Most of these groups were chosen to illuminate particular patients' views of access to care. As such they were biased towards patients' negative views and therefore not generalisable to other groups of patients.

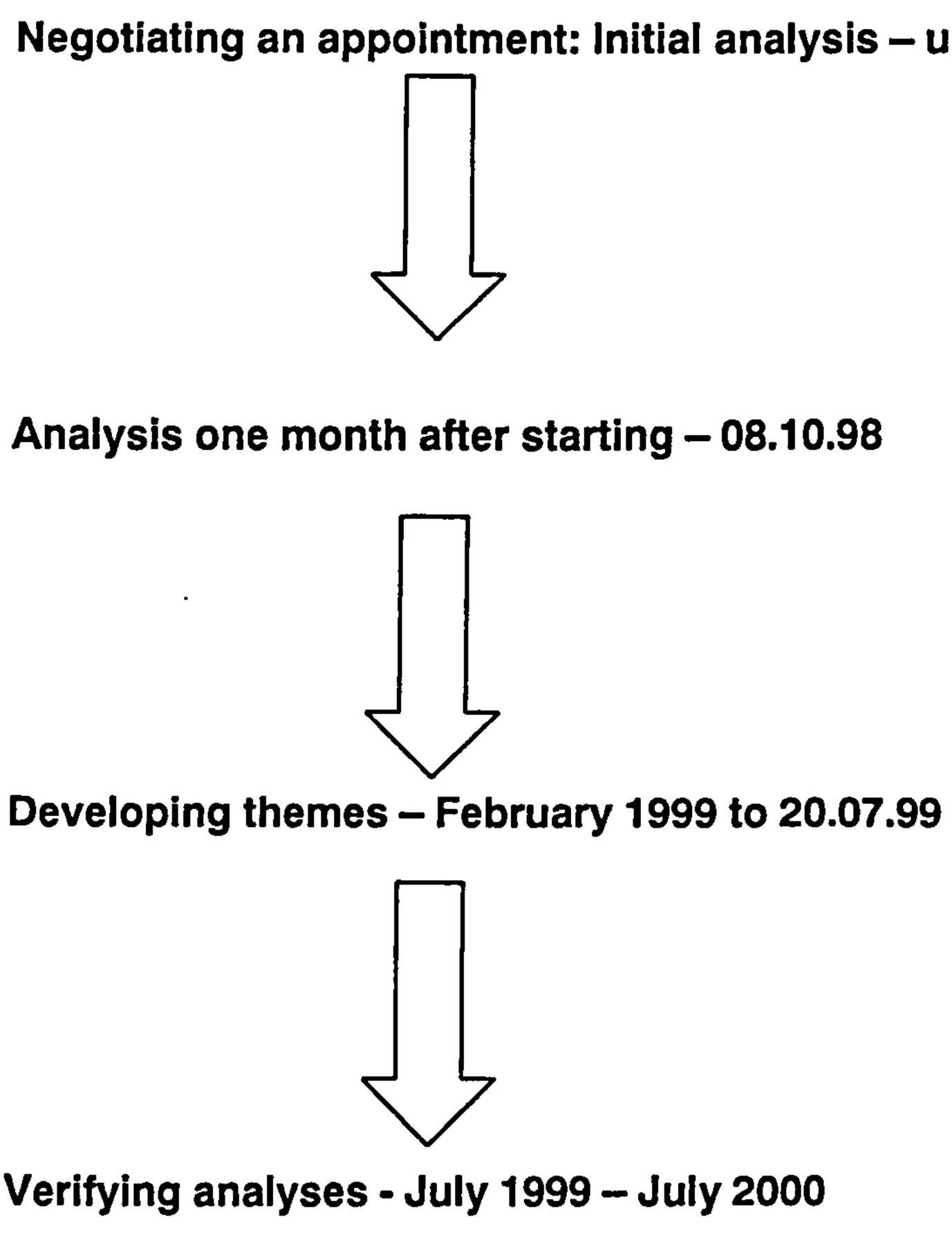
5.3.2 The process

Introduction

Qualitative data analysis is an iterative process, starting at the very earliest stages of data collection. It is complex and related to theory and sampling decisions. Miles and Huberman suggest three phases of data analysis: data reduction, data display, and conclusion-drawing and verification (Miles and Huberman 1994). Data reduction refers to the process of selecting, focusing, simplifying, abstracting, and transforming data. The aim of data reduction is to reduce the amount of data to be processed so that it is manageable. This begins before data is collected by the choice of conceptual framework, research aims and questions, and methods used. Thereafter coding and category development selects data that is interesting. Data display is "an organised assembly of information that permits conclusion drawing and action taking" (Miles and Huberman 1994). Conclusion drawing means, "Beginning to decide what things mean, noting regularities, patterns, explanations, possible configurations, causal flows and propositions" (Miles and Huberman 1994). Verification refers to testing out provisional conclusions.

I shall illustrate these processes by giving examples of how my analytical thinking developed and how I made choices about my data. I will concentrate on negotiations between patients and receptionists.

Four pieces of evidence were used to produce this retrospective view of the analysis process. They demonstrate an analysis audit trail. First, versions of the NUD*IST project folder were saved in their entirety on 03.09.98, 21.09.98, 30.09.98, 08.10.98, 19.11.98, 06.01.99, 20.07.99, 20.10.01. These dates usually preceded or followed significant changes in the coding framework of the project. The NUD*IST versions contain imported documents, command files, coding and category development, saved searches, and memos. The second piece of evidence was my reflective diary. This was begun on 11.03.98 and continued until 23.04.99. Thereafter, reflective comments were included as NUD*IST memos. The third piece of evidence was Inspiration maps. The final piece of evidence was notes, emails and summaries shared with my supervisors. I have divided my analysis process into four sections;



This example is a construction of the truth, which itself has been subject to the process of data reduction, data display and conclusion drawing to present what I think I did and why. It has, however, more validity than simply trusting to memory alone.

Negotiating an appointment: Initial analysis – up to 03.09.98

Transcripts processed.

Transcripts from 11 observations (AOR1, AOR2, AOR3, AOR4, AOR5, AOR6, AOR7, AOW1, AOW2, AOW3, AOW4), and five interviews with a GP, a practice manager, two patients and a practice nurse (AVGP1, AVMan1, AVPat1, AVPat2, AVPN1), were imported into NUD*IST.

Indexing the data

Much of the initial indexing of data were descriptive labels decided on prior to importing the data into NUD*IST. Review of the NUD*IST project for 03.09.98 shows that **five** categories of data or nodes were produced. The most extensive of these was a code listing the administrative and demographic data. A second node referred to the process of waiting. A third referred to comments in the text. The remaining two nodes referred to appointment making.

These categories are listed below, together with a key as to how I will display data codes, categories and themes in the text (Figure 5-3: Key to how codes, categories and themes are represented in the text Definitions of codes are given in brackets where they are not explicit.

1. **DESCRIPTIVE**
2. **WAITING**
3. **COMMENTS**
4. **APPOINTMENTS**
5. **TOPICS**

Figure 5-3: Key to how codes, categories and themes are represented in the text

Code = Upper case text e.g. SURGERY

Category or subcategory = Bold upper case text in a box e.g. **WAITING**

Theme = Bold upper case text in a yellow box e.g. **APPOINTMENT**

Each of these five categories contained collections of codes. One of these categories **DESCRIPTIVE** was highly structured even at this early stage. Other categories, such as **TOPICS**, acted as 'dumps' for a range of less organised codes and data. I will now detail the codes within these five categories. This will show how coding was organised and act as a foundation for examining how the analysis progressed.

1. The category **DESCRIPTIVE** for administrative and demographic data contained the following codes and sub-codes or 'children'. An example of this is the first code in the following list, SURGERY, which has two children SURGERY A and SURGERY B (and later on SURGERY C).

DESCRIPTIVE

SURGERY

A

B

INTERVIEWEE

PATIENT

RECEPTIONIST

MANAGER

NURSE

LOCATIONS

WAITING ROOM

RECEPTION

PATIENTS

GENDER

FEMALE

MALE

CASES (Interesting patients)

AGE

TEENS	(Looked like a teenager)
MIDAGE	(16-65 years old)
>65	(over 65years old)

PROBLEM PRESENTED (by the patient e.g. headache, rash)

These **DESCRIPTIVE** codes expanded as more documents were imported into the NUD*IST database. Administrative codes added later included other LOCATIONS such as coffee and administrative areas (COFFEE, ADMIN), interviewees (INTERVIEWEE), such as PRACTICE NURSE and GP. The PATIENTS category was expanded to include the people who complained about the service or receptionists, parents of young children, and those who had waited a long time in the surgery (COMPLAINER, COMPLIMENTERS, PARENTS, WAITERS). A category was also created to log every example of each APPOINTMENT made (URGENT, ROUTINE, REPEAT, HOME, PRESCRIPTION, REGISTERING, RESULTS).

For other categories of data I decided that coding labels should reflect the context in which the behaviour occurred, and the words people use in describing behaviour.

The next two categories of coding were **TOPICS** and **APPOINTMENT MAKING**

2. The category **TOPICS** (topics raised at interview) contained the following codes and their children

TOPICS

TRAINING	(Issues about receptionist training)
POLICY	(Practice policy issues)
NEEDS	(Use of the word 'need,' as in "I need to see the doctor")
TYPES	(Types of patient e.g. drug user, elderly, parent)
INFO	(Where information is requested by the receptionist)
FLEX	(Flexibility of receptionists during negotiations)
URGENT	(Urgent appointment)
NEGOTIATION	(Issues about negotiating an appointment)
HOME VISIT	(Home visit issues)
PERSONAL CARE	(Receptionist tries to maintain continuity of doctor care)

PREFERENCES (Preferring one patient over another)

TRIAGE (Triage issues)

These were marked with a prefix on the Word transcription and then imported by a command file under a heading of interview topics.

3. A Category called **APPOINTMENT MAKING** contained the issues associated with appointment making.

APPOINTMENT MAKING

REPEAT (repeat or return appointments)

URGENTS (urgent appointments)

ROUTINE (routine appointments)

HOME VISITS (home visit requests)

REGISTERING (registering attendance for an appointment)

NEGOTIATIONS (Phases of the negotiation)

BEGINNINGS

MIDDLES

CLOSURE

RELATIONSHIPS (relational issues between receptionists and patients)

ATTITUDES PRO (Attitudes of professionals to patients)

DISAPPROVAL

APPROVAL

ATTITUDES PAT (Attitudes of patients to professionals)

DISAPPROVAL

APPROVAL

LANGUAGE (Language used during appointment making)

At this stage the coding from three preliminary interviews in practice A were kept separate from coding of the observational data.

The final two categories created within NUD*IST in this first stage of analysis were WAITING and COMMENTS. Both acted as 'dumps' or repositories for data extracts on the process of waiting and comments about the process of the research entered in the fieldnotes. These extracts were not coded further until later in the project.

Data reflection

In parallel with indexing the data, I reflected on the data to develop issues (codes) and categories (collections of related codes). At this stage there was little attempt to develop analytic themes (theoretical perspectives linking the categories). My reflective diary shows that I was experimenting with matrices in Word to group together the beginning, middle parts and ends of the negotiations to try and identify the range of behaviours occurring. The complexity of the process was apparent, particularly the middle parts of the negotiation. The mapping revealed issues of unknown importance, such as an offer of a closed time for an emergency appointment, a disagreement about appointment time when the patient registered their attendance at the surgery, information requesting by patients and receptionists, and a query about patient mobility for a home visit request. Several appointment types were also not well represented, such as home visit requests. This suggested the need to sample these. I thought the issue of urgent appointments to be extremely important in appointment negotiations. I decided to see if this was so in Practice B. I decided to interview patients attending their urgent 'open access' clinic. At this stage I did not try to reduce the data much, as I was not sure what was important.

Analysis – up to 08.10.98

Transcripts analysed

By 08.10.98 more transcripts data had been analysed. Additional transcripts were six short patient interviews (BVPat1, BVPat2, BVPat3, BVPat4, BVPat5, BVPat6), and two receptionist interviews (BVRec1, BVRec2)

Further index development and data reflection

The coding and category development expanded dramatically to include many more labels to describe the behaviour of patients and professionals in appointment making. A total of 133 codes or categories were produced, most with a written definition of the code or category attached to the code in NUD*IST. Appendix 6 details the codes.

I am now going to concentrate on describing the evolution of the data, codes and categories associated with the issue of **appointment making.** We can see that in the category of **APPOINTMENTS** (appointment making phases and activities) there are three subcategories. All four categories and their subcategories contain codes and data extracts.

APPOINTMENTS

REASONS FOR MAKING URGENT APPOINTMENTS (PATIENTS)

REASONS FOR MAKING URGENT APPOINTMENTS (RECEPTIONISTS)

REASONS FOR MAKING A ROUTINE APPOINTMENT (RECEPTIONISTS)

Within each category there are codes for data describing the phases of the consultations from the observations, data from the short interviews about patients' reasons why they want to be seen urgently, receptionists' experiences from interview and observations about making urgent and routine appointments, including tactics used in the negotiation. The data was searched for the words 'need,' 'demand and 'want.' Some of the text associated with these word searches was coded in NUD*IST. Even with only a small number of professionals interviewed, this had produced an enormous number of new ideas, for example, receptionists' use a wide repertoire of strategies to manage negotiations. There was also some duplication of ideas. Major restructuring was needed and happened at the next stage.

Developing themes – February 1999 to 20.07.99

Transcripts by February 1999

Transcripts of remaining observations were incorporated into NUD*IST up to March 2000 (apart from one lot of joint observations). Interviews with professionals and patients were also processed during this period.

Index development

The index developed extensively to include observational data from all three practices and by mid 1998, preliminary coding of the long interview data. This phase however was characterised by the most intense phase of data reflection and the development of analytic themes.

Data reflection and analytic theme development

Hitherto my outlook was to develop codes reflecting the language that people used. There was much duplication of data. The 'leap' to an analytic interpretation of the data was accompanied by literature searching and reading around the subject of organisations and processes in health care. Particularly influential was Strong's work 'The ceremonial order of the clinic: parents, doctors and medical bureaucracies'. (Strong 1979). Associated with this period of coding, reading and reflection was the abandonment of my reflective diary. It was replaced by extensive use of memos about my thinking in NUD*IST. This had the advantage that my thinking was recorded closer to the relevant data.

Three overall **themes** were produced in relation to appointment making

1 CAUSAL ISSUES

2 ILLNESS BEHAVIOUR

3 NEGOTIATING ACCESS

Within the theme of negotiating access were subsidiary themes such as

CARING-DISCORD, DISCRIMINATION, THE RITUAL, TACTICS LEGITIMISATION – SENTRY ROLE. Some of these had a number of categories and subcategories associated with them. For example, 'legitimisation' begat the categories of RULE ENFORCEMENT, INFORMATION EXCHANGE and MAKING JUDGEMENTS. Increasingly, the coding and analytic themes contained data that provided context and explanation for behaviour encountered or described in the study.

Examples of my thinking are shown in the following memo extracts.

> "08.02.99. Looked up the definition of legitimate in The American Standard Dictionary on the Internet – insightful. " A definition of legitimate: 1. Being in compliance with the law; lawful: a legitimate business; 2. BEING IN ACCORDANCE WITH ESTABLISHED OR ACCEPTED PATTERNS AND STANDARDS: legitimate advertising practices; based on logical reasoning; reasonable: a legitimate solution to the problem.""

> "05.03.99 It seems to me that the ceremonial process, or ritual procedures, or bureaucratic format permeates all appointment making. This reflects my reading of Strong's research on bureaucracy in hospital clinics (Strong 1979)."

A number of tentative theories were also tested to develop ideas. For example, my initial analysis of practice rules was that Practice A enforced rules about appointment making more than the other practices. A matrix search in NUD*IST of practice against the data coded under rule enforcement showed that this was a feature of all practices Indeed a further matrix search showed that it occurred with routine appointment requests as well as urgent requests.

Another theme that was considered when conducting the long interviews with patients with positive and negative views of receptionists and the practice, was DISCRIMINATION by receptionists towards certain groups of patients. I had divided this theme of receptionist's discrimination into two groups of data, FAVOURITES and DISLIKED. I thought that some patients were perceived as more worthy of appointments than others by receptionists and some others were disliked for various reasons.

> "24.03.99 Who are favourites, why are they, and in what circumstances? Are they babies and old people? Is it to do with characteristics such as vulnerability that they see mirrored in them, not simply based on clinical need (pregnancy)? The point is that 'you would do more for them,' - they have better access to care perhaps with associated warmth."

Another theme that was developed was the notion of CARING receptionists. I discovered a report about a phenomenological study of ward nurses that created an analytic framework for describing caring and uncaring (Riemen 1998). Two memos on the theme of caring reflect my thinking about the nature of caring.

> "13.02.99. What is the nature of a caring? Often it is based on FAMILIARITY and regular contact. M *[a patient]* from Practice A is a case in point. The greetings to her are by using her first name. She is able to be honest about her unhappiness at the regular nurse being unavailable, and communicate this and her disappointment, which are expressed in tears. The receptionist's response is of recognising her distress, expressing sympathy, and helping her to arrange an alternative appointment."

"13.02.99. I haven't included things *[in the analysis]* such as 'fitting in' or 'fit you in' (searched as a NUD*IST string search), but this is more obviously a sentry action although it is helping behaviour. But what it the nature of caring as opposed to helping and assisting? Is it about EMOTION, expressed and/or observed? Caring is also expressed verbally – "Do you want to throw snow balls?" Mind you, perhaps this is not caring but positive or life enhancing communication?"

Verifying analyses - July 1999 – July 2000

This is the fourth and final phase that I want to describe to illustrate the analysis process. This was the stage at which a summary of the project was presented to all three practices. These presentations emphasised my thematic approach to appointment making and introduced the theme of the caring and uncaring receptionist. During this stage the first research papers were begun and there were further analyses of the caring theme. These preliminary findings were also discussed with key informants who were most helpful in confirming or questioning my analysis.

Only four stages have been presented to show some of the processes used in my study and described in my previous discussion of analytic techniques. This is, however, a simplistic presentation of a complex activity. The reality was that there were many more than four stages of indexing, coding, and displaying data, and of conclusion drawing and verification, proceeding in tandem, in a dynamic rather than linear relationship. The elements of data reduction and displayed occurred over a long period of time. Some sections of the data were well developed early on in the analysis process and changed little from the first presentations and papers. Other areas were seen as more important and necessary to analyse only when preparing a paper or the thesis. The process was demanding, sometimes tedious, often frustrating, but led to several insights into appointment making and patient-receptionist relations. These insights are considered in the following result chapters. A 'final' list of NUD*IST codes is given in Appendix 7.

5.4 Data management

Data management is the process by which data is recorded, organised and manipulated. This section looks at this in detail.

5.4.1 Recording data

Data was recorded by writing fieldnotes and comments, and audio taping interviews. The method used was dependent on the setting; observations or interviews.

Observations

In recent years efforts have been made to establish a convention for recording fieldnotes (Kirk and Miller 1986). The purpose of this is to make fieldnotes more reliable as a source of data, and to make it easier to identify opinions, prejudicial and otherwise, from the researcher. I adopted the fieldnote convention of Kirk and Miller (Kirk and Miller 1986). For example, verbatim quotes were marked with double quotation marks, and paraphrases or inaccurately remembered quotes were marked with single quotation marks. My own interpretations were either prefixed with the words 'Comment' or put in parentheses (Appendix 8).

The fieldnotes were entered into a hardback book in chronological order. Because the fieldnotes were sometimes with the transcriber for a week or so while I was still making new fieldnotes, I started a second book, and wrote in both alternately.

Patient and professional interviews

All interviews were audiotaped using a high quality SONY cassette recorder and separate microphone. Details of the people present, the venue, date, day and time were enunciated onto the tape in the presence of the interviewee(s), before the interview started. A brief outline of the purpose of the interview for the interviewee, and their verbal consent was also mentioned for the tape recorder. Impressions about the interview or the setting were dictated onto the tape, usually at the end of the interview.

Respondent validation interviews

Six 'key informants,' patients and professionals were interviewed a second time at the end of 1999, after they had seen a preliminary summary of my research findings

(Appendix 9). Comments made during these interviews were written in my fieldnote book during and after the interviews. This was the only piece of data not transcribed.

Reflective diary

Three forms of reflective diary or text were kept. The first was a daily diary in Microsoft Word from 8th of March 1998, three months before data collection began, to 3rd of January 1999. The diary covered ideas about the conduct of the research, my personal feelings, and my views of my supervisors. This text was imported into NUD*IST for analysis. At the beginning of 1999 the diary was replaced by use of the memo facility in NUD*IST to record impressions about the data and thinking. This ensured that my ideas lay closer to the data. The third collection of reflective data were comments made during observations and interviews, which were transcribed and imported, into NUD*IST using a command file.

Transcribing fieldnotes and tapes

A secretary who was experienced in transcribing my writing and audiotapes did my transcribing. Illegible text was marked and edited by myself. I listened to two audiotapes and compared them with the transcripts to check on the quality of transcription. There were only minor differences.

Organising data and references

All transcribed files were given a title in Word 97 and kept in a folder in Windows. These were converted into text only format with a short title code denoting the practice, the number of the observation, the location of the observation, and other information, e.g. document COR2 was the second (2) observation (O) behind the reception counter (R) at Practice C (C). Interviews were similarly labelled; e.g. document BVRec5 was the fifth (5) interview (V) with a receptionist (Rec) at Practice B (B). These text only files were imported into NUD*IST. The purpose of this approach was to make it easier to identify documents and to protect confidentiality by not including patient's names as file names. I thought the coding system was too cumbersome to use in papers and presentations when detailing the source of data extracts. I usually replaced the file code with written details of the source and observation or interview number as seen in Chapter 4.

References were searched for using a dial up facility to the university library website. Several databases were used: Medline, Embase, CINHL, the Cochrane collection, and the BMJ. Copies of the British Journal of General Practice and Family Practice were searched by hand. The librarian at South Tyneside District General Hospital Postgraduate Centre obtained most of my references and books. Web sites such as the Department of Health's, and the Royal College of General Practitioners' provided up to date information on access and demand management. An incomplete record was kept of all searches. The aim of searching the literature was to identify the key literature pertinent to the project. References were imported into Endnote where they were labelled with keywords to aid searching the reference database (Niles 1998).

The use of qualitative computer software

There is controversy about the use of computer programmes designed to 'analyse' qualitative data software (Fielding and Lee 1998). My view is that qualitative software programmes are extremely powerful organisational tools, but it is the researcher that does the thinking or analysis rather than the software.

I used the programmes NUD*IST version 4.0 and Inspiration version 5.0 (Helfgott and Westhaver 1997; QSR 1994). NUD*IST is an acronym which stands for Non-numerical Unstructured Data Indexing Searching and Theorising. It is marketed as an aid to coding, indexing, searching, retrieving and linking data, and theory development.

I was attracted to NUD*IST because it promised to be a sophisticated organisational tool. In practice, NUD*IST proved to be an excellent filing cabinet for the large number of files and memos that I produced. It also forced me to be disciplined in organising and coding data. The most common process used was of coding data, by highlighting text and giving it a conceptual label within the NUD*IST 'tree' of codes. These codes and the tree of codes could be endlessly reworked to reflect my thinking. Sometimes the reworking would be quite radical. The most useful feature, however, in NUD*IST was 'coding on'. This is the process by which one whole group of codes or categories can be cut and pasted to another location and given a new, perhaps more thematic label. Codes and categories can be given definitions, and memos made on the screen. Other commonly used features within NUD*IST were the production of

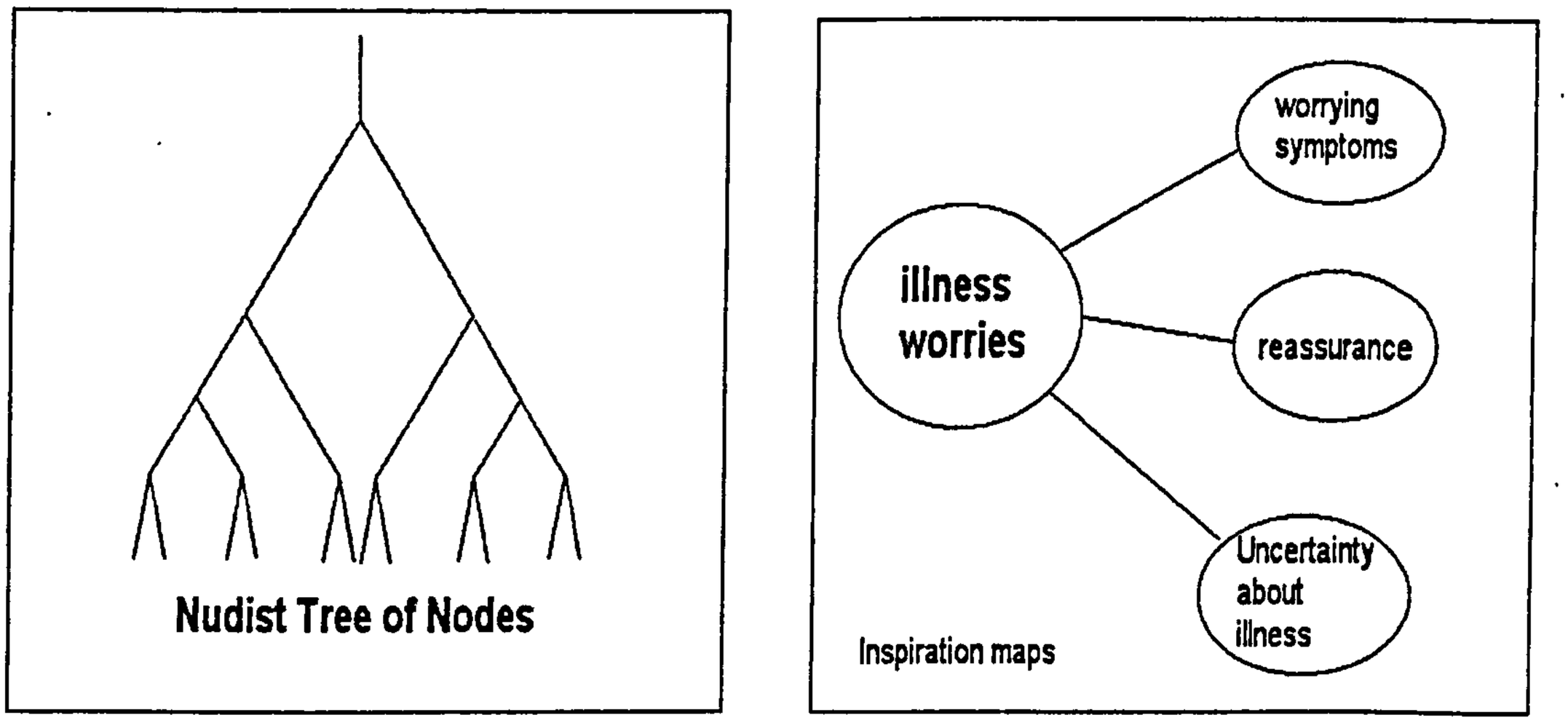
matrices, and searches for words or collections of words. Examples appear in the results chapters.

Several more advanced features were also used in NUD*IST. The first was the use of coding tables to code descriptive data on documents from the interviews and observations. Another labour saving feature was the use of command files to pre-code data. For example, analysis of transcripts would sometimes occur before being imported into NUD*IST. This preliminary reading of the transcript might identify concepts or codes, which were tagged in the Word file with a prefix %, as in %need or %negotiation. When these documents were imported into NU*DIST the command file would search for these tagged words and code the associated data into the NUD*IST tree of codes.

Another attraction of NUD*IST was that as I could save complete copies of the project for later reflection. This detailed documentary evidence, as I have shown in the previous section is important in giving an accurate and trustworthy account of the analysis process.

The weakest feature of NUD*IST is the graphical representation of the 'tree' of codes (NUD*IST calls these nodes). Fortunately, NUD*IST has a facility to export the 'tree' to two graphics mapping packages, Inspiration and Decision Explorer. Figure 5-4 compares the two graphical representations of codes. The Inspiration maps are easily manipulated, but the NUD*IST tree cannot be changed.

Figure 5-4: How codes are displayed in NUD*IST and Inspiration



In Decision Explorer the codes from the maps can, even when changed, be imported back into NUD*IST. I used Inspiration because it was easier to use and the printout was much clearer. I created many maps as a way of thinking about the data. This prevented me from seeing the tree as a hierarchical or linear list of codes. The structures of the thesis chapters were also created on Inspiration. I did not feel that I had 'tunnel vision' about the software. For example, I would sometimes printout observational or interview data to peruse and mark by hand before going back to re-code the data using NUD*IST. In the early stages of the project, however, I fell into the trap of obsessional coding at the expense of reflection.

Some critics argue that NUD*IST, unlike other software packages such as Atlas-ti, inhibits memo making, as the facility is not at the forefront of the software. I did not find this to be a problem.

One of the most important decisions to make in importing documents into NUD*IST is to decide the size of the unit that that can be coded and retrieved by NUD*IST. The smallest piece of text that can be referenced is called a *text unit*. Coding is done by storing references to text unit numbers at the relevant node. The text unit chosen can be as small as a word (appropriate for linguistic analysis) or as large as a paragraph. For my first six observations in Practice A I chose 'lines' as the text units. I realised that this was a mistake and thereafter imported all transcriptions so that the text units were paragraphs. I felt more comfortable assigning coding to larger portions of text. Sometimes these paragraphs (and text units) would be short, as in an interview, particularly if it was a "question and answer" type session. At other times the paragraphs (and text units) would be quite long, when participants talk at length. A problem occurs when searching the complete database to elicit comparative data. For example, if I searched the data for the concept 'Information volunteered by patients to receptionists' I obtained the following text units for each practice (Table 5-3).

Table 5-3: Number of text units (codes) for 'information volunteered' by patients to receptionists in Practices A, B and C

Concept	Practice A number of text units	Practice B number of text units	Practice C number of text units
'Information volunteered' by patients to receptionists	44	16	91

From the table one could assume that this concept was most evident in Practice C and least evident in Practice B. This may be so, but Practice B's text units could be bigger and therefore have less coding than the other practices for this concept. There is also the question of the first six observations in Practice A where the text units were lines and not paragraphs. To compound matters the number of observations and interviews are not the same in each practice. So is comparing text units of any value? What you *can* say from the data is that the concept of patients volunteering information to receptionists exists in all three practices. I have tended to use text unit comparisons in this way, to demonstrate the persistence of concepts in different contexts. If however comparisons show marked differences in number of text units for a particular concept, then this is suggestive (but not conclusive) of this being the situation.

I attended a two day training course in NUD*IST at the University of Suffolk in 1986. Thereafter, I received help from the Internet NUD*IST discussion group QSR-FORUM, and qualitative discussion group QUALRS-L. I also employed Clare Tagg, one of the foremost authorities in qualitative computer analysis in the United Kingdom, as a consultant. She helped me to organise my initial descriptive data, and later on encouraged me to move from more descriptive coding to conceptual and thematic coding. I also had some training at the First International Conference on Computer and Qualitative Research in 1998, in the use of Inspiration and Decision Explorer. I also briefly taught on an MSc module at Newcastle University on the problems and benefits of computers, using this research as an example.

5.5 Summary

In this chapter I examined how I managed the analysis and organised the data. A number of techniques or approaches were used in analysis, including grounded theory approach, textual matrices, visual maps and writing. The main 'tool' in analysis was my thinking in applying theory, experience and techniques to question the data and generate codes, categories and themes, with plausible sets of relationships between concepts and sets of concepts. A detailed description and audit of my analysis constructed by me has been presented using evidence collected during the process of analysis. I have also looked at the process of recording observational and interview data, transcribing audiotapes, and my experience of using two types of software for analysis, NUD*IST and Inspiration. The next chapters contain my results.

CHAPTER 6 : THE DECISION TO CONSULT – PATIENT ILLNESS BEHAVIOUR

Chapter 6 : The decision to consult – patient illness behaviour

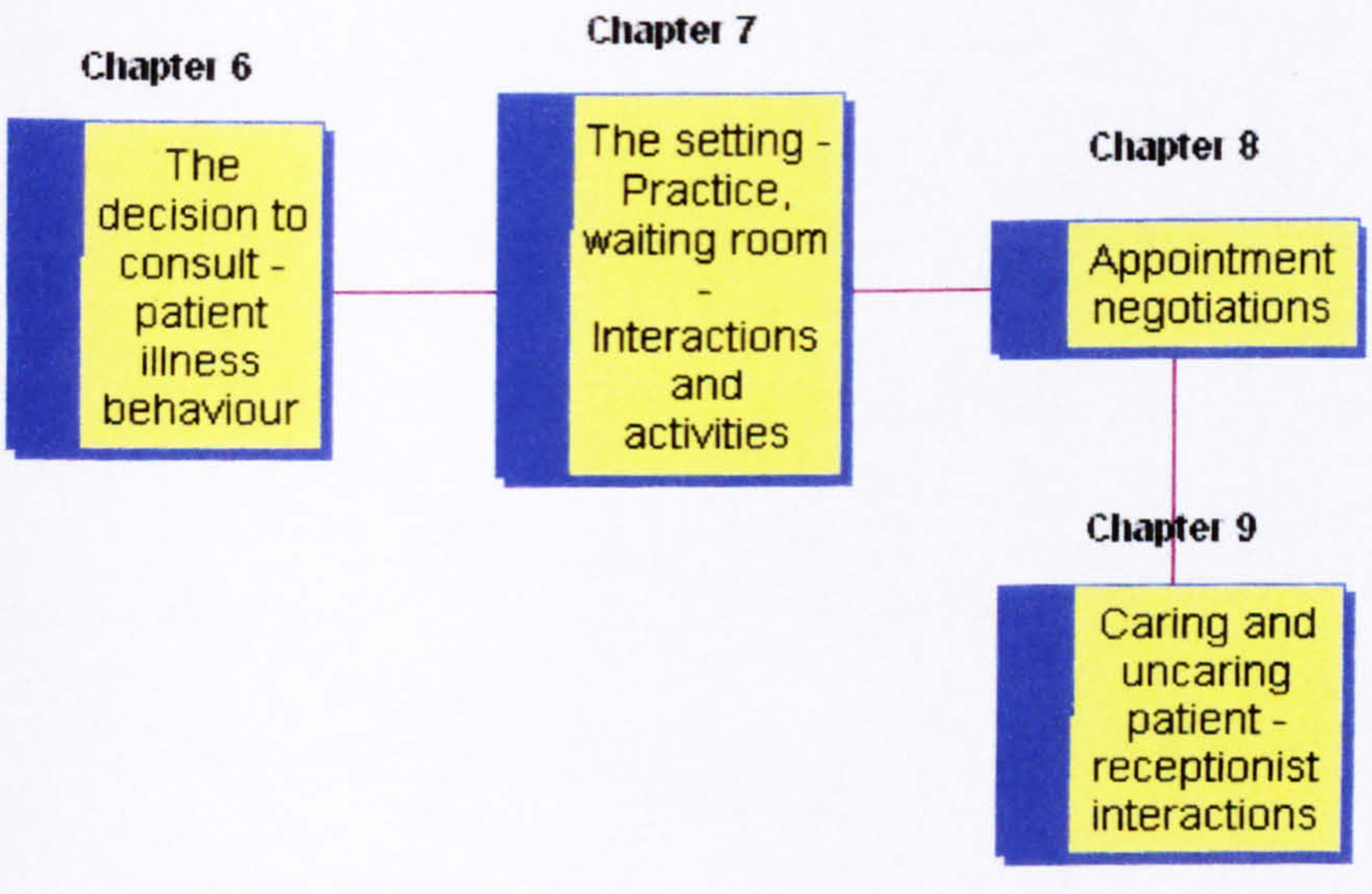
"There are few presumptions in human relations more dangerous than the idea that one knows what another human being needs better than they do themselves" (Ignatieff 1984).

"And nothing is working, so I thought I'd better come and see the doctor." Patient interview No 2.8.

6.1 Plan of results chapters

These next four chapters are the results. They follow the progress of patients with illness concerns from lay care and use of social networks to their general practice to negotiating an appointment. Finally, I examine caring and uncaring patient – receptionist interactions (Figure 6-1).

Figure 6-1: Plan of results chapters



6.2 Introduction

This chapter examines the theme of patient illness and consulting behaviour and its relationship to appointment making. Mechanic defines illness behaviour as (Mechanic 1978);

> "The ...examination of processes affecting the way pain and symptoms are defined, accorded significance and socially labelled, and consideration of the extent to which help is sought, change in life regimen affected, and claims made on others."

Several factors influence patients' decisions to consult the doctor or nurse. These include patients' judgements about the progress of the illness and specific symptoms, previous experience of a condition, and disruption to employment, family and social life. Conceptions about patient need and demand, conceptions about what is urgent and routine, and patient views about seeing the same doctor also influence patient consulting behaviour. These concepts and their relationships to each other are summarised in Figure 6-2.

The initial analysis of this theme was the 12 short interviews of patients attending the 'open access' surgeries in Practice B. All of these patients were consulting *urgently*, and most of the initial concepts generated reflected that. These patients were interviewed while they were waiting to consult. Subsequent analysis of this theme included data on routine appointments and the observations, and data from the long patient and professional interviews. There was considerable overlap of concepts on why patients consult urgently and by routine appointment.

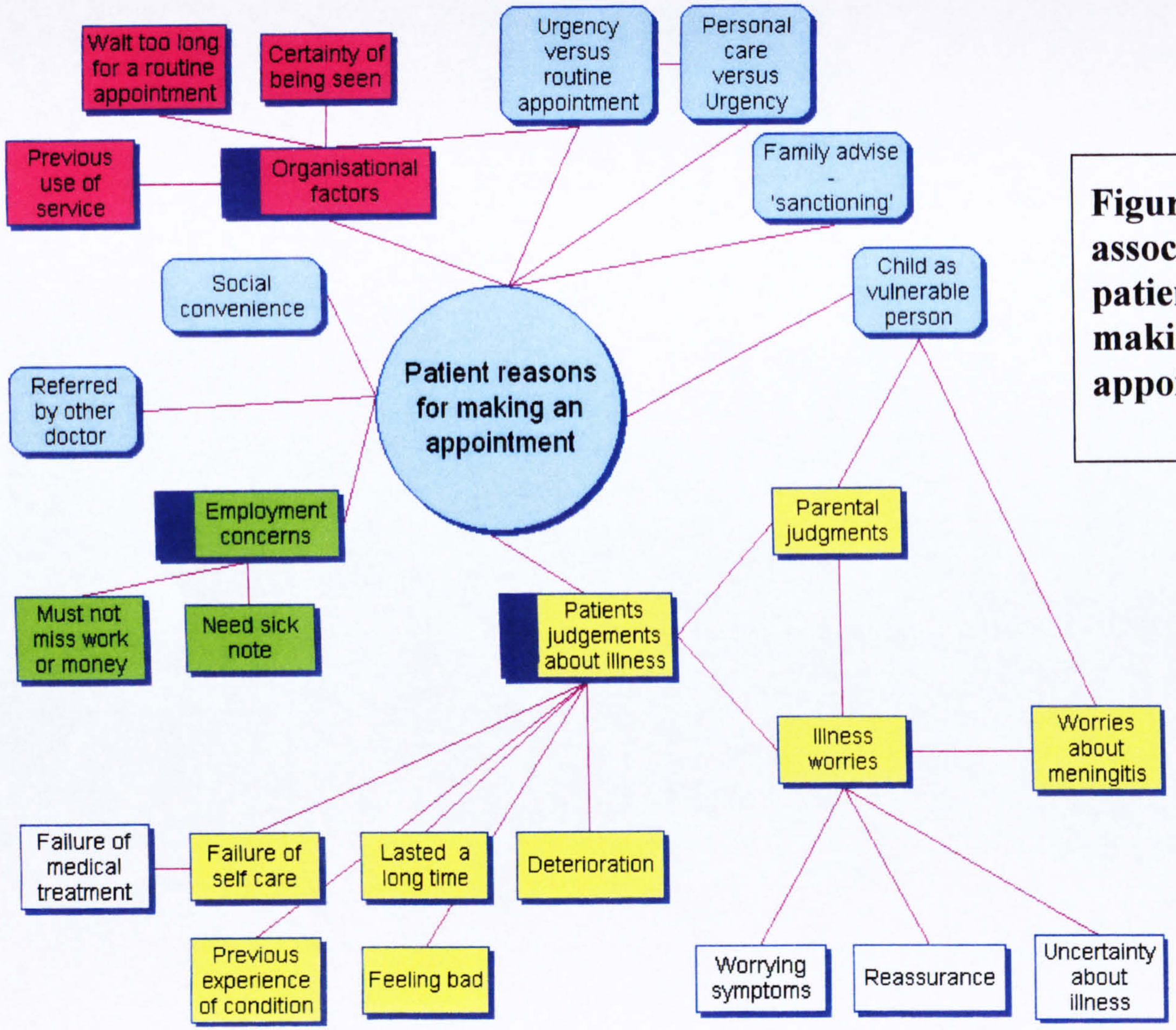


Figure 6-2: Concepts associated with patient reasons for making an appointment

6.3 Patients' judgements about illness

Patients make judgements about the nature and severity of their condition, and whether they can treat themselves or need to contact the doctor or another professional. Three inter-related categories demonstrate why and how patients make decisions to consult the doctor: the failure of self and medical care to improve the patients' illness; anxieties about specific symptoms; and concerns that the illness has lasted 'too long.'

6.3.1 Failure of self care and medical care

Most patients had tried some form of self care before making an appointment. This included "off the shelf remedies," such as, "tablets from the chemist," "drops for earache," "Calpol," and "taking Locketts." Usually these remedies had been used during previous episodes of illness or had been recommended by family members.

> "The receptionist says that it is "someone who lives in a hostel" *[on the telephone]*. He has had earache and head pains. "It is the carer who has rang. They have tried drops.""

Observation No 4, reception counter, Practice A

"I have got Junior Disprol and things like that for her, even Lemsips in case she's got head cold or something like that she's getting. And nothing is working so I thought I'd better come and see the doctor."

Patient interview No 2.8, Practice B

"I haven't been too well since last Monday. I have had a bit diarrhoea and I haven't been sick, but I didn't buy the tablets from the chemist 'til Saturday. It cleared up and it's come back again. I have been to work the day and I just feel absolutely terrible."

Patient interview No 2.2, Practice B

Patients had consulted practice nurses, health visitors, chemists and alternative practitioners for advice. Two patients in the long interviews mentioned receiving advice from Practice C's triage nurses, and expressed confidence in their opinions, "her being a nurse she knows all the type of minor ailments that children can get." One

patient had "been to a Chinese doctor, an herbalist," for acupuncture. The most popular source of advice on illnesses and self-management was the pharmacist.

> "I tried quite a few things and actually I went to the Chemist in [*town*] and asked the chemist for advice. And the chemist said, "I don't think you should buy anything, I think you should go to the doctors.""
>
> Patient interview No 3.1, Practice C

Three of twelve patients from the short interviews consulted because previous medical care had not improved their symptoms. There is overlap of this concept with that of the condition lasting a long time (Chapter 6.3.3). The durations of their problems were one week, two weeks, and a month. One of these patients had a painful joint and had not received promised physiotherapy. Another patient with asthma was "no better" after a week of "antibiotics and steroids." The third case follows.

> "I have had earache for about a month. And I went to Dr X about a fortnight ago and he says just take pain killers. But it's not shifting it. So I have come to see if he will give us something for us to put in, like drops."
>
> Patient interview No 2.7, Practice B

6.3.2 Worries about illnesses and symptoms

Patients feel that they can judge the right time and circumstances in which to seek help from the doctor. An important 'trigger' to consult was a worrying symptom such as headache, high fever or chest pain. Analysis of the short interviews suggested that this symptom anxiety was largely found in parents of young children. Patients and receptionists expressed the idea that children were more vulnerable to serious illness than adults and "cannot tell you what is the matter with them." Subsequent analysis of all the data, however, showed that parents of small children *and* adults share symptom anxiety, but about different conditions. For example, potent sources of anxiety for parents were symptoms of headache and visual phenomenon. These prompted fears about meningitis; parents mentioned fear of meningitis in one short and six long interviews.

"I mean you worry about meningitis and all things like this. ... You think about brain tumours and all this; because she says (my child) she is getting dizzy."

Patient interview No 2.5, Practice B

"If it had been a cold or a bad cough or something like that it could have waited five days. Or I could have got medicines out of a chemist, but with headaches and things like that you don't know what's caused them..."

Patient interview No 2.8, Practice B

6.3.3 Condition lasting too long

Duration of illness is a factor in whether patients consult, particularly when self or medical care has failed to resolve their illness. In the short interviews two of the twelve patients had tolerated their symptoms for more than two weeks before consulting. Patients and family members have a sense of how long an illness should last and when it has lasted "too long." This appears to be based on previous experience of managing illness in themselves or other family members. It may be that some people manage a period of waiting to see if their problem resolves, and others are unable to wait and consult more readily. My impression is that there are also differences between parents of children and adults, the former being less prepared to wait and see if their condition resolves without medical intervention. This concept of the condition 'lasting too long' operated with other concepts such as a worsening of the patient's condition, failure of self care, and onset of a new more worrying symptom, to trigger a request for a consultation with the doctor.

"Well I've had the flu for about a week since. I've been on medicine since last week and now it's all gone on my chest and I'm in agony. It was like pains in my back and everything with it - and he is loaded with cold as well."

Patient interview No 2.1, Practice B

6.3.4 Previous experience of conditions

A major concept influencing consulting behaviour was past experience of illness and its self-management. Patients with chronic illness felt more confident to manage exacerbations of illness, and when to consult the doctor. The commonest chronic condition mentioned by patients was asthma (13 interviews). Patients made a

distinction, based on their experience, between problems that they could manage themselves, those that needed "checking" by the doctor within a few weeks, and problems such as shortness of breath where they needed to see the doctor urgently. Two patients stated that their experience as health care workers helped them to manage their own health problems and when to consult urgently. One was a nurse, the other a practice secretary who considered she was more able than the receptionists to manage her recurrent urinary infections.

> "The first time it happened *[a* 'water infection'*]* I was very very poorly. ...And I popped in and put a sample in and she [*the receptionist*] said, "Oh, we can dip it for you here." And I thought, 'Oh that's excellent' not realising what was the follow on from that. And she went away and I sat and she came back and said, "Yes you have got an infection, take these antibiotics." So I went away and I took them [*antibiotics*] and they made me very very sick. And then I went back and said, "(a), they are making me sick, and (b), they are not helping." So they changed them to something else. ...So I now have to sort of be a bit awkward and when they come back and say, "Yes, there's an infection, the doctor's given you a prescription for..." And I have then got to say, "No, I am sorry I can't take that. Is it susceptible to this one? Is it sensitive to this one?" "Em, yes." I say, "Well, can I have that one then please because I know I can take it.""
>
> Patient interview No 3.3, Practice C

6.4 Disruption of work and family life

6.4.1 Employment concerns

Employment concerns were a factor in consulting urgently and when making routine appointments. These concerns were about illness causing disruption to work, trying to fit appointment times around work rosters, and needing sick notes to legitimise time off work and "not lose money." One patient consulted on their day off work and another while on holiday so as to not to disrupt employment. One patient also mentioned their employment as a cause of their health problems. Distance of work from the surgery was also cited as a problem in making an appointment.

"I hurt my back on the Sunday. I tried to go to work on the Monday. I was sent home because I couldn't manage it and I phoned up as soon as possible on the Monday morning."

Patient interview No 3.7, aged 16-65, Practice C

"Well I had to miss work last night. I had to miss college this morning so I don't really want to miss much."

Patient interview No 2.11, Practice B

"If you are working you can get an appointment on a night time, nobody likes to lose work. They try to keep the appointments for a night time for them that are at work but they close at 6 o'clock. A lot of people don't get in till after then so it means trying to get through the traffic."

Patient interview No 3.5, negative, Practice C

"So I have been off last week which is what I am entitled to anyway, but with being off this week I am obviously going to need a sick note."

Patient interview No 2.5, Practice B

Receptionists had ambivalent feelings about work commitments being a legitimate factor in patients making urgent appointments. One receptionist recognised the pressure that patients were under in not taking time off work to see the doctor. Most receptionists were unsympathetic to requests for sick notes, particularly for urgent appointments, although one receptionist in Practice A would try and 'fit them in' despite the manager in that practice making strident comments about requests for sick notes.

"We don't give appointments for sick notes. The doctor doesn't like it. ... He *[the patient]* then said his sick note needed to be backdated two weeks. I told him the doctor would probably only issue a sick note for the time he has been registered. (He has been on the practice list 12 days. An allocated patient). ...We must have a new policy on sick notes and emergency appointments. She is contemplating putting a notice in the waiting room saying, "Under no circumstances will emergency appointments be given for sick notes.""

Observation No 3, reception counter, Practice A

"Maybe they have got a day off work that day and so because of that, that the doctor is on that day it suits them better to come. Or because of shift work it suits them better to come that particular day to the open access as opposed to making a routine appointment."

Practice manager interview No 2, Practice B

"You do get the odd stroppy patient who will say "I need to come today, I can't get off work." Really it should be...something urgent you should be telling your boss that you need to come out from work."

Receptionist interview No 4, Practice B

"I ask [*receptionist*] how important work is in patients making appointments. She says, "Work is very important, because they're all frightened of losing their jobs. It is amazing how many people ask for a note on headed notepaper for work." The note is for the demanding employer."

Observation No 27, reception counter, Practice C

In the 'open access' clinic in Practice B five of 12 patients interviewed cited concerns about work or requests for a sick note as one of the reasons why they were consulting urgently. A search of observational and interview transcripts was performed in NUD*IST using the key words, 'work', 'job', 'employment', 'employee', 'employer', and 'sick note'. Only the main findings are shown in the Table 6-1.

Table 6-1: Results of word search of observation and interview transcripts

Key words or phrases used in searches	**Observational transcripts:** Number of relevant* finds (total finds)	**Patient interview transcripts:** Number of relevant* finds (total finds)	**Professionals interview transcripts:** Number of relevant* finds (total finds)
Work(s), working, worked	6 (40)	53 (123)	22 (134)
Job(s)	2 (5)	4 (32)	0 (40)
Sick note(s)	6 (7)	13 (18)	24 (29)

* Relevant finds were those where the key word was pertinent to the issue of employment *and* appointment making. Finds where I had used the key word as part of a question or response were also excluded.

Table 6-1 shows that most 'work' finds were from patients rather than professionals interviews. This is not surprising as more patients than professionals were interviewed, and patients were asked about employment influencing appointment making whereas professionals were not. Professionals raised the issue of employment without prompting and usually in the context of sick notes. Table 6-1 shows this with most finds for the key words 'sick note(s)' were from professional interviews. Professionals often mentioned the need to enforce practice rules for giving (and not giving) sick notes. Some professionals were more concerned with maintaining the practice system for appointment making, and did not regard employment problems and the need for sick notes as legitimate reasons for consulting urgently.

6.4.2 Disruption to family life

The list of symptoms disrupting family life includes pain, earache, shortness of breath, fever and abdominal pain and vomiting. Examples include one patient taking to bed and being unable to work, and being awake during the night with symptoms such as earache. There were four examples of sleep disturbance due to pain resulting in attempts to secure an appointment.

> "She was up through the night last night. ...I mean before it's been like the headache tablets were taking it away. But for the last week or so it has been getting worse and then with it affecting her last night, having to get up out of bed last night, which has never happened before."
>
> Patient interview No 2.8, Practice B

6.5 Patient needs, wants and demands

A recurring concept in the data is that of need and its relationship to appointment making. Analysis of this concept began after the earliest observations, but was facilitated by a search of the whole database for the words 'need', 'want' and 'demand.' Patients saw need as urgency, but also used it in the sense of it being imperative or essential that they should be seen and have treatment. They also used

'need' as a synonym for want as in 'I want to make an appointment.' The context in which the word 'need' was used was when patients were describing illness symptoms and signs, and when requesting appointments.

> "My little boy was really bad with his asthma and he **needed** an antibiotic to nip the chest infection in the bud, you know. You could have phoned up and you could have gone. It would have been worth waiting an hour."
>
> Patient interview 3.10a, parent, Practice B

> "Like I say you can never get an appointment when you **need** one. You have got to wait about three or four days before you get one."
>
> Patient interview No 3.13a, Practice A

> "I was annoyed because ...she [another patient] goes down and they take her on like that. She didn't even have to make an...She walked in and she went, "I **need** to see a doctor. I **need** to register with a doctor." "Ah, sit down." *[Says the receptionist]* "Straight away *[she was seen]*. I couldn't believe it. I was just gob smacked.""
>
> Patient interview No 3.16, negative, aged 16-65, Practice A

Professionals also defined need in relation to illness, but did not necessarily accept patients' definitions of need. They also defined need in terms of their capacity to manage appointment demand from patients.

> "We manage *[the needs and wants of patients]* through **demand** in some respects. Whatever the demand is we try to meet that demand in managing the systems and organising the systems around the **demand** that is expressed. If we feel that there is a massive deficit of appointments we would then sort of say we have to look at the whole thing rather than let's just put an extra surgery on because just putting an extra surgery on just meets it in the short term."
>
> Practice manager interview No 1, Practice A

> "If they come up or phone and say "I **need** to see a doctor today," then I will say "we have got no appointments for today, can I make an appointment for you?" And she will say, "Well I've got this chest infection.""
>
> Receptionist interview No 4, Practice B

6.6 Conceptions of urgent and routine appointments

It is impossible to talk to general practice professionals about appointment making without people using the words 'emergency', 'urgent' and 'routine.' Yet there is no research examining professionals' and patients' understanding of what these words mean. Do patients use the same terms to describe appointment making, and do they share similar understandings? I decided to investigate this area.

Patients and professionals were asked to give their personal definitions of 'emergency,' 'urgent,' and 'routine' appointments, and 'home visits'. For my first interviews I experimented with asking patients and professionals to brainstorm the words 'emergency,' 'urgent,' and 'routine.' Many patients enjoyed this, and could conjure up words like 'red', 'sexy' and 'immediate' in response to the word 'urgent.' Most professionals, however, found the exercise difficult and restricted themselves to their usual vocabulary to describe appointments. This difference in attitude may have been because patients were not so familiar with the nature of my research and were more able to think laterally about the words and subject.

Most patients, like all professionals, use and understand the terms 'emergency,' 'urgent,' and 'routine' appointments. A small number of patients used the words 'emergency' and 'urgent' to describe their illnesses, but were not aware of these as appointment types. They talked about getting an appointment of any kind.

6.6.1 Urgent appointments

The terms 'urgent' and 'emergency' were used interchangeably by patients and professionals in all three practices. As the predominant word used was 'urgent' that word is used in the text to also indicate 'emergency' appointment requests.

Several concepts define urgent appointments, such as where illnesses are perceived to indicate a serious health problem, which are of sudden onset, and where action and care are needed quickly (Table 6-2)

Table 6-2: Analysis of words and phrases used by patients and professionals to describe 'urgent' appointments

Urgent appointment concepts	Words and phrases used by patients	Words and phrases used by professionals
Perceived seriousness of condition	"I had this pain in the **chest pain** a few months back ...I did think, 'Oh my God, something serious is happening.'" "Maybe if I had **severe chest pain.**" "Sometimes I have got a **bad chest** and I have steroids quite a few times." "If they have got a **high fever** or anything like that." "If they **cannot breath,** like asthma." "So obviously a **rash of some sort, a high temperature, persistent vomiting.** It depends upon the age of the child." "Spine was in spasm with **pain.**" "Really bad cough, **coughing up gunge.**" **"A rash, high temperature or pain."**	"If it was a kiddie with **earache** or their eyes or anything like that." "Something like **severe chest pain.**" **"Chest infection or ankle injury."** "Well I think if it is a **child."** "Most people with **throat infections,** you know, we class them as urgent for that day. You know. **Ear infections,** anything like that."
Sudden onset	"If it's something that's **just happened** or you feel really dreadful, it has suddenly got worse then an emergency appointment."	"If it was an onset of a **sudden illness.** ...if somebody rang and said something like severe chest pain." "Something that has happened **within the last 24 to 48 hours."** "Something that has **just happened."**
Immediacy of action and care	"They've put you **straight in."** "If I feel really bad...you should go to the doctor **now."**	**"Immediate."** "It **couldn't wait** until the next day." "Something that **cannot wait** until out next available appointment, which could be 2 or 3 days." "I think if it is that urgent I would be recommending an **ambulance."**
Limits of urgency		**"Sick notes** or a **bad back for a week. I** would say this is not urgent." "Somebody with a severe **headache for months** had an afternoon off and his wife said to him, 'Get this sorted out.'" "Somebody saying 'Can I see the doctor **for a prescription?'"**

Patients and professionals shared ideas about what defines an urgent appointment. Professionals however often stated their limits to granting an urgent appointment request, where patients were concerned not to waste the doctor's time. This professional attitude reflects the receptionist's sentry role in rationing these appointments. The manager in Practice B told me of the results of practice audit of 'urgent' appointments. She divided urgent appointments into three categories, "a load of rubbish," "you could see why the patient felt it was urgent," and "genuinely urgent."

> "...from a doctor's point of view (a) this was a load of rubbish, (b) it was not urgent but they could understand why a patient felt it was urgent, and the third category was urgent. And there was very few actually genuinely urgent. The majority of them fell into the middle category of it is not urgent but you could see why the patient felt it was urgent."
>
> Interview, practice manager, Practice B

The conception of "a load of rubbish" was also used by the senior receptionist in Practice C to describe urgent appointments where the doctor expressed the view that the patient had consulted inappropriately, and could have waited for a routine appointment. This concept of "rubbish" consultations has been described by Jeffrey who observed patient-professional interactions in accident and emergency departments (Jeffrey 1979).

Professionals also saw children as a group that were more willing than other groups to give urgent appointments to. A few patients did not accept these definitions of appointment type and felt that they should be able to consult immediately whatever their problems.

> "As far as I am concerned if I need to see the doctor I need to see him that day."
>
> Patient interview No 3.15b, Practice A

"My husband has a completely different perception of the doctors to me and he will often say "get him [*patient's son*] down to the doctors." He does not need to go to the doctors this morning for that. That could wait, but because he does not work in a medical environment, his perception is of something needs to be seen."

Practice manager interview No 2, Practice B

6.6.2 Routine appointments

'Routine' appointments were defined by patients and doctors in terms of a condition or problems, with the exception of one practice manager who defined it as "the next available appointment" (Table 6-3). Usually a 'routine' appointment would be for someone who was already coming to see the doctor or nurse for blood test monitoring, asthma or blood pressure check and smear taking. Other conditions perceived as not needing urgent treatment and where the patients could wait to see the doctor.

Table 6-3: Patient and receptionists' sense of a routine appointment

Routine appointment concepts	Words and phrases used by patients	Words and phrases used by professionals
Ongoing illness or problem	"A **repeat prescription** - in and out" "If I was having **a few problems with her asthma** and she wasn't responding well to her inhalers ... to get advice off the doctor." "An **ongoing illness** would be a routine appointment ... like if you are here every couple of weeks to pick a prescription up." "... general health care really ..." "**Blood pressure** taken ..." "I take Thyroxine so **once a year I have to have my blood checked** to see what my thyroid levels are." "**Smear tests** are routine appointments."	"**Sick notes or a bad back for a week.** I would say this is not urgent." "Somebody saying 'can I see the doctor for a **prescription?**" "Well a routine appointment is more somebody who **comes regularly** to see the doctor."
Of long duration	"I'm on HRT so certain **checks** are done every time I get my prescription every 6 months, that's a routine appointment.'" "If you were having migraines and they had been going on **for a while.**"	"Somebody who has had severe **headaches for months** had an afternoon off on the Friday and his wife said to him, 'Get this sorted.'"

Two groups of concepts are relevant to understanding why patients choose an urgent or routine appointment. These are the concepts of the acceptability of the condition and the request and concerns about consulting inappropriately (Table 6-4).

Table 6-4: Patient and professional concerns when making appointments

	Acceptability of request	**Concerns about consulting inappropriately**
Patient dimensions	Serious, necessary	Don't want to "waste the doctor's time."
Professional dimensions	'Genuine'	Don't want a "load of old rubbish."

6.7 Personal care

Personal care is about the patient's decision to choose to see their usual doctor. Whether the patient preferred to see their usual doctor was contingent on whether they had a chronic health problem, whether that problem was urgent, and whether they could get an appointment with their usual doctor. If the problem was considered to be urgent then patients were more likely to see any doctor. If the problem was not urgent, or they felt they could wait, then they would try and see their usual doctor. The idea of personal care was not important to some patients. Some people had not developed a relationship with a particular doctor and did not feel the need to do so, "You see a different doctor each time," and, "You see any one of three or four doctors." People who would see any doctor felt that it was only important that the doctor was "qualified," as long as they saw somebody. Other patients liked the ability to 'shop around' because they did not like certain doctors and wanted to see what all the doctors in the practice were like.

"Researcher: How important is seeing the same doctor?

Patient: Well, I don't suppose it is really. If like it is something that is ongoing I would say probably yes. If it is for something different then it does not really matter."

Patient interview No 2.3, Practice B

"Researcher: Does it bother you which doctor that you see today?

Patient: I am not bothered. To be honest I can't remember my doctor's name (laughs) I just need something for my stomach. Any doctor would do."

Patient interview No 2.2, Practice B

"I would say that yes if they are having an ongoing problem they may choose if they make a routine appointment to see the same doctor. And it would be best to see the same doctor. But if they have an urgent problem, then I think that they should be prepared to see any doctor...*[This woman in a general practice secretary]*"

Patient interview No 2.5, Practice B

"There was one doctor, still there, not there now because of maternity leave I think, but she knew the whole background to this *[a* "relationship breakdown"*]* so I was sort of waiting for an appointment with her. It could be a week or two away from initially making the first move for it. But I suppose that is not an emergency though."

Patient interview No 3.7, aged 16-65, Practice C

Patients and professionals felt that the main benefit of seeing the same doctor was that they "know your history" and that they had developed a relationship over time. One older woman spoke affectionately about one of the doctors who she considered to be "Like a father to me." For a small number of patients, seeing their usual doctor with an acute problem was more important than seeing a different doctor. One practical benefit to professionals of patients seeing the same doctor was that it was considered to be a more economical use of the doctor and patients time, because the usual doctor would be familiar with the patients' problems.

"Patient: I need to see the nurse next week.

Receptionist: She's not in then. She's on a course.

Patient: She's not! She told me she was in.

Receptionist: I'll have to check. (She goes to the phone and rings the nurse. They have a brief conversation and she returns to the hatch). She says she's not in then. It's really up to you if you wait to see her or see someone else.

Patient: She's not doing my diet any good. I'm so intimate with her. I'm so disappointed. Since I've been coming I've lost two stone. I've lost four stone on my own, but then I needed some help. I'm feeling good now about myself..."
Observation No 8, waiting room, Practice A

"I tend to stick to the one doctor, for me. I tend to see the lady doctor. I do tend to build up a relationship where my son is concerned. I mean I know I have got a choice of three but I do tend to stick to one doctor where my son is concerned."

Patient interview No 3.12, parent, Practice B

6.8 Summary

In this chapter I have examined patient illness behaviour and its relationship to appointment making. I have also looked at related factors such as the ability of the practice to provide appointments, patients' views of personal care, and patient and professional understanding and use of the terms 'urgent' and 'routine' when making appointments.

Deciding to make an appointment is a complex activity which depends on patient and family factors. Several patient factors act together to 'trigger' a consultation with the doctor. These include factors such as failure of self and medical care, anxieties about the duration of illness, previous illness experience, and concerns about specific symptoms and conditions, such as meningitis. Other trigger factors include disruption to employment and the need for a sick note, and disruption to family and social life.

Patients and professionals define 'need' in relation to symptoms and signs of illness. Sometimes this is used in the sense of care being imperative, at other times it means a simple request. Professionals, however, also define need in terms of their capacity to meet the demands of patients.

Most patients and professionals share similar ideas about when to consult by an urgent or routine appointment. Patients prefer to consult urgently rather than wait, whereas professionals have ambivalent views about patient requests to be seen urgently, and particularly for sick notes. For patients who wish to consult urgently, seeing a competent doctor is more important than seeing their usual doctor.

Chapter 7 : The practice setting

"All the world's a stage,
And all the men and women merely players:
They have their exits and entrances;
And one man in his time plays many parts,
His acts being seven ages." (As You Like It. W Shakespeare).

7.1 Introduction

This chapter examines the structure and organisation of the three research practices. I examine the setting of the waiting room and its dramas from a dramaturgical perspective. I will also look at data about interactions and appointment making activity between patients and receptionists.

7.2 Describing the practices

The context in which observations occur influences the observer and observations, and gives information and insights that help interpret observations. The practices were visited between 1998 and 1999. For the sake of anonymity they are called Practice A, B and C. A summary of practice characteristics follows in Table 7-1. A more detailed version of this table appears in Appendix 10.

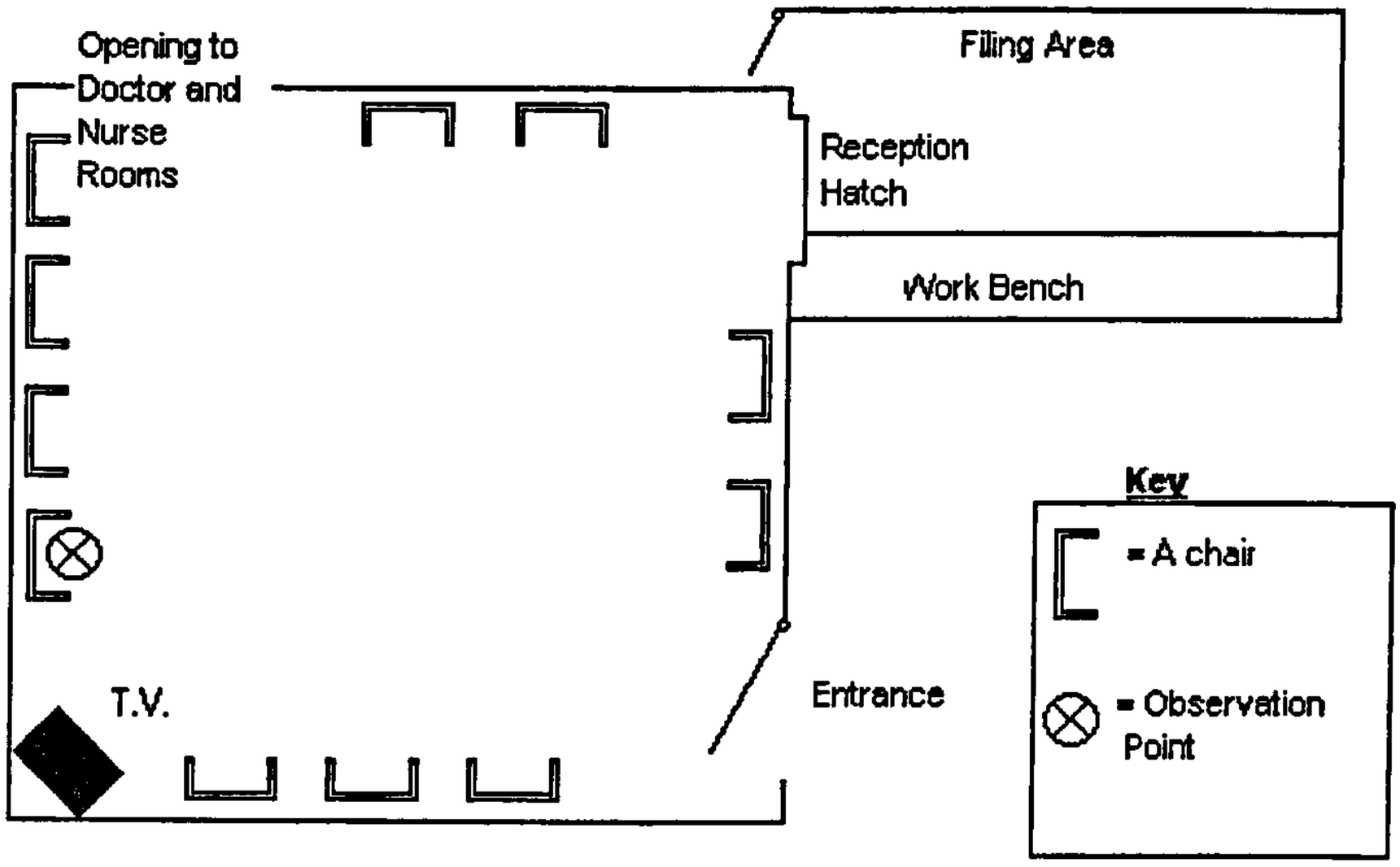
Table 7-1: Summary of practices' facts and figures

Practice	A	B	C
Population	1,700 patients	6,500	10,500
Doctors	1	3	7
Receptionists	3	5	10
Modes of managing demand	Spaces for 'extras' at end of surgery	'Open access' clinic	Nurse telephone triage for 'same day' requests

7.2.1 Practice A

This practice is a single-handed general practitioner working from a converted end-terrace house in a densely populated residential area in Gateshead. Patients enter the practice through the side yard and door (Figure 7-1).

Figure 7-1: Plan of waiting room and reception area of Practice A (not to scale)



This door opens into a waiting room that was previously a dining room. The walls are lined with large white plastic garden chairs, except for an electric fire and grate, a door to the hall and doctor and nurse consulting rooms, and a small sliding glass window at face height in one corner of the room. It is at this 'hatch' that patient-receptionist interactions occurred. A small colour television is at head height at the opposite corner of the room to the reception hatch. It is always switched on, but only just audible. The reception area is the converted 'galley' kitchen of the house. It opens onto a back door, the hall door and the reception hatch. Three computers, two printers, a fax machine and a single telephone are arranged along a worktop down one side of the room, where the receptionists sit. On the opposite wall are four grey filing cabinets and shelving where the Lloyd George records are stored. The 'thicker' records are stored at the end of this room in the old pantry. A radio is usually playing the Metro radio station, but it is not obtrusive. The doctor's consulting room is through the hall of the house in the original front room. Upstairs is the manager's room, a common room, and the practice nurse's room. There were two chairs outside the nurse's room for waiting patients. CCTV scans this area and is transmitted to a small TV in the reception area.

The practice has 1,700 patients. The single-handed doctor moved from a group practice to work here 14 years ago. The practice manager had been in the practice 16 years. She was a receptionist in the practice for many years but now works part-time as practice manager. Two senior receptionists have been in the practice for over 12 years. A third receptionist who has two small children joined the practice three months previously. The practice nurse works 20 hours a week and has her own clientele. A second practice nurse works three hours on a Friday.

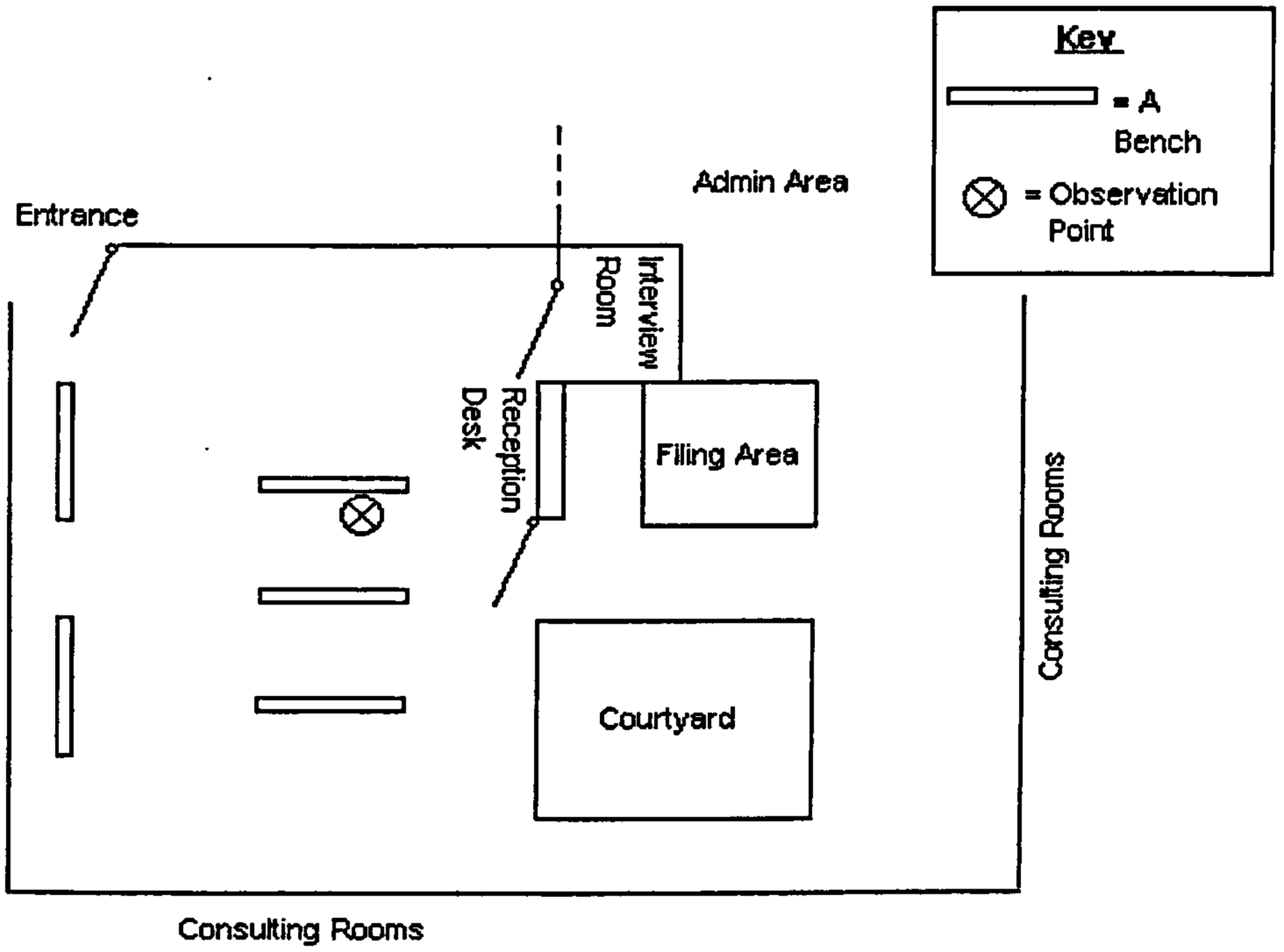
Throughout the practice there are pictures and models of dolphins. This reflects the doctor's interest in Greenpeace. The staff had chosen the dolphin motif as a positive and uplifting image - in contrast to the dilapidated working conditions –, and this appears on the practice literature.

7.2.2 Practice B

This three-doctor practice is based at a purpose-built new red-brick health centre beside the main road of a South Tyneside town of about 20,000 people. A wall and high fencing surround it. Adjacent to the surgery is the rear of a shopping complex area, several pubs and a block of flats.

The waiting room is approximately 10 metres by seven metres in size (Figure 7-2). You enter the waiting room through the double doors in one corner of this room.

Figure 7-2: Plan of waiting room and reception counter of Practice B



To the left is a window which overlooks the practice's car park, and facing the entrance door is a reception counter with a phone at its far end. There are usually two receptionists here. Behind them is the rear of the A4 record store and access to the other administrative rooms. Either side of the counter are two doors: one leads to a room for interviewing patients (I use it for interviewing patients), the other is the main staff entrance and exit. Past the reception desk is a glass-fronted courtyard with floor to ceiling glass on all four sides. It is open to the elements. On the far side of the courtyard is a glass fronted corridor with the coffee room and secretary's room off it. To the left of the courtyard the innards of the filing area is clearly visible, together with views of receptionists passing through. The glass wall to the right of the courtyard displays another corridor with consulting rooms off it. This corridor opens onto the waiting room in the corner opposite the practice entrance. In the glass courtyard is a Japanese style garden with block-pavers, pebbles and trees and plants. The upper storeys of the adjacent block of flats are clearly visible through the courtyard.

On the two remaining walls of the waiting room are several consulting rooms for doctors and nurses. Off the filing area are two rooms, the practice manager's room and

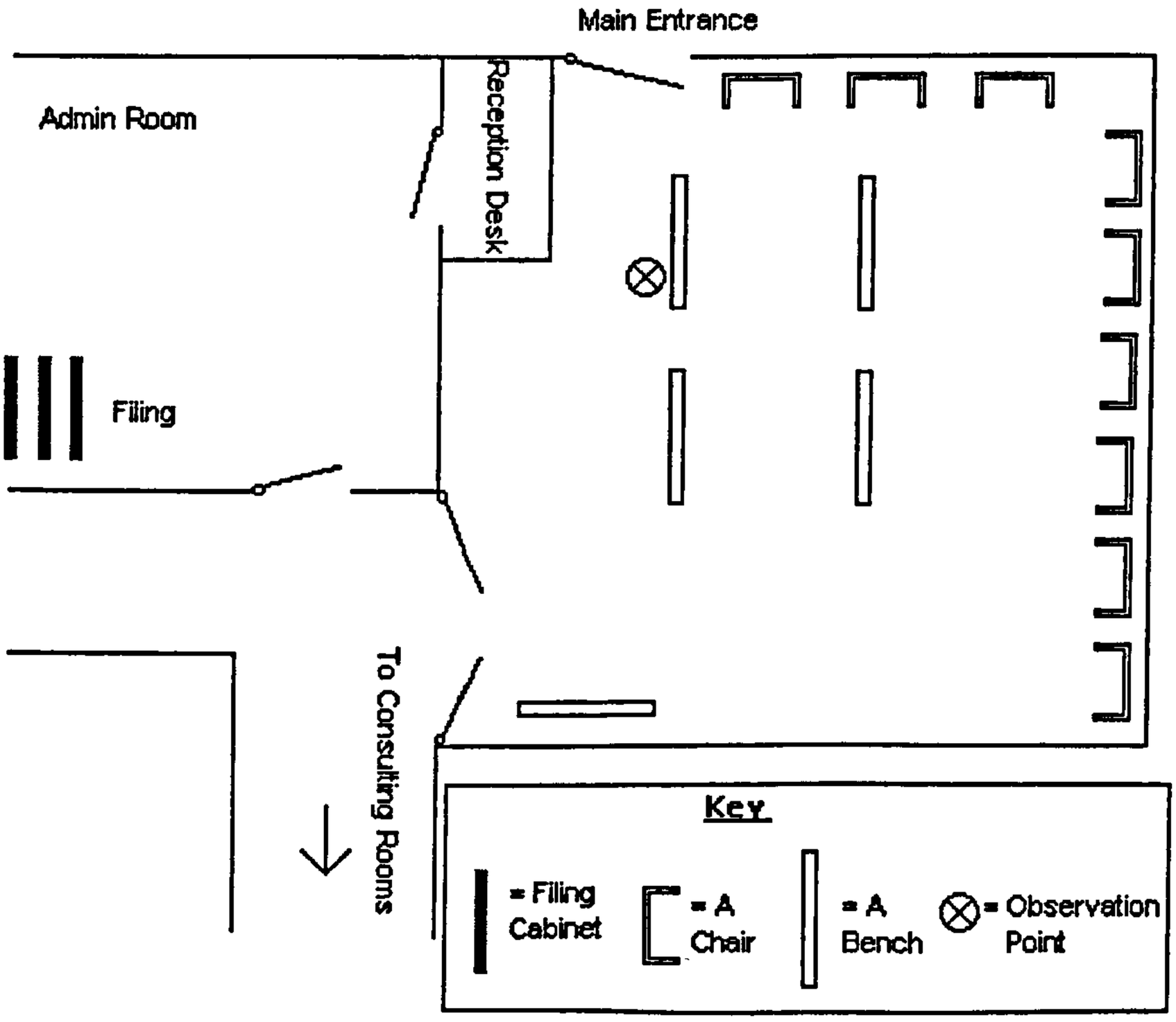
a large administration room where telephone queries and repeat prescriptions are managed.

The practice has 6,500 patients. There are three doctors, a practice manager, a senior receptionist and four other receptionists, two of whom work on the reception desk at any one time. Surgeries are offered during mornings and afternoons. They have an 'open access' surgery daily for people who wish to see the doctor the same day. Telephone requests for home visits are triaged by an attached district nurse. Data which I examined from this activity showed that they had consistently reduced the number of home visit requests by 60 per cent, usually by offering appointments or telephone advice from the nurse or doctor. The receptionists were not involved in this work.

7.2.3 Practice C

Practice C is a single storey building opened in 1989. It is adjacent to a shopping arcade and bus concourse in a town just outside Gateshead. It is surrounded by acres of parking space. The main waiting area is about 10 metres by 10 metres, and is lined with fitted bench seats covered in a rusty coloured fabric (Figure 7-3).

Figure 7-3: Waiting room and other areas of Practice



To the right of the main entrance double doors is a small reception area with a low counter. There is only space for two people at the counter, on which are two computer terminals. Behind the counter is a door to the filing and administrative areas. On the same wall are double doors to the consulting areas. One corridor, immediately opposite this entrance, is lined by nurse consulting rooms on the left hand side. At the bottom of this corridor a door leads to the secretary's and manager's rooms, toilets, and the common room. To the left of the entrance, off the waiting room, is another corridor. This leads to a secondary waiting area lined by the doctors' consulting rooms. There are eight seats here. In this corridor there is also a door to a nursing room opposite which are four more seats for waiting. In the main waiting room are three displays of weeping figs and evergreen plants, a fish-tank and some children's toys. A TV is in one corner of the waiting room. There is piped music throughout the practice. It is not intrusive and not memorable. The roof of the waiting room is of stained timber work with a hoisted gallery above. The whole practice appears to have been recently decorated, as few carpets show wear.

Incoming telephone calls are managed in the administrative area. The senior receptionist has her own space and there are three other computers and telephones. At right angles to this is the filing area of new pink metal filing cabinets.

Seven doctors work in this practice of 10,500 patients. Four are full-time and three part-time. They provide a range of appointments throughout the day, and a month before I visited the practice they had introduced a same day triage service similar to that pioneered in my own practice. Their business manager is shared with my own practice, although he is not involved in receptionist activities; this is the responsibility of the practice manager/senior receptionist and doctors. Apart from the business manager I do not know anyone in the practice. The doctors and nurses meet mid-morning for coffee during a break in their surgeries.

The next section examines my impressions of the 'stage' on which patients and receptionists, as actors, perform their roles when visiting the waiting room and reception counter. I will also examine patient experiences of waiting to see the doctor.

7.3 The drama of the waiting room

My analysis of waiting room behaviour is influenced by dramaturgical sociology, and particularly the work of Erving Goffman (Goffman 1971; Hunt and Benford 1997). Dramaturgy is a perspective that uses a theatrical metaphor to understand social interaction. Its central concept is that people in a social context *act* to create meaning and demonstrate purpose. Goffman called such action 'impression management' where people develop and present particular images of them or fronts (Goffman 1959). These images can be presented deliberately or accidentally. Elements of dramaturgy include staging of the setting, constructing roles and identities, dialogue and direction, backstage control and the performances themselves.

7.3.1 Staging the setting

'Staging' refers to the use of space to segregate audiences and provide performing regions, and the use of costumes and props (Hunt and Benford 1997). In the three practices there is a distinct separation of the reception counter where the receptionists work and the waiting area where patients wait. The interaction area is at the reception counter which all patients visit. Patients 'travel' to visit the doctor and leave the practice along a 'corridor' between the counter and the rest of the waiting room. In Practices B and C the reception counters were of polished hard wood which, on the side facing the waiting room, sloped inwards from counter top to the floor like the prow of a ship. The counter in practice B was so high that you could not lean on it. The effect was that both reception counters projected into the waiting room. The reception counter structures are not simply stages for receptionist performances and dramas with patients, but are also barriers to interactions. This may be why many patient – receptionist interactions are short and businesslike: it is not a stage which encourages prolonged discourse. It is also unusual for patients to return to the reception counter once they have been in the waiting room. Perhaps the barrier of the reception counter discourages further contact apart from approved activities such as appointment making.

The costumes worn by the receptionists in Practices B and C were colour co-ordinated blouses and skirts, embroidered with the surgery name and embellished with name badges. Patients wore a diverse range of clothing; there was no patient uniform. The only other distinctly dressed group of actors which I observed on three occasions were the be-suited drug representatives with their hard black briefcases and leather personal

organisers. Receptionists worked with props of paper, pens, computers and the telephone. The practice provided ambient music, television, and tropical fish in a tank, seating and leaflets on health problems and social services and posters. Patients brought props such as other people, newspapers and magazines, food, buggies, coats, bags, hats and a dog.

> "Two middle-aged men enter the waiting room. They sit together and chat. A third woman joins the younger and older woman in the waiting room. She also has a green canvas shopping bag which she puts on the seating. She sits beside the older woman. Folds her arms (without letting go of the shopping bag). They talk in turn. The middle-aged woman talks using her hands but not relinquishing the comfort of her shopping bag."
>
> Observation No 20, Practice C

I have already mentioned the fact that my costume as a researcher in the waiting room was t-shirt and denim jeans, with the props of a notebook, pen and rucksack. I was concerned that the prop of the notebook, and writing in it, would affect my performance and that of the receptionist and patients. In practice it did not seem to.

During all my time in the waiting rooms and reception areas of all three practices the doctors only appeared once in the waiting room. They did not use it as a thoroughfare. The one time a doctor visited me in the waiting room was to say 'Hello.' I felt embarrassed and that my 'cover' was being blown, as there were several patients in the waiting room at that time. On another occasion a health care professional whom I knew, who had just visited her general practitioner, noticed me in the waiting room, came over to where I was sitting and started to talk about her health problems. Again, I felt the pressure to step out of my role as a researcher.

> "I probably didn't give her the right cues. I was trying to give the message that I wanted to be left alone but without being rude, so I didn't return the conversation and just said - you know, "I'm sorry about that," or "that's interesting," or whatever. I felt a bit awkward by that, I wasn't quite sure what to do, but eventually *[receptionist's name]* explained a bit about what I was doing, and she left."
>
> Discussion of joint Observations Nos 33a and 33b, Practice C

Backstage control

An important aspect of staging the setting of the waiting room is backstage control. In the waiting room area it is important that patients do not obtain uninvited glimpses of what is happening behind the scenes. These glimpses have the potential to compromise the practice's production.

In Practice A backstage control was tightly controlled. Most patient – receptionist interactions happened at the reception hatch, which was an opaque glass sliding door, measured one metre by one metre. Except when busy the hatch door was closed after every patient encounter, allowing few glimpses of the actors backstage. This contrasted with Practice B where patients could view an administrative area of the practice where receptionists were extracting and replacing A4 records. On the face of it the practice was displaying the backstage action. This was a trick. Some reception work was visible from the waiting room, but patient telephone requests for repeat prescriptions and other services were performed out of sight.

In Practice C backstage control was managed by shutting a door behind the reception counter and the rest of the practice. This was a threshold over which the receptionist crossed to perform.

> "In the administrative area the receptionist comments to me about someone in the waiting room. "Why don't you look at Mr X? He's a disgusting bastard. He's just an unpleasant man. He's always dropping in expecting to be seen." (I go through to the reception counter, and look at him in the waiting room. He does appear to be grumpy in demeanour). She goes through to the counter to deal with another patient. She is all smiles. Indeed, her face changes from a grimace to smiles as she crosses the divide from the administrative area to the reception counter."
>
> Observation No X, administrative area, Practice X

On other occasions comments by receptionists, which might compromise the drama at the reception counter, were asides which were not audible to patients.

"A tall man in his 30s to 40s comes to the reception desk to ask if his wife has been seen by the doctor. She checks on the computer to see if she is in. As she is doing this, his wife comes through to the desk. When he has gone she comments, "He works on the buses and he's as miserable as anything. You can tell by just looking at him what he's like.""

Observation No 26, Practice C

All practices had separate entrances for doctors and other staff. The doctors did not perform in the waiting rooms. Their performance areas were consulting rooms, administrative areas and coffee rooms.

7.3.2 Scripting

Another dramaturgical concept is 'scripting' which refers to "the directions that define the scene, identify actors and sketch expected behaviour" (Hunt and Benford 1997). These scripts are not slavishly followed, but act as guides for those that take part on how they should perform. The scripting of 'dramatis personae' identifies a cast of characters with roles and identities, and dialogue 'provides actors' rationales for taking a particular line of action (Hunt and Benford 1997).

Constructing roles and identities

The receptionist is cast as the helper who meets people's needs and requests. They also control the movement of patients from the waiting room to the doctor's consulting room where the main drama occurs. My fellow observer Joy Guy made this comment about receptionists.

> "When you see the receptionists directing operations, it's like a scene from Star Trek where the captain shouts "Engage!", and the performance begins."

Discussion of joint Observations Nos 33a and 33b, Practice C

Receptionists also act out other roles. For example, they control the conduct of patients in the waiting room, especially if they should act inappropriately according to the practice rules. The following example is a young woman who describes feeling anxious while waiting to see the doctor.

> "I am up and I open the door and I get wrong, you know, off the receptionist, "Can you shut that front door please?" (She imitates the receptionist's voice in a sarcastic way)"
>
> Patient interview No 3.11, complainer, Practice A

The patient's role is to interact with the receptionist in the waiting room on arrival and then prepare for the main drama the consultation with the doctor or nurse. Patients, while waiting to see the doctor, may interact with other patients, usually with a repertoire of small talk as most other actors are strangers or keep themselves to themselves.

Dialogue and direction

While the scripting of dramatis personae identifies a cast of characters, dialogue provides actors' actions for taking part (Hunt and Benford 1997). "Patients and receptionists script dialogue and construct vocabularies to justify their actions" (Hunt and Benford 1997). Usually this occurs before visiting the surgery. Patients and receptionists construct scripts that allow them to manage the uncertainties of the interaction. These scripts are informed by their past experiences, and previous dramatic encounters. The next chapter identifies receptionist and patients' scripts when negotiating appointments and other services.

7.3.3 Performances

A performance is a *visible* interaction between actors. If the interaction was not apparent to an audience then it would be an encounter, but not a performance. Performances are also empowering to the actor. As Hunt puts it, "By acting, participants undergo a transformation from someone acted upon by external powers to an agent actively affecting the scene" (Hunt and Benford 1997). Some patients give performances that are received well by receptionists, and are rewarded with a service that the patient wants. Other performances, such as one made by a drug user I observed, are not acclaimed, and the patient is unsuccessful in getting what he wants. Patients and professionals expect the actors to perform in a certain way. If they do not, their behaviour is viewed with approbation by other participants. Other performances stand out for their poignancy;

"I mean we have sat there and there has been difficult people come in. ...They demand to be seen. I want an appointment, today, now.' And they *[the receptionists]* have gone about it the right way. They explained things and I mean if they haven't been able to give them an appointment I mean all they have said to them is ...There's just no vacancies. No appointments. And they have gone out and they have banged doors, haven't they?"

Patient interviews Nos 3.13a and 13b, Practice B

"A woman in her 40s exits through the waiting room. She is crying, her eyes are red and she has a tissue in her hand with which she wipes her nose. She is accompanied by a man of a similar age. He has his right arm around her shoulder. I have been in the waiting room 45 minutes - she was not here during that time. I presume she has been here some time. (I later learn from the doctor has just been told her she has cancer). All of human life is here - all emotions expressed - crying, joking, frustration at waiting, agitation, quiet, self containment, friendliness."

Joint observation No 29, Practice C

People make many entrances and exits to and from the waiting room. Some come only to the reception desk, but many sit and wait to be called through to the doctor or other parts of the surgery. The range of displacement activities exhibited by patients is extensive. This includes 'foot tapping,' leaflet looking', 'magazine flicking,' reading, watching TV, getting up and down, coughing, talking, and going outside to have a cigarette.

"A teenage girl dressed in long flared skirt and T-shirt and fitted jacket registers."I've got an appointment with Dr ..."

Receptionist: "Just have a seat."

She has her legs crossed and her foot beats rhythmically up and down at two beats a second. This continues for about 10 minutes. She looks at her watch and contorts her mouth as if displeased. She holds her body closely with her arms crossed about her and resting on her top. Sometimes the leg beating increases in frequency, but I am staggered at how long it lasts - 14 mins!"

Observation No 20, Practice B

"Two teenage boys sit. One sits with his arms closed. The other flicks through two copies of 'Best' magazine very rapidly. He is not reading them. He walks across the room to retrieve more magazines, returns to his seat and flicks through them very rapidly. He asks the boy next to him, "What are you in for?" He replies, "My chest," and resumes his magazine flicking. He crosses the waiting room for even more magazines. He does this a total of four times."

Observation No 20, Practice B

"Opposite me is a couple. They are in their mid-twenties. They sit together. Her legs are turned towards him, and he rests his chin on the hand adjacent to her. They are a self-contained unit. They talk intermittently. She reads intently a leaflet on AIDS. After a while he reads over her shoulder (to see what she is finding interesting). They read together, but sometimes he looks at the TV. He now picks up the AIDS leaflet, which she has discarded. He reads the AIDS leaflet. He rests his chin on the hand furthest from her. She adjusts her position to move both of her legs together towards his chair. (His and her movements mirror each other). They do not engage the other two people in the waiting room. (Comment - Their behaviour reflects their togetherness, but perhaps it is also a defence against the 'intimidating' waiting room or the stress of waiting to see the doctor/nurse)."

Observation No 14, Practice A

7.4 Experience of waiting to see the doctor

During my research I postulated that many patients found the experience of waiting stressful. I was also curious to see if patients rehearsed their consultation with the doctor. I decided to recruit for long interview three patients who had been waiting more than an hour in the waiting room. I also asked most other patients in the long interviews about the experience of waiting.

The predominant patient reactions to waiting were tolerance because "the doctor's busy," and "it can be really monotonous and boring." People also felt fearful of waiting to see the doctor and angry about the length of time waiting. Some patients prepared for their visits to the doctors. One parent (with her baby) who waited for 70 minutes explains (the baby's grandmother was also present at interview);

Grandmother: "If I have got to sit and wait I think of other things I could be doing rather than sitting there. I appreciate he is busy.

Parent: As long as he *[the baby]* is happy and not whingeing I am fine. Obviously people wait various lengths of time to see the doctor. Sometimes I am in ages and some people behind me will be complaining.

Grandmother: Fed up yes. I sit down I think I wish I had brought my book.

Parent: You see I go prepared... (Laughs).

Researcher: What sort of things do you take?

Parent: I have all the baby wipes and all the nappies, and I have his bottle of juice and I have some sweets for him and I have his bottle of milk. So I am all ready for him, waiting for him to whinge (laughs)."

Patient interviews No3.15a and 3.15b, waiter, parent, Practice A

"And then when you do go down for your appointment, you have got to wait sometimes an hour before you see the doctor. ...You have got people coming in... and they get seen before you. Which I think it is just all wrong."

Patient interview 3.5, complainer, aged 16-65, Practice C

7.5 Activity recording

7.5.1 Introduction

Activity recording is the term I give to records made by me of the number and type of interactions and practice activities witnessed in the waiting room and reception areas. The aim of the observations was to describe and record the range of patient – receptionist interactions, particularly when making appointments. On my first visits I made lists of all interactions and activities seen in the waiting room and reception area. From these lists two Excel spreadsheets were constructed, one each for the waiting room and the reception area. Each interaction and activity was described and defined on the spreadsheet. No account was made of time taken to do a particular task. For example, extracting a set of patient records was recorded as one event, as was typing and printing out a repeat prescription on the computer, even though the latter activity took longer. Printouts of the spreadsheet were used as a proforma for recording

interactions and activities on subsequent visits. These were refined, over several observations, to be as inclusive as possible. Usually activity recording was followed by a period of observation with informal interviewing which was written in fieldnotes.

7.5.2 The diversity of interactions

Activities visible at the reception desk included appointment making, managing repeat prescription and other queries, dealing with visitors to the surgery, and social interactions between patients and receptionists. A total of 228 *appointment* related interactions between patients and receptionists were noted on the activity records of all **three** practices. Six types of appointment related activity were identified: requests for 'routine', 'urgent' or 'emergency' appointments and home visits; registering the patient's arrival for an appointment; changing a previously booked appointment; and telephone calls to resolve queries. Both larger practices had receptionists who specialised in appointment making. In contrast, receptionists in Practice A had several functions including making appointments.

The next three sub-sections describe interactions from three different vantage points:

- ❖ Behind the reception counter in Practice A
- ❖ From the waiting rooms of Practices A, B and C
- ❖ Telephone interactions in Practices A, B and C

7.5.3 Behind the reception counter in Practice A

The reason why Practice A is considered alone is that unlike the other two practices it was possible to observe and record a 'complete' *range* of receptionist interactions with patients, other activities behind the reception hatch and telephone calls. My vantage point in the reception area gave me good views of the hatch through to the waiting room and the bench at which the two receptionists sat. In Practice B it was not possible to record all interactions with patients because repeat prescription requests and results of investigations and filing were managed in two other places not visible from the reception counter. The situation was similar in Practice C where all patient telephone calls were taken in an administrative area behind the reception counter. The filing area was also in a different room to the reception area.

In Practice A 268 patient separate events were recorded during six periods of activity, each lasting 30 minutes, in June and July 1998. These are shown in Table 7-2.

Table 7-2: Interactions and activities observed and recorded in the reception area of Practice A

Activities recorded in the reception area	Number (%) of activities
Appointment making at the reception hatch - Includes registering patients, new, repeat, urgent appointment requests and home visit requests	37(14)
Other reception hatch activities - Includes calling the patient, managing repeat prescriptions and answering queries	32 (12)
Appointment making on the telephone - Includes new, repeat, urgent appointments and home visit requests	19 (7)
Repeat prescription phone calls	15 (6)
Other phone calls - Includes results of investigations, internal calls and other calls	14 (5)
Filing (of records)	68 (25)
Computer tasks - Includes registering patients, processing prescriptions, typing referral letters, putting investigation results on computer and miscellaneous tasks	39 (15)
Other administrative tasks -Includes talking to professionals, receiving and opening post, making coffee and other tasks	44(16)
Total number of activities	**268(100)**

Appointment making activities on the phone and at the reception desk accounted for 21 per cent of activities, but the biggest areas of activity were filing, computing and

general administrative activities which accounted for 68 per cent of the workload. Eighteen per cent of receptionist work was done on the telephone. These percentages are misleading because they do not take account of time spent on each activity. For example, it could take five or ten minutes to negotiate an appointment request or 15 minutes to type a referral letter, compared with 30 seconds to file or extract a patient's record. The table shows a complete range of receptionist and administrative activities. Practice A, however, is atypical because in the other practices receptionist duties were to some extent specialised and performed in different rooms. A copy of the Excel spreadsheet containing detailed data converted to Word appears in Appendix 11.

7.5.4 Interactions visible from the waiting rooms of all three practices

One vantage point of observation common to all three practices was the waiting room. Table 7-3 compares the activities recorded in Practice A, B and C.

Table 7-3: Patient – receptionist interactions and activities visible from the waiting rooms of Practices A, B and C

Interactions and activities visible in the waiting room	**Practice A** (7 observations)	**Practice B** (4 observations)	**Practice C** (4 observations)
Registering for an appointment	21	20	47
Making a new appointment	0	14	15
Making a repeat appointment	7	3	2
Making an urgent appointment	0	2	1
Managing a home visit request	0	1	0
Calling the patient – to go through to the doctor or nurse	6	10	11
Managing patient queries	1	3	13
Other tasks	5	9	19
Taking repeat prescription requests, or giving them out	13	17	33
Total events	**53**	**79**	**141**

Note: A detailed spreadsheet appears in Appendix 12.

In Practice B telephone requests for appointments were also taken at the reception desk and were visible from the waiting room. These telephone contacts appear in the next section. In Practices A and C it was not possible to observe telephone requests for appointments from the waiting room. Activities recorded in Practice C include two observations behind the reception counter, but all waiting room activities were visible there so they are included.

The works of the practices are not directly comparable as they are influenced by time of day and how the practice organises its work. Different numbers of waiting room observations were made at each practice. Registering and calling patients and repeat prescription negotiations were the most frequent type of patient – receptionist interactions. The larger the practice also, the greater the visible number of interactions and activities.

7.5.5 Telephone interactions in the three practices

In practice A it was possible to observe all telephone appointment requests and other administrative work. It was not possible to observe doctor, manager and nurse use of the phone in other rooms. In Practice B telephone appointment requests were made at the reception desk where an appointment book was kept, but home visit requests and telephone repeat prescription requests were managed in a separate area of the practice. In practice C all appointment requests were managed in a large administrative area behind the reception area. On busy days such as Monday mornings there would be up to five people taking routine and urgent appointment requests.

Table 7-4 displays appointment related telephone activity *visible* in all three practices. In practice A the vantage point is the reception area. In the other practices the vantage points are behind the reception counter. Detailed data from the original spreadsheets appears in Appendices 11 and 12.

Table 7-4: Comparison of telephone activities recorded in Practices A, B and C

Telephone activities recorded in each practice	Practice A Number of activities in reception area 6 observations	Practice B Number of activities at reception counter 4 observations	Practice C Number of activities at reception counter 6 observations
Making a new appointment	10	19	
Making a repeat appointment	4	1	
Making an urgent appointment	2	7	
Managing a home visit request			
Internal phone calls	2	4	6
Giving results	1	4	0
Other calls	11	10	1
Total events	**30**	**45**	**7**

More than half of calls were related to appointment making. This may have been because most of the activity records were made in the mornings, when most appointment requests may be received. Observing at other times of the day might show different patterns of telephone use, but my visits to the surgery were constrained by times when I could visit.

Table 7-4 does not have data on making telephone appointments for Practice C, because most telephone working there was done in the administrative area. To make a comparison I observed one hour of telephone appointment making in the administrative area in Practice C. In this time three receptionists managed 35 requests for new and emergency appointments, plus another nine other telephone calls. This is about twice the rate for Practice B.

In summary, the activity records show the nature and range of patient-receptionist interactions, particularly related to appointment-making in the three practices. They also show that as the practice size increases so does the commensurate activity.

7.6 Summary

This chapter describes the three research practices, examines patient – receptionist and waiting room interactions from a dramaturgical perspective, and looks at data from activity records of interactions.

Practice A is a single handed practitioner working from a converted terraced house in an urban area on Tyneside. Patients make an appointment at the surgery through a small hatch which opens onto the waiting room. The practice has 1,700 patients. Three receptionists manage appointment requests, as well as performing other functions. Practice B has three doctors and is based in a new health centre in urban area in South Tyneside. The practice has 6,500 patients. A team of five receptionists specialise in appointment making. They see patients who wish to be seen the same day in an 'open access' surgery each morning. Practice C has seven doctors and is based at a health centre in an urban town on the edge of Gateshead. They have 10,500 patients and have recently introduced a telephone triage nurse to manage patient requests to be seen the same day. Like Practice B a team of five receptionists specialise in appointment making.

I have examined waiting room activity and behaviour from a dramaturgical perspective. This includes the elements of staging the setting, constructing roles and identities, dialogue and direction, backstage control, and the performances themselves.

From the activity recording, seven types of appointment-related activity were identified: requests for 'routine', 'urgent' or 'emergency' appointments and home visits; registering the patient's arrival for an appointment; changing a previously booked appointment; and telephone calls to resolve queries. Data were presented on interactions and appointment related activities visible in Practice A, and from the reception counters and waiting rooms of all three practices.

Chapter 8 : Negotiating an appointment

"...there is a limit to manageable workloads. And part of that is the ability to say to patients, "Well what is it? Why is it that you feel the need to see the doctor so urgently?" And if they say, "It is because I have got a sore throat", then they are into a negotiating situation." Practice Manager interview No1, Practice A.

8.1 Introduction

In Chapter 6 we examined patients' experiences of illness and reasons why they make an appointment with the doctor. In Chapter 7 we described the setting in which appointment making occurs. This chapter concentrates on patient - receptionist interactions when negotiating appointments. Appointment making is presented as a complex social process where patient, professional and practice factors, and social policy issues are important. I will analyse the 'accommodation dimension' (Chapter 2.2.2) of appointment making, outlining differences between patients, professionals and practices, and examine how practice policies inform the work of appointment making.

8.2 The process: complexity

Seventy-eight appointment negotiations were recorded in observation fieldnotes. Other negotiations were observed, but were not recorded when they did not illustrate new aspects of appointment making activity. Appointment making episodes were also discussed and recorded in the interviews.

Appointment making has repetitive and ritualistic elements, such as receptionist and patient greetings, appointment requests and offers, and appointment closures (Figure 8-1). Offers primarily consisted of offers of time, day, doctor, nurse and 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 the availability of appointments, and patients' expectations of when they should be seen.

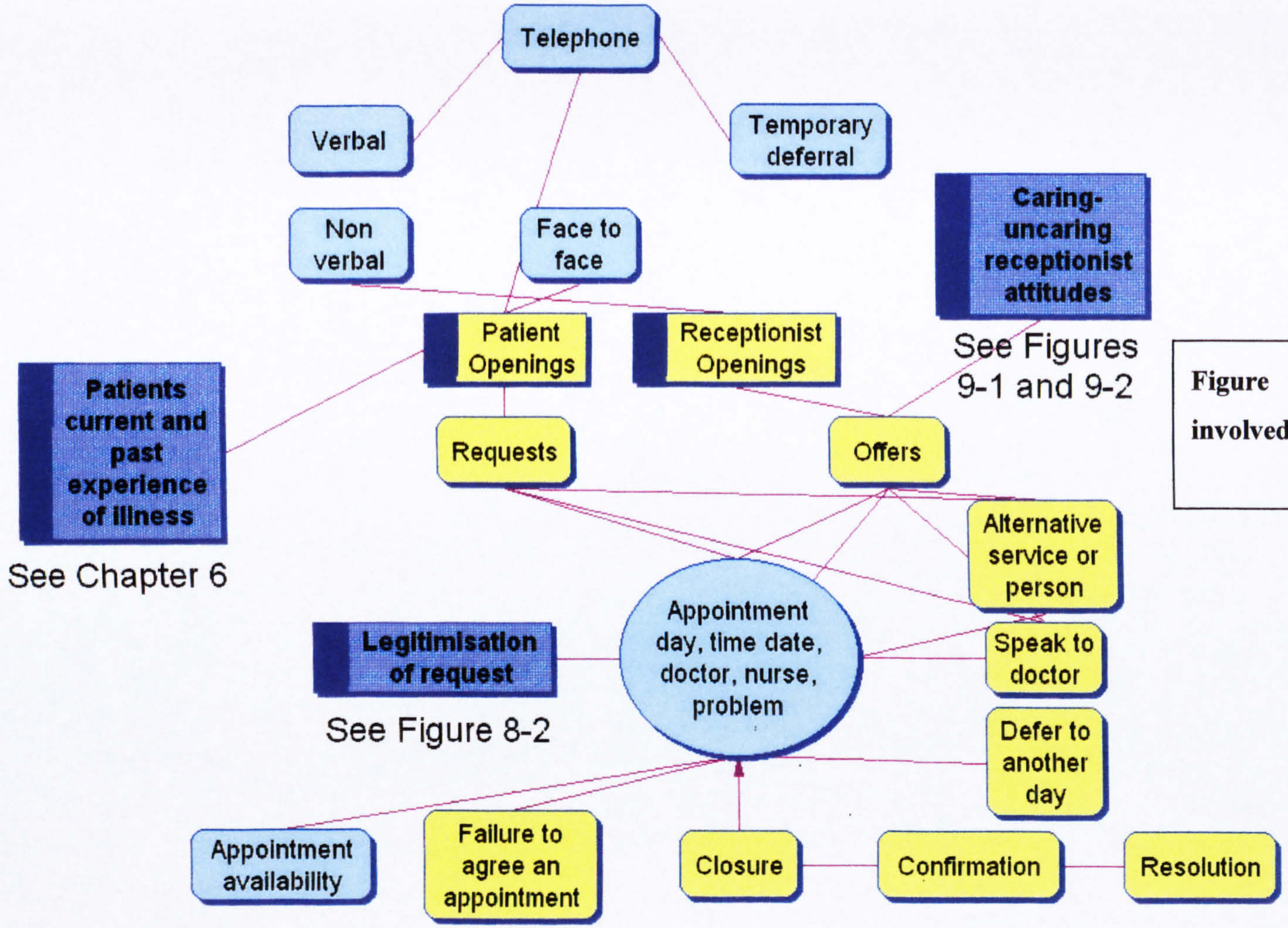


Figure 8-1: Summary of processes involved in making an appointment

8.2.1 Openings and requests

The opening request or invitation would come from the receptionist or the patient. On the telephone the initial response was usually by the receptionist, and identified that the caller was through to the surgery. Typical examples include, "Good morning, Coverdale Surgery. Can I help you?" or "Heathcote Health Centre?" (these are fictitious names). Openings were more diverse at the reception desk because of the opportunities for non-verbal communication. The patient or receptionist would open the meeting. The receptionist might use a spoken opening such as, "Can I help you?" Alternatively, the patient would be invited to speak by non-verbal cues such as the receptionist looking up from the computer or reception counter, and smiling or giving a questioning look to the patient. Patient openings varied. These could be jokes or requests for services such as repeat prescriptions and appointments. Appointment requests were usually specific about day, time, problem, or type of appointment.

Patients registering their attendance usually make a statement that they had an appointment with a particular doctor or nurse or at a specific time.

> "A 30-year-old man walks through the door. Goes straight up to the reception desk. He smiles at the receptionist and says, "Appointment at quarter past 11." The receptionist responds, "Mr E is it? Running late at the moment, by quite a bit actually.""
>
> Observation No 29, reception counter, Practice C

Sometimes the initial request for an appointment was deferred. This was a feature of Practice B where the counter receptionists also dealt with telephone requests for appointments. The patient on the telephone would be asked to wait while they dealt with someone at the reception counter, "Heathcote Health Centre. Just hold on just a minute." Deferral is a tactic for managing competing appointment demands. I did not canvass patients' views of this tactic.

8.2.2 Offers

At the heart of appointment making are offers made by receptionists to patients. These are offers of time, day, doctor, nurse, routine or urgent appointment, home visits, and alternatives to making an appointment. Sometimes a request by the patient and the

offer by the receptionist are agreed immediately and lead quickly to confirmation of the appointment. Usually there is more than one offer before closure. The patient may reject multiple offers by the receptionist until a final offer is accepted.

> Patient: "I'd like to make an appointment.
>
> Receptionist: What about the Wednesday?
>
> Patient: I had to switch from the Wednesday two weeks ago.
>
> Receptionist: Ok. What about Tuesday, twenty past ten? (Receptionist makes lots of keystrokes on the computer).
>
> Patient: (He indicates non-verbally that the time and day are acceptable).
>
> Receptionist: (Gives him the appointment on an appointment card).
>
> Patient: All right sweetheart, bye bye."
>
> Observation No 6, reception counter, Practice A

All receptionists offered alternatives to a face-to-face appointment with the doctor or nurse on that day. These included deferring requests to another day, deflecting or diverting requests to other services, offering telephone advice, or speaking to the doctor on behalf of the patient. The practice manager in Practice A saw these alternatives as a useful way of diverting patients away from surgery appointments, and Practice C used their triage nurse for same day appointment requests in the mornings. As her work was conducted away from the reception area I decided not to observe her telephone working. I also felt that the focus of observations was on patient-receptionists relations, and that I did not have time to spend with the new triage nurse. There were also limitations in observing the work of the triage nurse as the majority of her interactions in negotiating advice and appointments were on the telephone. In retrospect observing the nurse-patient interactions might have provided useful contrast to receptionist-patient observations.

> "Well if somebody said well 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 somebody said, "My brother has just had a cholesterol check and it is such and such and I want to discuss it with the doctor, because I think mine will be high." We would say, "You can see the dietician to discuss things like that." So there is lots of services available that you can divert to."
>
> Interview No 1, Practice manager, Practice A

Sometimes the offer made by the receptionist was unacceptable to the patient. I observed two examples where patients who had long periods of negotiation on the telephone (one of whom registered their discontent) who terminated the calls without making appointments.

8.2.3 Confirmation and closure

Confirmation of requests occurs for almost all patients. Usually this was a brief verbal or non-verbal exchange that was sometimes supplemented by the receptionist giving an appointment card to the patient. On the telephone it usually involved the receptionist confirming the day, date and time of the appointment, and the name of the doctor or nurse. The patient acknowledges that the request is acceptable or the receptionist checks verbally, by asking the patient, "Is that all right?" Negotiations with patients who registered for their appointment at the reception counter were sometimes terminated by the receptionist directing the patient to a subsidiary waiting area. This occurred in Practices A and C, which had one or more subsidiary waiting areas.

8.2.4 Differences between practices

Appointment making can be seen as a ritual. Ritual can be defined as "any formal act, institution, or procedure that is followed consistently," which is characterised by "stereotypical behaviour" (Collins 1989). The ritual nature of appointment making was most striking when comparing the smaller practice (Practice A) with the larger practices (B and C). The larger practices have two, three or more people, on any one day, making appointments. The larger practices each had a 'house style' for opening and closing appointment negotiations, particularly on the telephone. That style consisted of the repeated use of the same openings and closing remarks, particularly on the telephone. In contrast, Practice A usually had only one receptionist making appointments at a time, and opening and closing remarks were less stereotypical, with less formal language. The style of negotiation in Practice A could be classified as informal with ritual elements. This individualised element to appointment making in Practice A contrasts with the corporate flavour of receptionist responses in Practices B and C.

These differences between practices may be due to the specialisation of tasks in Practices B and C. For example, in Practice B two teams of two receptionists took it in

turn to take face to face and telephone appointment requests. The deputy manager also worked behind the reception counter on Mondays, and led both teams. Other receptionists did not get involved in appointment making and had their other tasks, such as taking repeat prescription queries on the telephone or data management. In Practice C five receptionists each had a day on the reception counter, with additional help from a second receptionist if they were busy. One or more receptionists also took telephone appointment requests in another part of the building. In both larger practices the receptionists wore colour co-ordinated uniforms, and projected an air of efficiency and professionalism. In Practice A, however, the three receptionists all had other tasks to perform, apart from appointment making, and wore their own clothes rather than a uniform. The impression they gave me, from observing them at the small reception hatch from the waiting room, was of informality rather than formality in patient dealings. When I visited Practice A 18 months after my initial observations I found that the single-handed doctor had merged with another practice, so that there were now three doctors and many more receptionists. They greeted me in their new uniforms with a new formality. I wondered whether the loss of some elements of informality in managing patients' requests affected their relationships with patients. 'Professionalism' (in the sense of carrying out a service with great competence) appears to be defined by corporate ritualised and formal receptionist behaviour. The antithesis of this is individualised, de-ritualised, informal receptionist behaviour. Perhaps this is considered to be 'unprofessional'?

There are also advantages to patients having a ritual form of appointment making. Familiarity with and knowledge of the process of appointment making may make it easier for patients to make requests when ill or distressed. They know what is expected of them, and they know what to expect when visiting or telephoning the surgery. Small practices, however, which have less ritual and more informality in their dealing with patients may be more flexible in responding to patients, as there is less need to conform to practice norms.

8.3 Difficulties of appointment making

All patients between the ages of 16-65 (6/6) in the long interviews had experienced problems with accessing care. "I expect to be told that there's no appointments available. Time and time again this is the kind of thing that happens," said one patient.

This confirmed findings from the short interviews of patients attending the 'open access' surgery in Surgery B. 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 patients' or parents' assessment of the severity and urgency of the patients' 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. This is not surprising as they were a self selected group of patients.

Many receptionists expressed difficulties in managing appointment requests. A receptionist with 13 years experience commented, "Patients are getting more demanding now than ever. It's more stressful for the receptionist, trying to fit patients in." The doctor is also feeling the strain, "The demand is too much," moaned a GP waiting to see patients at an 'open access' surgery for patients with urgent problems. What these comments don't illustrate is the dynamic nature of patient-reception interactions associated with making an appointment. A tense encounter which I observed at the reception desk is more revealing:

"A young man in his 20s approaches the reception desk. He says he'd rung to say he'd be late. The receptionist looks at the computer screen, and says she will see the doctor. "I'll leave a message on the doctor's (computer) screen," and in an aside to me, "They're 'druggies' so will need medication. Got to check it out with the doctor." After he had been waiting 20 minutes the receptionist calls him to the desk and explains that the doctor cannot see him today, but will leave a prescription after 2 o'clock, and see him next Friday. The receptionist turns her attention to the computer. The patient picks up a scrap of paper from the desk. "Don't worry," says the receptionist, "I'll write the appointment out for you. Is that time all right?" She looks at him fully - gives eye contact. He fiddles with the paper. He asks the time again and looks blankly into space. The receptionist says, "So, (she addresses him by his first name) after 2, your prescription will be ready and doctor will see you next week." She holds eye contact with the patient. The patient's face is inexpressive, and his eyes glazed. He breathes heavily, takes the appointment slip and walks haltingly to the door. The receptionist says, "Phew! I thought he might have reacted. He's always late, sometimes 20 minutes, but today one hour and 10 minutes. I don't think he knows what the time is most of the time. It's a shame.""

Observation No 30, reception counter, Practice C

8.3.1 Discord with appointment making

Discordant negotiations occur when there is a mismatch between the patient's expectations and the receptionist's ability to meet their needs. Most dissatisfied patients felt that receptionists did not acknowledge their requests or distress, and that their primary function was to "get me off the phone," and "protect the doctor."

"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. 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."

Patient interview 3.5, complainer, Practice C

Initially I thought that discord was most evident with urgent appointment negotiations. Patient-receptionist discord, however, is a feature of routine *and* urgent appointments. A matrix search of the codes for 'appointment disagreements' (Table 8-1) showed that discord is common to both kinds of appointment making activity or discussion.

Table 8-1: Number of text units for the concept 'Discordant patient-receptionist interactions' for four different types of appointments.

	Repeat appointments – number of text units	**Urgent appointments** – number of text units	**Routine appointments** – number of text units	**Registering appointments** – number of text units
Discordant patient receptionist interactions	0	55	60	8

> "Well, no. I was a bit disappointed that I couldn't get an appointment last week. I have had a recurring problem for about a couple of months and you know it lasts for 2...I was getting stomach pains the last time for about 3 days. So the difficulty is trying to get to the doctor's while I am feeling ...So I rang on Wednesday to try and get an appointment because, you know, the problem was there again. And the earliest appointment I could get was today and of course by today I didn't have the pain in my stomach."
>
> Patient interview 3.1, aged 16-65, Practice C

This woman wanted to be seen soon, and did not negotiate an urgent appointment (or emergency appointment). As we have seen in Chapter 6.3.3 some patients can cope with their illness for a long time without seeking an appointment, whereas other people with similar problems seek an appointment more readily.

Researcher: "When you came in on the telephone to make the appointment, did you say you were unhappy about how long you had to wait. Did you express that?

Patient: No. I just said it to myself, 'six days to wait.'...She didn't have an appointment. It was no good getting aerated about it. ...I mean what's the point. She can't make places if they are not there. I was just upset that I had to wait that length of time

Researcher: Sure. So you were upset but nevertheless you didn't express that to them?

Patient: No. Mind if I had been more ill I would have done. And I would have wanted to be in there and then."

Patient interview No 3.6, aged 16-65, Practice C

Discord between patients and receptionists was expressed most in informal conversations with receptionists, doctors, nurses and patients, and during in depth interviews with patients and professionals, than was apparent during observations. There are a number of possible explanations for this disparity between the observations and interviews. Patients and professionals may conceal their discontent, the proverbial 'stiff upper lip', where negative emotions are suppressed and not displayed. There are also restrictions intrinsic to the process of appointment making. It is also a public setting which discourages people from acting out their true feelings. These incidents are probably uncommon; they are remembered by patients because they have been important negative experiences.

8.4 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 and their illness. The American Heritage Dictionary of the English Language gives two meanings of the word legitimate which are relevant to appointment making; "being in accordance with established or accepted patterns and standards", and "an authentic or genuine complaint" (HMC 1992). The first meaning

emphasises the process by which receptionists grant or refuse appointments according to the rules of the practice. The second meaning implies a judgement about the patient's illness or need. Three strategies were used to legitimise appointment requests: enforcing practice rules, volunteering and requesting patient information, and asking patients to judge the urgency of their problem. These are summarised in Figure 8-2.

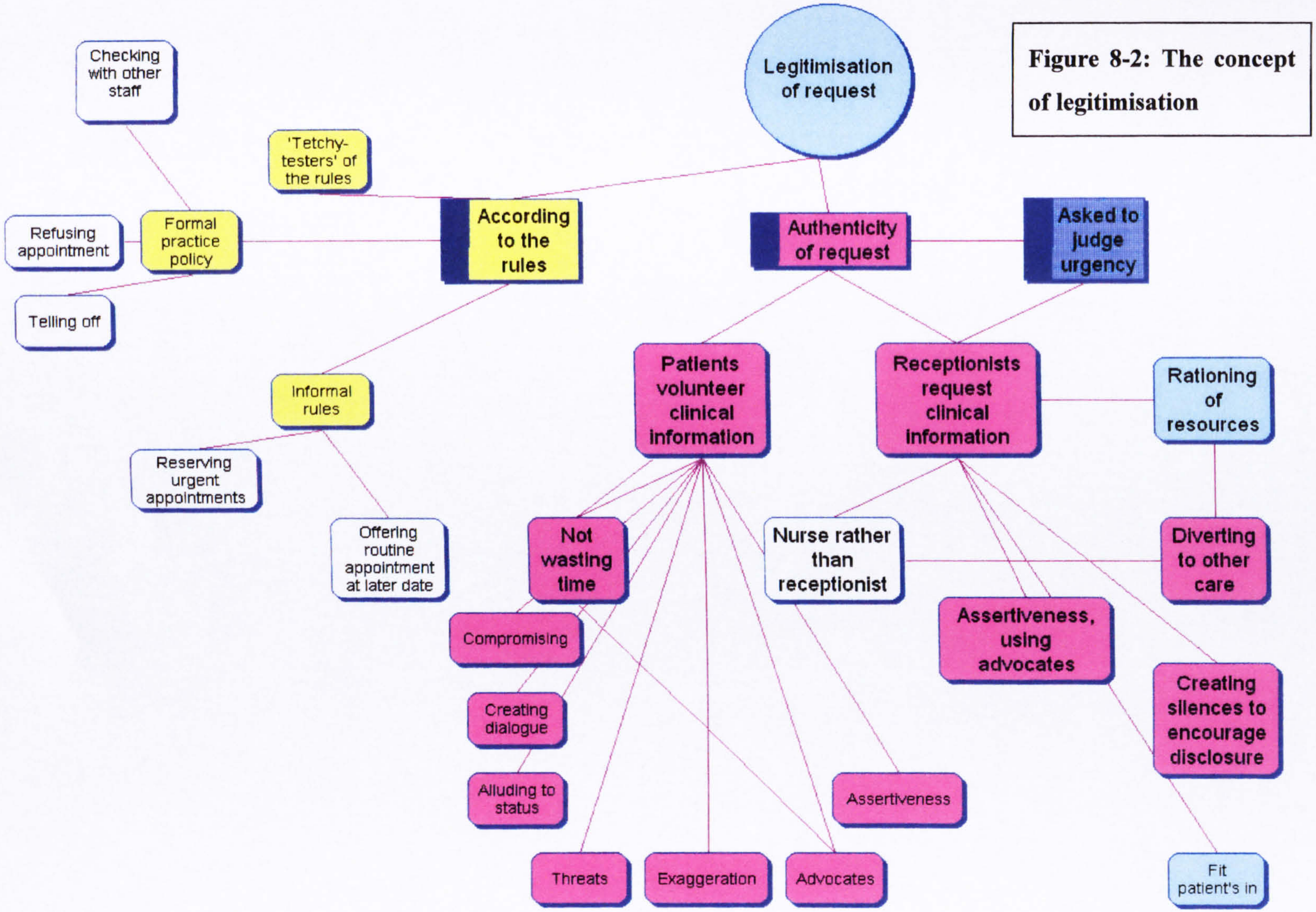


Figure 8-2: The concept of legitimisation

8.4.1 Enforcing practice rules

If the patient's request for an appointment lay outside the parameters usually adopted by the practice, the practice's rules on appointment making were enforced. Usually this was by a statement such as, "You can't do that", or, "That's not the practice policy." This was evident in many observations and interviews, particularly for unsuccessful urgent appointment requests.

> "The receptionist says that she has little sympathy for those who can't organise themselves (such as drug users). She also says, "We must have a new policy on sick notes and emergency appointments". She is contemplating putting a notice in the waiting room saying, "Under no circumstances will emergency appointments be given for sick notes.""
>
> Observation No 3, reception counter, Practice A

Several concepts were associated with the category of rule enforcement. These included refusal of the request, re-directing the request to another person or service, checking by the receptionist to confirm their stance on appointment availability, and 'telling off' the patient. The commonest of these rule enforcement activities *observed* was 'refusal' of an appointment (55 text units coded). In contrast, the commonest of these rule enforcement activities coded from patient and professional *interviews* was 're-directing' the patient's appointment request to another service (71 text units coded).

The most striking examples of rule enforcement were patients who made appointment requests that were impossible to meet. These requests were well outside the practice appointment rules. Three cases illustrate this behaviour. In my original coding I called them 'tetchy-testers' as they tested the limits of the appointment making system and the ability of the receptionists to enforce them, and were bad-tempered individuals. The first case was a patient who insisted on having an appointment at a time when the doctor did not consult. The second was a request for an urgent appointment time when none were available. The third patient wanted a repeat appointment when no one was available to process their request. All three patients were known to the receptionists, and their behaviour was thought to be 'typical.' They were judged by the receptionists to be familiar with the practice's appointment system. There are several potential explanations for their behaviour. They may have limited social skills and do not learn

to negotiate their requests or they deliberately or subconsciously set out to test the system. All of these patients were unhappy with receptionist responses to their requests.

The receptionist narrates a conversation with a patient that she has just had at the reception desk. She acts it out for me.

> "He (the patient) said: I want you to look at my kid.
>
> Receptionist: He's not in yet.
>
> Patient: Oh, I'll just catch him outside.
>
> Receptionist: He won't like that.
>
> Patient: It'll only take a few minutes.
>
> Receptionist: That's not the system.
>
> Patient: But I'm the key holder at [*a local institution*] and I need to get to work.
>
> Receptionist: Which is more important the doctors time or yours?
>
> Patient (unhappy): I'll ring back. I'm getting this every time I make an appointment."
>
> Observation No 7, reception counter, Practice A

The ability of the receptionist in Practice A to enforce appointment rules was valued by practices as an important skill. The trainee receptionist in this practice was criticised for being too accommodating with patients and was told to be "more assertive" with patients' appointment requests.

More rule enforcement was observed with routine appointments than other appointment types (Table 8-2). I thought that this might be because more routine appointments were observed and recorded. An analysis, however, of the numbers of each appointment type coded in the observations and interviews showed that 349 routine appointment requests were observed or discussed at interview, compared with 344 urgent appointment requests. This suggests that rationing appointment availability is a necessary function of all appointment negotiations. If there were more appointments then receptionists would not need to enforce practice rules.

Table 8-2: Number of text units coded for the concept 'rule enforcement' by appointment type requested in all Practices A, B, and C.

Appointment type request	Routine appointment	Urgent appointment	Home visit	Return appointment
Number of text units coded for 'rule enforcement'	51	18	0	2

Enforcing practice rules has several benefits. It educates patients, protects doctors and manages workload.

> "To some degree they (the receptionists) are protecting the GPs because there is a limit to manageable workloads. Therefore, they are aware of whatever rules the individual GPs lay down as their manageable workload. So if you were a GP and say, 'I can manage 15 appointments between 4 o'clock in the afternoon and 6 o'clock in the afternoon', and they have already booked 16 people in, then they have got to do something. This situation enforces the ability to say to patients, 'Well what is it?', 'Why is it that you feel the need to see the doctor so urgently'. And if they say it is 'because I have got a sore throat', then they are into a negotiating situation."
>
> Interview GP No 1, Practice A

8.4.2 Information giving and requesting

Two main types of information were requested or given during patient receptionist negotiations. The first is concerned with the availability of appointments and the processes used to obtain an appointment. The second, more interesting information is about the patient's illness.

Some patients believe that giving the receptionist information about their illness 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, complimentor, Practice C

Four patients (long interviews) felt it was acceptable and seven felt it was unacceptable to exchange information about their illness with the receptionist. Patients make judgements about the extent and relevance of professionals' knowledge and ability to manage patients concerns.

> "If you want an emergency appointment you have got to tell them the symptoms, exactly what's wrong with you. Which I don't think is right because, as I say, they are not qualified to make a judgement on what's wrong with you."
>
> Patient interview No 3.9b, positive, aged 16-65, Practice C

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 3.12a, parent, Practice B

Receptionists said that asking patients for clinical information enabled them to direct patients to alternative and more appropriate sources of help. The official policies were not to ask the patient about their problem, but most receptionists solicited information to inform decision-making. Receptionists did this overtly or 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 No 1, Practice A

Requesting information by receptionists was most evident when patients requested urgent appointments, and home visits (Table 8-3). In contrast, volunteering information was associated with routine appointment making. Receptionists, and to some degree patients, see it as legitimate to request clinical information where the problem is considered to be urgent. In all but one of the home visit requests receptionists asked the nature of the problem. There was an acceptance by patients and professionals that this was a context where it was legitimate for them to ask. This contrasts with routine appointment requests where patients had ambivalent feelings about being asked.

Table 8-3: Number of text units coded for the concepts 'volunteering information' and 'requesting information' by appointment type

Exchange of information between patient and receptionist	**Routine appointment** requests – number of text units	**Urgent appointment** requests– number of text units	**Home visit** requests– number of text units
Information **'volunteered'** by patients – number of text units	24	10	1
Information **'requested'** by receptionist – number of text units	6	36	8

Exchange of illness information was evident in all practices, in both observations and interviews (Table 8-4).

Table 8-4: Number of text units of codes for information 'volunteered' by patients and 'requested' by receptionists, by practice.

Concept Practice	Practice A	Practice B	Practice C
Information **'volunteered'** by patients – number of text units	44	16	91
Information **'requested'** by receptionist – number of text units	52	116	55

As I have described already in Chapter 5.4.1 (the use of qualitative computer software) there are limitations to the data in the table. Also, less observations were recorded in Practice C because these concepts where already well developed by the time I visited that surgery, and the focus of observing was on other things.

8.4.3 Asking patients to judge the urgency of their problem

In practices B and C the official practice policies were that patients were asked to judge if their problem was "urgent" or "could wait" rather than being asked for details about their illness. It was thought that this would prevent discord in patient receptionist negotiations. The observations show that this behaviour was most evident for urgent appointment requests. In practice B these patients would go to the 'open access' clinic, and in practice C these would be put through to the triage nurse. The reality, however, was that contrary to the official policies, receptionists did not pass the responsibility for deciding upon urgency to the patient, but retained responsibility for decision making or it became a shared process.

"Some say, "Well what do you mean by urgent?' I say, "Well, do you think you need to see a doctor today, but not actually wait until tomorrow or whatever?" And she will say, "Well, no, no, I think it is urgent. I need to see a doctor today." They say, "Ah yes, when's your next appointment?" Then I will just say my next **routine** (stressed word) appointment is Wednesday or whenever. But I normally just leave it up to them."

Receptionist No 4, Practice B

Researcher: "Do you request information *[about appointment making]*?

Receptionist: Not usually, no. We don't ask them what it's for. Sometimes they go ahead and tell you. And other times, there's no way they are going to tell you.

Researcher: Does it make a difference what they say is the matter as to whether you give an urgent appointment?

Receptionist: It can do. ...I mean some you will get some who are prepared to wait four days with earache or something and you will say, "Well, you know you can be seen today," if they give you the information. What a lot of them tend to do is say, "Well, what do you think?" because they want you to decide rather than them."

Receptionist interview No 5, Practice B

As we have seen in Chapter 6.6.2 patients are concerned about consulting inappropriately and 'wasting the doctor's time.' This may act as a brake to patients asserting their wishes to be seen quickly.

8.4.4 Other legitimising strategies

To overcome receptionist reluctance to give appointments patients used strategies such as compromising, using advocates such as health visitors, chemists, 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 3.12, 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 3.12, 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 3.12, 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 3.15a, 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 illness.

"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 2 day's, 3 day's time which basically isn't any good."

Patient interview 3.7, 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, 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, waiter, Practice A

Receptionist strategies include referrals to other professionals, using advocates (doctor or receptionist), deferring appointments, and assertiveness. They also "fit patients in", and reserve appointments for those who 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 3.4, Practice B

"But even if you cannot get an appointment 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 anyway, don't they if they cannot fit you in?"

Patient interview 3.14b, patient waiter, Practice A

"Lady came to the desk, "Can I have an appointment for next Friday?" Receptionist: "There aren't any. But you can ring in next Monday for the week after." These are 'repeat' appointments."

Observation No 2, reception counter, Practice A

Verbal messages and judging the tone of voice, particularly on the telephone, are very important cues for receptionists. It is not just what is said but the way in which it is said. Judging the patient's condition is also important. Receptionists also alter the tone and emphasis of words to convey information or attitudes.

"The next appointment is Tuesday. Only if it's **extremely** urgent." (Extremely is emphasised in the sentence) It will have to be 10 past 11. ...Okay?"

Observation No 4, reception counter, Practice A

> "It's a certain way of talking as well. You know how, if they sound urgent, sound poorly and that, and you say "I'm sorry I've got nothing for today, would it wait until tomorrow?" You try to be concerned as well. But you also try to, hopefully, [transcript unclear] an appointment if they can wait for an appointment."
>
> Observation No 4, reception counter, Practice A

Not all verbal messages are seen by patients as helpful.

> "Well some are very abrupt. Sometimes you can tell in the mannerism that I think if you speak to a receptionist the wrong way she picks up. Like arrogant like tone from her voice."
>
> Patient interview 3.13a, aged 16-65, Practice B

As we have seen in Chapter 7.3 patients and professionals act out their roles. In this last example the receptionist departs from their usual script and acts in an unsympathetic manner. The nature of patient and professional relationships is considered in my next chapter (Chapter 9).

8.5 Organisational Factors

Organisational factors were very important in determining how quickly the patient was seen, and whether they would request an urgent appointment or a routine appointment. One reason for attending urgently was that the patient would have to wait "more than five or six days" for a routine appointment. Attending urgently, as one patient commented, " you can be seen straight away." Difficulty in obtaining a routine appointment, resulting in attending an urgent appointment, was mentioned by three of the 12 patients consulting the 'open access' clinic in Practice B. Several patients preferred "dropping in" to the open access clinic to make a routine appointment, "I had to put my prescriptions in and I thought, 'Well I'll see him while I'm here.'" Patients' past experience of using the 'open access' clinic encouraged them to use it as the preferred option for seeing the doctor.

> "I used to put appointments on but I found it was a week away. It was too long to wait, especially when you are suffering. So I thought I would come and try this. This is only my second time."
>
> Patient interview No 2.4, Practice B

While patients liked the convenience and immediacy of attending the 'open access' clinic in Practice B, receptionists and doctors did not. When I returned to the surgery a few months after completing the 12 short patient interviews, I saw a large A4 sized notice on the surgery's front door which said, "Due to overwhelming demand we have had to stop running our open access clinic. As from 23 November 1998 patients needing to see a doctor will be asked to make an appointment as previously." The practice had reverted to having extra appointments at the end of their surgeries as a way of managing people who wanted to be seen 'urgently.' Receptionists felt that the service was being "abused" and that patients were consulting for things that were not urgent. There was also the feeling that the service had become too popular with patients and that the large numbers attending this clinic were creating stress for receptionists and doctors.

> "It's because of the demand [that the open access clinic was stopped], it's too much. I've had the experience of going into the waiting room to see an enormous queue of people waiting. Waiting for me. It's like Warner Brothers and the Titanic - a whole hoard of people waiting to be seen. (She describes the scene where the passengers are scrambling to get into the lifeboats.)"
>
> Observation No 16, reception counter, Practice B

8.6 The influence of practice and social policy

We have already seen that practice policies and rules affect the process and outcome of professional–patient negotiations. This section examines in more detail the influence of practice and social policy.

I will use data from observations, interviews with professionals, and the short patient interviews. All professionals were asked about the influence of "practice policies" on appointment negotiations, and how policies were developed and reviewed. Only patients in the short interviews who attended the 'open access' clinic in Practice B

were asked if they understood how the practice was 'organised' for them to make an appointment.

8.6.1 Practice policies

Practices A and C had written appointment policies. They emphasised the organisational aspects of appointment making, such as how to use the computer. These were not made available to patients. In Practice A no receptionist, apart from the trainee, could remember seeing a policy, only that it was "somewhere." In all three practices there were differences between official practice policies as espoused by the practice managers and most receptionists, and what most receptionists did in practice. There was considerable variability in what receptionists offered patients, even in the same practice.

The most striking area of official versus unofficial policies was where receptionists asked patients for information about their condition so that they could make a judgement on what appointment to offer – if any. As we have seen earlier official policies were not to ask the patient about their problem, but most receptionists solicited information to inform decision-making. 'The system' was thought to be unworkable without doing so.

Receptionists covertly and overtly break practice rules by soliciting clinical information from patients and when allocating appointments. Receptionists felt that official practice policies did not recognise the practical problems of appointment negotiations, "I think it would be very difficult to list criteria for what is urgent." Informal policies and approaches were considered to be essential to the job of being a receptionist and the smooth running of the practice. One receptionist called these "our own little policies".

> "We do have a written policy but we don't necessarily adhere to it. It chops and changes because with being a single handed practice and there only being one doctor here all of the time, you have got to be more flexible."
>
> Receptionist interview No 1, Practice A

8.6.2 Policy development

In all practices the appointment system was seen as something that had evolved and had its own specific history. Its nature was "communicated by word of mouth" and passed on to new incumbents by the process of apprenticeship. As one receptionist in Practice B commented, "I think it is just really experience, you just sort of learn from whatever is going on."

The process of negotiating changes to the appointment system usually began with 'grumbling' by receptionists and other members of staff. This generated momentum which led to the practice discussing the issues at a practice or other meeting. An example of a change to an appointment system occurred in Practice B. When I observed the practice most receptionists and doctors expressed their discontent about the 'open access' clinic. They were unhappy about the number of people attending the clinic and the resultant stress on doctors and receptionists. It was, however, three months after leaving the practice that the issue was formally considered by the manager, senior receptionist and doctors, and the clinic replaced by 'extra' appointment slots.

"I think we just all collectively moaned about it to each other and then decided as a practice, that the partners and the practice manager and the deputy practice manager. I have been moaning about it for much longer than everybody else. And I have recruited another partner to say 'I am sick of this, can we carry on like this or can we not think about another way.'"

General practitioner interview No 2, Practice B

"It probably starts off as something you notice that is mentioned informally, or people are pointing it out that there's a problem. You would then take it a step further... we would take it forward to him [*the doctor*] to ...discuss this because it is a problem. It is recorded in minutes and somebody has to action it and we will decide that we will look at it in three month's time to see if it is getting any better. Has it improved? And generally speaking there are improvements."

Practice manager No 1, Practice A

In practices A and B receptionists, managers and doctors felt that the main responsibility for managing patient demand and the appointment systems lay with the manager and receptionists. In these practices, the practice managers took overall responsibility for organising the appointment system, and the general practitioners accepted their manager's role as legitimate. In practice C the receptionists felt that they had little say in managing the appointment system and that this was largely in the control of the doctors. This led to a feeling of disgruntlement amongst the receptionists who did not feel that their views were sought or valued when changes were made to appointment making. In all three practices, however, there was an acceptance that "the doctors" had the last word on appointments. There were also tensions between doctors and receptionists about appointment making.

> Practice manager: "I wouldn't say we always succeed in that *[agreeing about how the appointment system is organised]*, particularly because the doctor and I have a difference in opinion about repeat appointments. For example, I think they see too many repeats. He reckons it is good clinical practice. I don't feel I can argue with that because I don't necessarily have the background in order to be able to do that.
>
> Researcher: How do you resolve that, or is it something that is not resolvable?
>
> Practice manager: It is unresolved as far as I would like it resolved, but we have made concessions on either side. I try not to go on about it too much and what we have sort of said is things like I have said can you sort of space out the repeats a bit more which he has you know tried to do."
>
> Practice manager No 1, Practice A

"Obviously they welcome the receptionists' opinion but at the end of the day the reception staff basically have to go along with the way the doctors would prefer."

Receptionist interview No 8, Practice B

8.6.3 Differences between patients and professionals

All receptionists, apart from a trainee receptionist, felt they understood the complexities of the appointment system. They acknowledged that most patients did not.

> "I doubt that very much *[they understand the practices appointment system]*. I think they totally do not understand this thing about repeat and acute and that we have the system set up so that repeat appointments are open until they are gone, so to speak, but acute appointments are only open up eight days before. They cannot understand that."
>
> Practice manager No1, Practice A

This manager attributed this lack of understanding to the lag between implementing a change in appointment provision and the majority of patients understanding it. My experience from the short and long patient interviews was that most patients *did* understand the complexities of the system. Their complaints were about the inflexibility of the system in meeting their needs.

Professionals and patients used different words and phrases to describe the work of the practice. All transcripts were searched to identify some of these phrases. The commonest were "the doctors," "the practice,", "the surgery," "the system," and the "organisation. Table 8-5 compares how patients and professionals used these phrases.

Table 8-5: Phrases used by patients and professionals (and the researcher) to describe general practice.

Phrases used to describe the practice	**Patient** phrases or words	**Professional** phrases or words	**Researcher** phrases or words
"the doctors"	Most widely used word by patients– as a **collective noun** for all doctors, but also used to describe **the whole practice** and it's organisation	Mainly used by receptionists to describe the doctors as a **group**	Not used by me initially in patient interviews, then used to describe the doctors as a **group**
"the practice"	Used only five times. Twice to describe the **size** of the practice e.g. "big group practice". Three times in the sense of as an **organisation**	Most widely used expression by professionals, especially doctors, and managers to describe the practice as an **organisation.**	Widely used by me in interview questions - describes practice **organisation.**
"the surgery"	Rarely used as a synonym for the **organisation,** and to describe **appointment slots**	Rarely used by professionals -describes practice **organisation.**	Used widely by me in questioning –to describe the practices **organisation.**
"the system"	Only four uses of the expression – all as a synonym for **organisation** and in the context of appointment making.	Used specifically to describe the detail of **appointment systems,** particularly as an **inflexible process**	Not used by me
"organisation"	Not used.	Not used.	Used by me three times

Table 8-5 shows that the most widely used phrase by patients to describe the work and organisation of the practice was 'the doctors.' The practice is defined by patients through the personal presence and work of the general practitioners. In contrast, professionals used the impersonal phrase 'the practice' to describe the organisation of

the practice. My original patient interview questions included questions about 'the practice' and 'the surgery', but as the interviews progressed it became clear that the predominant phrase used by patients was 'the doctors,' and I started to use that phrase.

> "I have got a four year old who is actually backwards and forwards to *the doctors* with kidney problems."
>
> Patient interview No 3.2, parent, Practice C

> "And they go, "Oh come down. Can you be down in 10minutes?" And it really was quite funny - it was that quick. And you think 'Well I am not trying to beat *the system*.' I do feel he should be seen today or I wouldn't be phoning you up. I am not a one that bothers you every five minutes."
>
> Patient interview No 3.3, parent, positive, Practice C

8.6.4 Social policy

In all three practices appointment making was rarely discussed in the context of health service policy. There was an acceptance that it was the practices' responsibility to manage the appointment system, without recourse to external help and support. My research was conducted before central (Primary Care Collaborative) and local (PCG/PCT) initiatives associated with improving general practice access. It would be interesting to revisit the practices to see if externally applied pressure to improve access had affected appointment provision.

Patients recognised the workload of doctors in general, and of general practitioners specifically. Three patients compared their current experience with more favourable experiences in other practices and other countries.

> "...because I lived in Germany. If you need to see a doctor you go to like their version of the DHS office and say. 'Look I would like to see a doctor please. I have got a sore throat.' And they give you a list of ear, nose and throat specialists. They are all GPs but they specialise. ... You just go straight into the surgery, straight in. And there may be a couple of people there, you're in, you're seen and you're out. ...But the actual system itself, I feel, is much better."
>
> Patient interview 2.3, Practice B

8.7 Summary

Appointment making is a complex social process and involves ritualistic behaviour by patients and receptionists. At the heart of the patient-receptionist negotiations is the process of legitimisation where practices enforce practice rules on appointment making. Receptionists also judge the authenticity of the patient's request by soliciting information from patients, using information volunteered in the negotiation, and ask patients to judge the validity of their appointment request. We also have seen that patients use many other strategies to negotiate an appointment. These include compromising, using advocates such as health visitors, chemists and other doctors, trying to create a dialogue with the receptionist, alluding to social standing, being assertive, threatening to "call the doctor out", and exaggerating their condition. Receptionists use strategies such as referrals to other professionals, using advocates, deferring appointments, being assertive, 'fitting patients in' and using reserve appointments for those thought to be at greatest need.

Practice policy informs the work of receptionists with responsibilities for making appointments. Most of these policies, or practice rules, are not written down but are widely understood by receptionists. In all three practices there were differences between the official practice policy and what receptionists did. This was particularly evident where receptionists asked for clinical information to judge the veracity of the patient's request for an appointment. In two practices the official policy of not asking patients for clinical information was contradicted by unofficial policies where receptionists did. The unofficial policies were thought to be essential to the smooth running of the practices.

Chapter 9 : The caring and uncaring receptionist

"It was just her manner, an abrupt No! No! No! She *[the receptionist]* couldn't care less."
Patient interview No 3.6

9.1 Introduction

The previous chapter focussed on patient–receptionist negotiations when making appointments. This chapter examines my own ideas and theories on 'caring' and 'uncaring' in patient-receptionist relations.

Previous research on receptionists labels them as 'dragons behind the desk' (Arber and Sawyer 1985; Hayes 1988). This negative view of receptionists is based on interviews with a large cohort of patients and not on observed behaviour (Arber and Sawyer 1985). Despite initiatives designed to improve receptionist training, this view of receptionists pervades public consciousness about receptionists (Drury and Collin 1986).

In previous chapters we have seen that most patient-receptionist interactions could be classified as 'emotionally neutral' and that this is related to the ritual process of appointment making. Some patient-receptionist interactions can be considered to be 'positive,' where the receptionist is complimented by the patient, and some interactions can be thought of as 'negative' where the receptionist is thought to have performed poorly.

At the beginning of my observations in Practice A I looked for positive and negative interactions between patients and receptionists when observing appointment making. These positive and negative interactions were also actively sought in Practices B and C. I also sampled patients for long interviews who expressed negative and positive views of receptionists or the practice. All long patient interviewees were asked about their relationships with receptionists, including what they felt were the characteristics of 'good' and 'bad' receptionists.

It was during my time in Practice C that I developed the notion of the caring and uncaring receptionist. I was searching for a metaphor to describe positive and negative patient-receptionist interactions. I had developed a tentative theory of the 'saintly' (and 'unsaintly') receptionist to explain the concepts and categories generated in my

analysis. I was not comfortable with this concept, and my supervisors and other people shared my misgivings. The weakness of this theory was that it described only one dimension of patient-receptionist relations, and did not incorporate all my data on positive and negative interactions. While observing and conducting the long interviews I discovered a report of a phenomenological study of ward nurses that created an analytic framework for describing nurse caring and uncaring (Riemen 1998). The concepts presented by Riemens were similar to those I had developed from my data. During later data analysis my supervisor (PP) introduced me to another phenomenological study of nurse caring that she had seen presented at a conference in Iceland. I corresponded with the researcher and felt that some of her ideas and concepts accurately described some of my data (Halldorsdottir 1996). The final analysis of my research data adopts the central concept from these two researchers of 'caring' and 'uncaring' interactions, but the subcategories are of my own invention and reflect the unique nature of my data.

Three categories of data demonstrate caring and uncaring interactions between receptionists and patients: valuing and helping behaviour; emotional involvement; and verbal and physical intimacy.

9.2 The caring receptionist

The context of these interactions is the organisation and bureaucracy of general practice. These are, therefore, concepts that illustrate *professional caring* rather than personal and individualistic caring. These concepts are summarised in Figure 9-1.

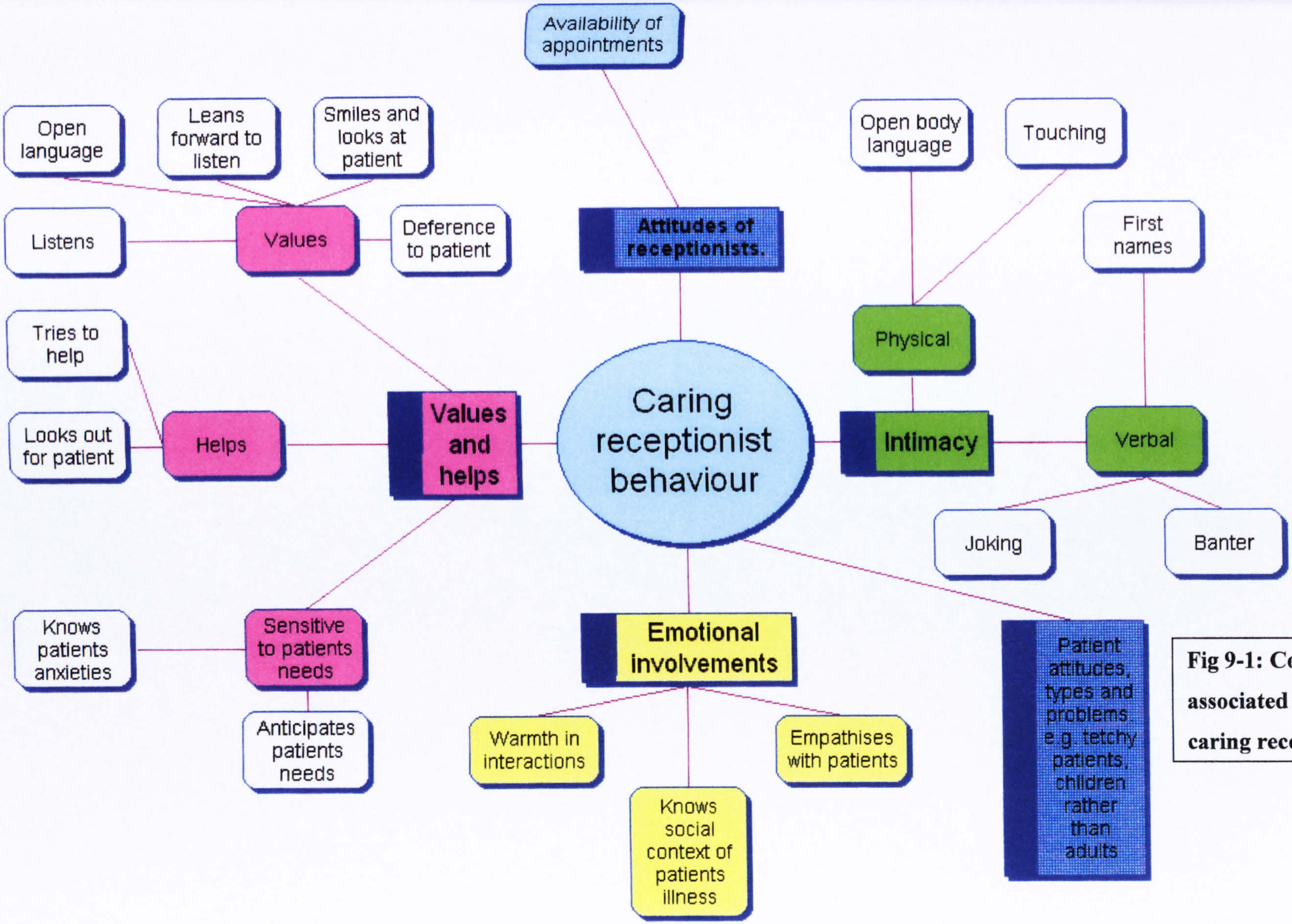


Fig 9-1: Concepts associated with caring receptionists

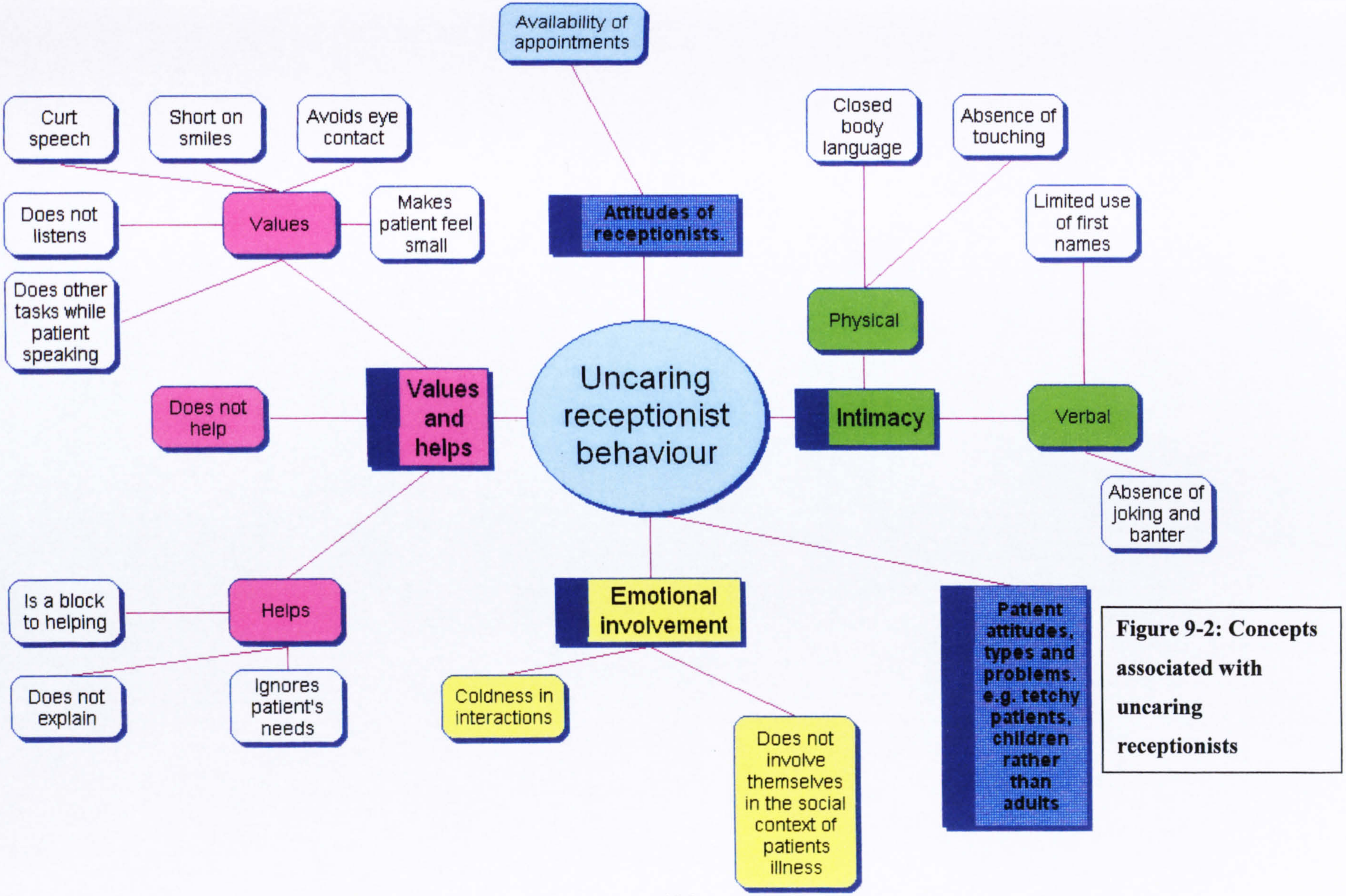


Figure 9-2: Concepts associated with uncaring receptionists

9.2.1 Valuing and helping

Patients describe a 'good' receptionist as someone who "smiles and looks up from what they are doing," who "says good morning," "treats people as individuals," and communicates that they are interested in the patient and their problems. This contrasts with patients' descriptions of receptionists who, "don't look at you or smile," who are "abrupt," who "don't explain," who "haven't got time for you," and who "convey the impression that you are wasting their time."

> "Receptionist X has a curt approach to patients at the counter. She doesn't look at the patient when they make an appointment and when talking to the patient. Receptionist Y looks from the computer to the patient when making her appointment offers. She also leans forward and raises her voice when questioning the patient or making an offer. She talks a lot, explaining what she is doing. She is more variable in her range of speech and conversation. It is fluid."
>
> Joint observation, No 33a, reception counter, Practice C

All receptionists saw their main job as "helping people," and "giving a good service to the patient." Patients agree with the notion that receptionists are there to provide, or at least try to provide, 'a service' and stress the importance of them having "a good people attitude."

> "Somebody who is going to do what you want them to do. Who tries to give you an appointment when you can have one, but be able to say sometimes you can't have one. You come off the phone and think, 'Well at least they have tried.'"
>
> Patient interview no 3.3, parent complimentor, Practice C

> "An elderly lady with a walking stick requests a taxi. The receptionist comes out from behind the reception counter and helps the lady to a seat next to a window where she can see the taxi when it arrives. Over the ensuing 20 minutes she regularly checked on her comfort and whether the taxi has arrived."
>
> Joint observation No 33b waiting room, Practice C

Some of the observed helping behaviour occurred at quiet times of the day when there were few people in the waiting room. This suggests that receptionist need time to help and care.

Another element of caring for the patient is treating patients with respect and deference. A situation that taxes receptionists is dealing with difficult patients. Receptionists knew many of these patients from previous encounters. A deferential approach enables the receptionist to control their negative feelings for the person and continue to help them. Receptionists, doctors and nurses moaning about 'difficult' patients were a feature of all three practices. I saw these 'backstage' comments as cathartic responses to difficult and stressful encounters with patients, and similar to comments that I might make in my own surgery. There was no evidence however that these negative comments about patients translated themselves into negative behaviour towards patients. For example, I observed a doctor in Practice C on the telephone to a patient that he had just complained about. He did not communicate his annoyance to the patient. Professionals appear to, in most cases, be able to disassociate their negative feelings for a patient from their 'onstage' performance with patients.

As well as responding to patients' requests, receptionists also anticipate patients' needs or actively explore them.

> "You can't always tell looking at people; some sit there really quiet and don't say anything (laughs). And then one morning you walk past and go, "that old man in the corner doesn't look very well, and you fit him in as well."
>
> Receptionist interview No 5, Practice B

9.2.2 Emotional involvement

Some receptionists share patient's concerns and anxieties.

> "Receptionist: "And how is he at the moment?" *[She is talking to an elderly woman]* (The receptionist appears concerned. She looks through the pile of prescriptions trying to locate the right one). "It seems to have been me that's taken all the calls *[about her sick husband]*." She finds the prescription and hands it over. As she does this she says, "You've had a hard time of it.""
>
> Observation no 28, reception counter, Practice B

This emotional involvement appears to be rooted in familiarity and frequent association with patients, and tends to be with older people and people with serious health problems. Receptionists are affected by this emotional involvement. They can be distressed.

> "She (the receptionist) did say when she was talking privately that some patients' conditions affect her and she finds it really hard if somebody is really poorly or in a bad state, she finds it hard to cope with everything."
>
> Joint observation discussion 33a and 33b, Practice C

> "That's interesting, she mentioned that to me a few times that she saw a man who'd just found out that he had just got out of prostrate cancer or just died and was talking to his wife. She said, "I just can't help, you, you just can't help getting involved. I can't, you know, when you get to know them, you get to know their problems and you can't help it.""
>
> Joint observations No 33a and 33b discussion, Practice C

9.2.3 Verbal and physical intimacy

Four types of verbal intimacy were observed: the use of first names; banter, joking; and terms of endearment.

Receptionists and patients commonly use first names. Patients addressed by their first names are more likely to be known to the receptionists than those who are addressed by their title. Use of first names may be a sign that their relationship has advanced from merely being professional to personal – but may also be a routine part of the interaction. Banter and jokes are also made during interactions to lighten tense moments.

> "Receptionist says to patient who has just arrived. "You're late!" *[to see the nurse] "[Patients name]*, she's going to kill you." (in a joking manner). The patient replies, "I know," and continues through to the nurse's room. The receptionist rings the nurse and says "You're not going to like this but *[patients name]*'s in now.""
>
> Observation No 28, reception counter, practice C

On Tyneside a number of terms are used to convey affection. Two examples include, "And how are you my love," and, "Are you all right pet." A search of the data for terms of endearment identified the following ones, 'luv', (1 find) 'love' (2), 'pet' (5), and 'hinney' (6).

Physical intimacy between patient and receptionist was rarely observed. In one example a receptionist tickled the soles of a baby attending a baby clinic. In the following case the receptionist was observed to break the barrier of the reception hatch by putting her torso through the hatch to define the intimacy of their relationship.

> 'The receptionist leans through the hatch to look down at a child accompanied by his mother. She says, "*[Child's name]*, have you done my picture yet?" On the last occasion he was in she asked him to draw a picture in the waiting room. Apparently *[Child's name]* is a 'regular'.
>
> Observation No 3, reception counter, Practice A

9.3 The uncaring receptionist

9.3.1 Valuing and helping

The uncaring receptionist does not value or help the patient and is not sensitive to their needs. They do not listen to patients' concerns, and make the patients feel as if they are wasting the receptionist's time. The receptionist can also criticise, mistreat, ridicule or ignore the patient at the reception desk.

> Patient: "There is another lady *[a receptionist]* there who is extremely abrupt. And I hate having to talk to her because she really does... She manages to annoy you without even saying anything (the patient laughs). And that's awful.
>
> Researcher: How do you pick that up?
>
> Patient: Em, her manner. The eyes. The way she stands when she looks at you. A sort of, 'What are you doing here, wasting my time.' And she is very very abrupt, and she talks to you, "Next!" And you think, 'Oh God.' (laughs). And it is not, 'Hello', 'Good morning' or anything. It is really very clipped and very stern."
>
> Patient interview No 3.3, parent complimentor, Practice C

A patient describes one encounter with an old man, "he must have been about 85," who was attempting to obtain his repeat prescription from the receptionist seated at the computer behind the reception counter.

> "And this old guy is going "Ah-ha, ah-ha, mmm, hmm." And then she *[the receptionist]* got up and started to walk towards the door and said, "So you want them all?" And he said, "No. I don't want them all. Some of those I don't take now." She said, "Some of them you don't take now? Well that was why I was calling them out to you." She told him to come back the next day for the prescription. Her eyes went up to the ceiling to me and shook her head, and she said, "I am sorry I will be a while now sorting this out (nastily)." And off she stomped. This poor old guy. She didn't take her displeasure out on him but she showed me her displeasure."

Patient interview No 3.1, aged 16-65, Practice C

> "And I was sitting there was I was in there for about what 50 minutes. And I went to the desk and I went, "Excuse me. What's going on? You know, I am not very well." She says, "If you start causing havoc in the doctors, the doctor will not see you." ...She just went ballistic. I thought, 'Oops.'"

Patient interview No 3.17, complainer, Practice A

9.3.2 Emotional involvement and verbal and physical intimacy

The uncaring receptionist is emotionally distant from the patient and does not involve themselves in the patients' lives away from the surgery. These aspects of communication were observed and recorded mainly during joint observations. Some receptionists were limited in their use of first names, did not joke with patients and had a flat affect. Their body language was 'closed,' and they did other tasks while the patient is speaking rather than making the patient the main focus of their attention.

> "When you go in she *[the receptionist]* will say, "Yes, what do you want (said curtly)." She doesn't even say good morning or good afternoon or anything. Which is very bad mannered, you know. And she asks my name and my address and she knows my name and she knows my address because she has known me for years, you know."

Patient interview No 3.11, complimentor, Practice C

"Well some are very abrupt. Sometimes you can tell in the mannerism that if you speak to a receptionist the wrong way she picks up...like arrogant, like tone from your voice. You get nowhere."

Patient interview No 3.16, aged 16-65, Practice B

9.4 The caring and uncaring patient

This analysis of caring and uncaring patient-receptionist relations concentrates on *receptionist* rather than patient behaviour. This is not surprising as more time was spent observing and interviewing receptionists rather than patients. There are also more patient opinions, from the interviews, about receptionist relations than of professionals' opinions about 'good' and 'bad' patients. Receptionists, however, shared similar views to patients about the behavioural characteristics of 'good' and 'bad' receptionists.

To what extent do patients care for professionals? Do they exhibit valuing behaviour? Are they emotionally involved and physically and verbally intimate with receptionists? Patients in receptionist-patient relations play the role of *patients* and not professionals. Patients do not have a duty of care, but health care professionals do. The duty of professionals to care is usually articulated with reference to nursing or doctoring, but also applies to allied professionals including receptionists. Receptionists, like doctors and nurses, make real this duty to care in their daily dealings with patients. Patients have a 'duty' to behave as patients in obtaining health care for themselves and their families. Caring for receptionists is not their prime responsibility or function. I think it would be inappropriate to describe patient behaviour as 'caring' and 'uncaring' in patient-receptionists relations.

9.5 Summary

The uncaring receptionist is well documented. Three categories of data demonstrate caring and uncaring interactions between receptionists and patients: valuing and helping behaviour; emotional involvement; and verbal and physical intimacy. These are summarised in Table 9-1 on page 204.

All receptionists saw their main job as "helping people" and "giving a good service to the patient." Caring receptionists treat patients with respect and deference. A deferential approach enables the receptionist to control their negative feelings for the person and continue to help them. As well as responding to patients' requests, caring receptionists anticipate patients' needs or actively explore them.

Some receptionists share patients' concerns and anxieties. This emotional involvement appears to be rooted in familiarity and frequent association with patients, and tends to be with older people and people with serious health problems. Receptionists can be distressed by their emotional involvement with patients.

Four types of verbal intimacy were observed: the use of first names; banter, joking; and terms of endearment. Receptionists and patients commonly use first names. Patients addressed by their first names were more likely to be known to the receptionists than those who are addressed by their title. Use of first names may be a sign that their relationship has advanced from merely being professional to personal, but may also be a routine part of the interaction. Banter and jokes are also made during interactions to lighten tense moments. Physical intimacy between patient and receptionist was rarely observed.

The uncaring receptionist does not value or help the patient and is not sensitive to their needs. They do not listen to patients' concerns, and make the patients feel as if they are wasting the receptionist's time. The receptionist can also criticise, mistreat, ridicule or ignore the patient at the reception desk.

The uncaring receptionist is emotionally distant from the patient and does not involve themselves in the patient's life away from the surgery. These aspects of communication were observed and recorded mainly during joint observations. Some receptionists were limited in their use of first names, did not joke with patients and had a flat affect. Their body language was 'closed,' and they did other tasks while the patient was speaking rather than making the patient the main focus of their attention.

We should re-formulate patient - receptionist interactions to include encounters that are characterised by valuing and helping the patient, emotional involvement and verbal and physical intimacy - the caring function.

Table 9-1: Summary of characteristics of caring and uncaring receptionists

Concepts	Caring characteristics	Uncaring characteristics
Helping and valuing		
Values the patient	Welcoming: 'smiles and looks at the patient,' expansive language, 'explains' procedures. Patient feels receptionist 'listens' is 'interested in me,',responds to concerns. Respects the patient, treats them with deference even when objectionable, and makes the patient the centre of attention.	Unwelcoming: 'short on smiles,' 'avoids eye to eye contact,' 'curt' speech, 'does not explain.' 'Does not listen' to patients' concerns. Make patient feel as if 'wasting receptionist's time.' Criticises, mistreats, ridicules, ignores the patient
Helps and 'goes the extra mile'	Patient acknowledges that receptionist is 'trying to help' meet their requests. Checks several times to make sure the patient is comfortable - helping goes beyond that normally accepted.	Patient states that the receptionist is a block to them getting help.
Perceives and responds to patients' expressed and unexpressed needs	Is sensitive to the patients' concerns, particularly those who are vulnerable because of illness, age or other conditions	More concerned with getting the job done than meeting the patients' needs. Is insensitive to patients' visible and covert concerns
Emotional involvement	Warmth in interactions. Knows about patients' lives and problems away from the surgery. Expresses knowledge and emotions about patients' problems. Feels a part of patients' problems.	Coldness in interactions Does not involve themselves in patients' lives outside the surgery.
Verbal and physical intimacy		
Verbal intimacy	Use of first names, joking, banter, and terms of endearment	Limited use of first names, joking, limited speech
Physical intimacy	Touches patient. 'Open' body language, leans to speak to and listen to patient	Does not touch patient. Does other tasks while patient is speaking. Closed body language

Note: Interview comments are in inverted commas. Other items reflect observations.

Chapter 10 : A question of quality

"It is the quality of our work which will please God and not the quantity." Mahatma Gandhi (Quoted on QUALRS-L@LISTSERV discussion forum 03/02/99)

10.1 Introduction

In this chapter I question the quality of my research. Is my study believable, accurate and correct (Creswell 1998)? In short, did I get it right? It is the beginning of my discussion. This chapter is divided into three parts. The first part describes how publication criteria for qualitative research influenced my research. The second part details how I have applied criteria and terms such as objectivity, reliability, validity and trustworthiness. These criteria were initially discussed in Chapter 3. The experiments that I will describe, particularly on the subject of reliability, could have been included in the methods or results, but as they bear on the subject of quality they are included here. The third part of this chapter examines how methods for data collection have enhanced the quality of my research.

10.2 Publication criteria

Before starting my research I wanted to try and ensure that my research would be as good as it could be, and that any future publications met established criteria for the publication of qualitative research. These publication criteria were the starting point for my thinking about what methods I could include in my research design to enhance the quality of my research. Two of my methods, respondent validation and comparing coding with other researcher, were included in my original funding application to the BMA in 1997. Particularly influential were criteria and publications by Mays and Pope and Hoddinott (Hoddinott and Pill 1997; Mays and Pope 1995; Mays and Pope 1996a). Later on in my research, publication criteria by Seale, the British Medical Journal (BMJ), and British Journal of General Practice (BJGP) influenced my research design and writing of publications and the thesis (BMJ April 26th 2002; Seale 1999, Murphy et al. 1998).

There are three main sets of publication criteria pertinent to publishing qualitative research in general practice. These are Mays and Pope, as adopted by the BMJ (BMJ April 26th 2002; Mays and Pope 1996a), those by Murphy et al, as adopted by the

BJGP (Murphy et al. 1998) and those by the British Sociological Society, as adopted by Seale (Seale 1999). In Table 10-1 I rate these criteria with some criteria of my own.

Table 10-1: My rating of the quality of three sets of publication criterion

Feature of publication criterion	**Mays and Pope/ BMJ criteria** **My score and comments – out of 10**	**Murphy et al/BJGP Criteria** **My score and comments – out of 10**	**Seale/ British Sociological Society criteria** **My score and comments – out of 10**
Comprehensiveness	7/10 Missing some of the detail of other two	9/10 Lots of textual discussion alongside criteria	9/10 Criteria and sub-categories clear
Readability	9/10 Excellent – short appropriate list	5/10 Chapter in a book – poorly organised	8/10 Long detailed, but very clear list
Accessibility – ease of finding a copy	9/10 Available on the world wide web, and in May's and Pope's book.	6/10 Referred to in BJGP but no web link. Needs a library visit	6/10 ? on the web
Applicability/relevance?	9/10 Highly applicable	9/10 Highly applicable	9/10 Highly applicable

I conclude that all of the three sets of criteria are highly relevant to thinking about publishing any qualitative research in general practice. The Mays and Pope/BMJ criteria have three advantages over the other two sets. They refer specifically to observational research, are easily accessible on the World Wide Web, and are the most readable. The other two sets of guidelines score highly on comprehensiveness, particularly the Murphy guidelines as there is explanatory text about the criteria.

10.3 Exploring positivistic and interpretivistic criteria

In my Chapter 3.5.1 I proposed two groups of criteria by which we could judge the quality of qualitative research (Lincoln and Guba 1985). These are positivistic criteria such as objectivity, validity and reliability, and interpretivistic criteria such as trustworthiness, credibility and transferability (Table 10-2).

Table 10-2: Lincoln and Guba's schemata of criterion (adapted by me)

Criteria	**Positivistic criteria**	**Interpretivistic criteria**
Main idea(s) connected with criteria.	**Ideas of** validity, reliability and objectivity	**Idea of** trustworthiness
Components **of main idea(s).**	**Truth value** – internal validity **Applicability** – external validity **Consistency** – reliability **Neutrality** - objectivity	Credibility Transferability Dependability Confirmability

10.3.1 Objectivity

As we have seen in Chapter 3.5.1 objectivity is concerned with producing facts that are not influenced by the researcher. The reality is that there are limitations to objectivity, particularly by a single researcher who has only one perception and interpretation (Mays and Pope 1995). Also, the researcher *does* influence observations (Gribich 1999; Roethlisberger and Dickson 1939). The more useful question to ask is, to what *degree* objectivity exists within the research. Seale suggest that this is best done by detailing procedures to enhance objectivity so that the reader can judge the degree of objectivity (Seale 1999).

To what extent did I influence patients' and receptionists' behaviour? In my dataset there are several examples of changes in receptionist behaviour or attitude due to my presence as a researcher. For example, in Practice A one of the receptionists saved their story of an interaction with a 'difficult' patient. She thought that it was relevant to my research (page 169, Observation No 30, reception counter, Practice C). Similarly in Practice C a receptionist insisted on giving me her interpretation of an interaction with

a patient that we had both observed (page 61, Observation No 27, reception counter, Practice C). I felt that this was a desire by the receptionist to please or help me. William Whyte in Street Corner Society had a similar experience (also quoted on page 61).

After a few weeks in the practices I felt accepted by most staff. I felt they were less self conscious about my presence, and that I had less impact on the work and behaviour of receptionists. Towards the end of the time in Practices A and C the receptionists increasingly confided concerns about the practice, themselves and their families, rather than commenting on what was happening at the reception counter. I had adopted the role of trusted observer. This was usually the precursor to me leaving the practice.

It is more difficult to comment on how my presence influenced *patient* observations. Some patients deduced that I was a researcher from my behaviour in the waiting room and the notice advertising my presence, but I cannot detail incidents which show that I influenced patient behaviour. Similarly, the researcher's presence alongside a receptionist behind the reception counter must have had some impact on patient – receptionist relations, but I cannot describe or quantify that effect.

I believe that it is impossible *not* to influence observations because of one's physical presence, and that the incidents I describe here and in my methods chapter are part of the 'normal' process of working in the field. They act as evidence to support 'good' researcher working in the field, where the researcher is aware of things that might make the research more or less objective.

Another challenge to the objectivity of my research is the interpretation of observations. To demonstrate to myself this problem I conducted an experiment in Practice C (Observation No 28). I observed a teenager and older woman sitting together in the waiting room for over an hour. I speculated in my field notes that they were mother and daughter, that there was tension between them, and that the girl was particularly anxious. I then briefly interviewed them in the waiting room and later at length in their home (they were selected for long interview as they had waited more than an hour). I established that their relationship was of grandmother and granddaughter who were waiting for daughter and mother respectively. The relationship between the observed was not antagonistic, and the predominant feeling of the girl was boredom and not anxiety. This exercise emphasised the need for caution in

interpreting events, and the need to seek out corroborating evidence, usually by informal interview, to give more confidence in interpretation of events. I had done this from the start of my observing. I also gave more weight in analysis to observations that had been verified by being observed from more than one perspective. For example, I observed a patient in the waiting room and then saw them later on in the same session from behind the reception counter where the receptionist gave additional information about the patient and the receptionist's dealings with them. Another important strategy for minimising individualist interpretations was joint observing with an experienced observer. Several experiments were conducted in this area and are detailed under the heading of reliability (Chapter 10.3.3).

10.3.2 Validity

Validity is concerned with whether something is true or not (Chapter 3.5.1). Triangulation is one way of enhancing the validity of my findings.

Triangulation

Denzin identified four types of triangulation: of **method, data, investigator and theoretical model** (Denzin 1970). Participant observation could be considered to be a 'self-triangulating' form of research as it is a **multi-method** approach, employing observation, interview, collecting numerate data and documentary analysis. I believe that the different methods I have employed increase the comprehensiveness of my research data. I do not believe that different sources of **data** necessarily confirm one view, rather that divergent findings from different sources may produce a more complete understanding of the phenomenon under study (Murphy et al. 1998). Murphy et al illustrate the limitations of using data from one source to validate that from another from the work of Stimson and Webb (Murphy et al. 1998; Stimson and Webb 1975). They discovered inconsistencies between their observations of patient - doctor interactions and what patients said. Rather than reject one of these accounts, they embraced both sets of data including them as explanatory data, but recognising the context in which the data was collected.

My own research parallels this. There is considerable overlap in findings from observations, informal interviews and long interviews, but there are also significant differences. For example, I noted a discrepancy between what I had observed and what

patients said at interview about making appointments (Chapter 8.3.1). I observed few episodes of discord, yet this was a feature of the interviews. One explanation for this may be bias in sampling interviews of patients with problems in making an appointment. There are, however, other explanations, for example, patients do not visibly express discord as it is socially unacceptable, and instead internalise these feelings. These could be safely expressed in the social setting of an interview where these experiences are sought by the researcher. Rejecting the interview data would exclude information that gives insight into patients' feelings and motivations. Another potential explanation for differences in data is that situations and people's behaviours change over time; we often assume that things don't change.

In the next section I will describe joint observing with an experienced researcher which can be thought of as **investigator triangulation.** Another aspect of the concept of investigator triangulation is the influence of my co-workers in thinking about research planning and analysis. Some specific examples appear in the section (10.3.3) under the heading of reliability where several researchers coded and discussed the same data.

The final element in Denzin's quartet of triangulation types is of **theoretical model.** I have already detailed the influence of theories such as grounded theory in planning and doing my research (Chapter 3.2). Some models, such as dramaturgy, influenced my thinking about observational settings, but did not become major influences until analysis and writing-up (Chapter 7.3). Similarly, I adopted a central component of two models on caring receptionists in Chapter 9.1 (Halldorsdottir 1996; Riemen 1998). I believe that using different theories and theoretical models has enhanced the quality of my research. Of all the aspects of my research, an understanding of theory and theoretical models has been the most difficult for me to acquire. I am not a sociologist and my training as a doctor, GP and researcher has been limited in understanding qualitative research ideas and the sociology of medicine. To redress this lack I attended six sessions of an undergraduate module 'The sociology of health and illness,' and the entire postgraduate module, 'The nature of enquiry and explanation in the social sciences,' both at the Faculty of Social Sciences, the University of Newcastle upon Tyne.

10.3.3 Reliability

Reliability is concerned with the search for a single external reality which different researchers can find and measure (Chapter 3.5.1).

Internal reliability

Internal reliability refers to the extent to which researchers applying similar constructs would match these to the data in the same way as the original researchers (LeCompte and Goetz 1982). LeCompte and Goetz list five features that enhance internal reliability (LeCompte and Goetz 1982). I have already discussed these in my methods chapter (3.5.1). Two of these quality features, the use of multiple researchers and peer review and audit, are considered here. These quality features are considered in four experiments that I performed during my research. I was interested in how practical and useful the idea of reliability was to my qualitative research. The experiments are summarised in Table 10-3.

Table 10-3: Summary of reliability experiments

Date	Experiment No	Type of experiment
July 1998	One	*Coding* of transcripts of eight observations from Practice A by MG*, PP*, VE*
Feb 1999	Two	Joint ***observing*** **and** ***coding*** of one period of observation in Practice C by MG and JG*
Sept 1999	Three	Joint ***observing*** **and** ***discussion*** of a second period of observation in Practice C by MG and JG
Sept 1999	Four	*Coding* of three extracts from long interviews by MG, PP and JG

Note *: MG= Morris Gallagher, PP= Pauline Pearson, VE= Valerie Elsy, JG= Joy Guy

Experiment one: comparing coding of my observations - July 1998

Experiment one was an experiment in comparing coding. The main reason for this experiment was educative, but as we shall see later it can be viewed as an experiment in inter-rater reliability. I had not observed or coded observational data before and

wanted to learn to do it by working with more experienced researchers. PP, VE and MG made and compared coding of observational transcripts made by MG. There were eight sides of A4 paper detailing three periods of observation in Practice A. Two observer locations were a waiting room and behind a reception hatch. PP and I agreed to write our codes on the computer printouts and compare them informally at one of our regular meetings. The same process was repeated separately with VE. My main difficulty was finding a vocabulary that would describe what I had observed and appeared in the transcript. I collected these notes together later to convert them into the table below (Table 10-4). The thematic labels were made by me as a way of categorising the data from our discussions.

Table 10-4: Coding of the first three observational transcripts by Pauline Pearson (PP), Valerie Elsy (VE), and me (MG).

Theme	Coding by MG	Coding by PP	Coding by VE
Verbal communication	Negotiation, use of first names, offers of time or day, checking, disclosure, confessional, disagreement, personal care, understanding of patients' health needs, confirmation, closure, receptionist empathy. Requesting, volunteering information, flexibility, refusal, relationship.	Negotiation, theories of communication, negotiation, relationship, unpopular patients, heartsink, strategies disclosure, checking with others/patient, giving patient options, criticism. Nurses' strategies, regulars, discussions about follow up, legitimisation of enquiry, prioritisation, I'll tell the doctor.	Closure, reassurance, Receptionist keeping focus - steering back to practical task at hand, emotions-betrayed by misinformation by nurse.
Non-verbal communication	Foot tapper, leaflet looker, reading, gaze avoidance, smiles, listening, watching TV, avid reader, emotions, supervisor listening.		Dress – inappropriate to outside temperature/season, clean, dirty, ill fitting, in-out of style. Chairs and choice of posture.
Power and control	I'd like, needs, policy and norms.	Ideas about power and control. I can't, we can't, inflexible policy. Offstage. Inflexible computer.	I depend upon her, I need her, I've really tried, double check, questioning the system. Receptionist rule, gatekeeper, keepers of time system. Offstage. Little autonomy, limited control I'm getting there, I'm hurting, It's threatening.
Other themes	Home visits, coupling, training, documents, procedures, sick notes, emergency appointment.	Perceptions of health/illness, roles, patient choice of services, assumption of shared understanding of system, considerate, inconsiderate, seriousness of problem.	Layout – standing, sitting.

We can see similarities in descriptive coding from MG and PP. MG concentrates on non-verbal communications, but PP generated a much greater range of codes. PP as an experienced researcher includes theories that she felt might be relevant, and VE's coding is influenced by dramaturgical sociology. PP had greater breadth of ideas including patients' perceptions of illness. Issues of power were more developed in the coding by PP and VE. The effect of these comparisons and the discussion with PP and VE was to encourage me to read more widely about organisations and lay concepts of health care.

Experiment two: Joint observing and coding – February 1999

In total I conducted three one-hour sessions of joint observations with two different observers. The first joint observer was Mrs Joy Guy (JG), who is a general practice counsellor on Teesside. She has a sociology degree and trained in psychotherapeutic observation at the Tavistock. The second joint observer was Mrs Val Elsy (VE). She has a degree in sociology, research experience, and is a lay member of a Health Authority. Both of Joy Guy's observational periods were in Practice C in February and September 1999. The joint observing with Val Elsy in Practice B in July 1998 took the form of both sitting in different parts of the waiting room and talking about our experiences afterwards. These observations were not recorded and are not discussed further.

By July 1999 I had read about Armstrong et al's experiments with inter-rater reliability where six experienced analysts coded focus group transcripts of people with cystic fibrosis (Armstrong et al. 1997). They concluded that there was considerable concordance of analysis themes, and that divergent analyses were also helpful in thinking about the research. Marshall, in a qualitative study of interactions between specialists and general practitioners, had also experimented with inter-rater reliability (Marshall 1998). He concluded that "there were no significant inconsistencies" in comparing coding of interview and focus group transcripts with three experienced researchers. I decided to experiment with joint observing and coding to help me to learn the process of coding and to try and enhance the quality of my research.

This second experiment considers my first period of joint observation with MG and JG which took place on Wednesday 11th February between 11 a.m. and 12 noon. The surgery was moderately busy with five doctors and three nurses consulting. One receptionist was seated behind the reception counter; towards the end of the observational period she was replaced by a second receptionist. Joy Guy sat beside the receptionists. Their heads were visible to me from the waiting room. From their vantage point they could only see the upper torso of the patient. I was seated on a bench four metres from the reception counter. I could see the whole of the patient consulting, but not hear all of the interaction if the waiting room was noisy.

MG and JG met for several minutes before observing to summarise the purpose of the study and the purpose of the joint observations. We agreed to record observations in two field note diaries. The aim of the observations was to observe in our own way events or phenomenon associated with appointment making. We also shared and audiotaped our observations and experiences, concordant and divergent, immediately after the observational period. The fieldnotes and discussion were transcribed at a later date.

Several things were apparent from our discussion. First, there was a high degree of agreement about the number of events that occurred at the reception desk. Second, both observers had recorded the key events that had occurred. For example, one receptionist at the reception counter was replaced by another one. There was a marked change in the receptionist's demeanour and approach to the patient. The first receptionist made eye contact with the patient, leant forward and raised her voice when questioning the patient. She also looked up from the computer when addressing patients. The second receptionist tended to avoid eye contact, was curt with patients, and did not look up from the computer when making appointments. Third, we agreed on the meanings of the key events. For example, the two receptionists were classified as warm and welcoming, and cold and distant because of their verbal and non-verbal language. Fourth, there were differences in the detail of observations. For example, both observers witnessed a woman who brandished a letter at the receptionist informing her of an abnormal smear, and wanted to see the practice nurse. Only MG witnessed and recorded the agitated body language and conversation with another patient, her friend, about the abnormal smear. This was because the woman and her friend sat next to MG in the waiting room. Fifth, there were differences in *what* was observed. These were

usually minor events. These differences could be attributed to the positioning of the observer. For example, the observer behind the reception counter usually heard and remembered more detail of the negotiation, and observed more facial expressions. In contrast, the waiting room observer witnessed more of what happened in the waiting room and could view the whole patient. Another explanation for observer differences is conscious and subconscious selection of patients and events which reflect the observer's personal and research experiences. For example, I became interested in the place and setting of my research in my second period of joint observing with JG. This influenced what I saw and recorded. JG is a self-confessed Star Trek fan which led her to interpret the directive function of the receptionist behind the reception counter as similar to Captain Kirk on the bridge of the Starship Enterprise.

The joint observing took place after I had been observing in the practices for nine months. All of these observations had been done by me. Despite help in interpreting these observations from my supervisor (PP), I felt isolated in conducting the research. The main benefit to me (MG) of joint observation and sharing the experience of observing was a feeling of relief. I was encouraged that someone else had come to similar conclusions in observing and interpreting the same events. I was elated, and felt that my observational skills had been validated. After the joint observing, my confidence in my observational skills and analysis increased immeasurably.

To introduce rigor to the analysis of the first period of joint observing MG and JG agreed to code and compare the observational transcripts, using our own ideas of coding i.e. not a formal coding scheme. These were analysed, initially by me, and later by JG, for concordance and divergence of coding labels (Table 10-5).

Altogether MG and JG identified 20 separate concepts for four sides of transcript. Table 10-5 details the similarities and differences in coding. Fourteen of MG's codes were comparable with 12 of JG's. The similarities were the ritualistic process of negotiations, the 'directorial' function of the receptionist, and verbal and non-verbal communications. These were subdivided by me into themes such as the negotiation process and non-verbal language. There was some variability in the level of coding. For example, MG coded non verbal signals as such, but JG coded these with a number of sub-codes such as smiling, eye contact and 'body closed in'. The most interesting aspects of the analysis were *differences* in coding. Some, such as receptionist distance from the patient and emotional distance from the patient, were recognised by both

observers in the discussion following the observations, even though only one party coded these ideas. Other differences reflect MG's interest in coding the detail of the ritual process of the negotiation, and JG's description of public intimacy where personal details are disclosed or requested at the reception desk.

Table 10-5: Comparison of coding labels allocated by MG and JG to their transcripts of a joint observation conducted in February 1999

Themes	Similar coding labels	Different coding labels
The process of negotiation	Ritualised process X3 *(3 examples)**, opening, closure, information requesting, information helping, negotiation **(MG)*** Rituals X2, greets and greetings X5, information *(exchange)* negotiation **(JG)**	Confirmation, explanation, checking X2 **(MG)** Doctor delay **(JG)**
Receptionist behaviours	Directing *(patients)* **(MG)** Starship X5 *(as in James Kirk directing operations on the bridge of the Starship Enterprise)*, another director **(JG)**	Checking *(to resolve problems)* X2 **(MG)** Patient familiarity, receptionist *(emotional) distance (from patient)* X3, receptionist as intermediary, familiarity of structure, receptionist anxiety **(JG)**
Non-verbal communication	Non-verbal X10, waiting anxiety, displacement activity *(reception)* x2, displacement activities of waiting X2, patient distress **(MG)** Eye contact X3, body closed in X2 **(JG)**	
Verbal communication	Joking X2, voiced criticism **(MG)** Shared humour X3, generous verbal language, reassurance **(JG)**	Public intimacy *X3 (personal details disclosed or requested)* **(JG)**
Other themes		Patient distress, alliance *(support of another person)* **(MG)**

*Note: explanations of codes and other notations are in *brackets and italics*

Experiment three: comparing joint observations September 1999

MG and JG had found the joint observations interesting and valuable. JG felt that the process of writing fieldnotes while observing was distracting and wanted to try observing again, but writing the fieldnotes after completing observations. This second period of joint observation occurred on Thursday the 3rd of September between 10 and 11 a.m. Again, JG sat with the receptionist behind the reception desk and MG sat in the waiting room. The post-observation discussion lasted over an hour and yielded 15 pages of A4 transcript. I analysed the transcript of the observations and discussion.

There was consensus about the main observations and interpretations. There was discussion and exploration of events where there were differences in interpretations.

The experience of observing was different to the first time for JG. She still had a sense of "being in a little time capsule" (behind the reception counter), but did not feel so disconnected from events, although "the waiting room was still a long way off." She attributed her feelings to increased familiarity with the setting. In contrast, the setting was familiar to me and my approach was to reflect on the importance of the waiting room as a 'place' or context in analysing negotiations; structure, policies and people affect what happens at the reception desk. There were three reasons for this approach of mine. First, the waiting room was initially quiet and encouraged introspection and reflection. Second, I had not visited the surgery for seven months and felt I was able to take a wider view of what I was observing which was influenced by my analysis. Third, I had been reading Strauss on negotiated order (Strauss 1978). He emphasises the importance of the 'setting' or context in which negotiations occur e.g. this is a general practice waiting room and not the common room of a university department. As I have indicated in the last experiment, there was a clear link between reading and theory influencing observing and interpreting.

Both observers were approached by health care professionals while observing. JG was questioned by a receptionist, who appeared to be testing out who she was by asking JG details about her work and role in the practice. The receptionist also disclosed feelings of stress when coping with some people and increasing levels of demand. I was approached by the senior partner of the practice while in the waiting room. This was a social visit. I was also approached by a health professional who was visiting the surgery as a patient. She confessed that she was taking a cancer drug, and made

positive and negative comments about two practice services. JG and I felt awkward and unsure about how much to say, and both adopted the tactic of listening rather than full engagement. These experiences illustrate some of the difficulties of negotiating relationships during fieldwork.

Experiment four: comparing coding of interview extracts - September 1999

The final experiment in inter-rater reliability involved MG, PP and VE who coded three interview extracts for the five most important themes. This was a similar approach to that adopted by Armstrong and his five fellow coders in coding focus group transcripts (Armstrong et al. 1997). One of the extracts from the long interviews is reproduced below. It concerns a male patient whose wife initially agreed to be interviewed at home as she had recently complained about the GP and surgery. When I arrived at the house she had changed her mind about the interview, but her husband agreed to be interviewed.

MG: "Do you think that they *[the receptionists]* hinder you getting an appointment or do you think that they help you or does it depend?

Patient: Ah, I think they are straightforward. If there is something crops up.

MG: Right, right.

Patient: I wouldn't say that they would hinder you in any way. I don't think they would.

MG: Right, right.

Patient: I think they would be straightforward you know and tell you what was what.

MG: Right, right. What about asking for information? I mean do they ask for information about what is the matter or do you give them information about what is the matter on the telephone?

Patient: Well if something is the matter they might say, "What is it? What's wrong?" You know and explain the situation and if they think it's, if they think it's vital or you know needs treatment there and then they will say, "Well can you come down at half past 11 when the doctor's surgery finishes."

MG: Yes. Do you feel happy with them asking for information or not?

Patient: Well I suppose its part of the run of the surgery.

MG: Right, right.

Patient: I mean they couldn't just bring anybody in willy-nilly if they have got a sore finger you know. That's not? They would want to know exactly what the situation is to bring in for emergency."

MG: Right, I understand. Yes. So you feel that that's part of their job and...

Patient: I would say so, aye."

The codes generated by the researchers are shown in Table 10-6.

Table 10-6: Comparing coding of a single interview transcript by MG, PP, and VE

Themes	MG's codes	PP's codes	VE's codes
There is a system for appointment making, that the patient is familiar with	Understanding of process of appointment making	Honest, straightforward communication	There is a system. Patient 'knows the ropes'
Patient assumes fairness in the system	Acceptance of process	Honest, straightforward communication	Assumption of fairness
System requires some sort of assessment	Action based on information giving	Seeking information. Explanation of situation. Need to know exactly.	System requires some sort of assessment. Necessary to operation of surgery.
Judgement of receptionist important	Acceptance of judging	If they think it's vital, then ...	If the problem matters you have got to have them confirm an agreement
Patient awareness of practice priorities	Resource awareness – not to 'bother the doctor'	Recognition of priorities; view on priorities	
Other themes		Role of information understood	Needs, urgency differ

The allocation of coding to different themes is debatable, but we can see that there was strong degree of concordance on the main themes in the data.

These four experiments in reliability testing had a number of benefits. The process of doing that was interesting and educative to both observers, and validated the observational skills of the main researcher (MG). The structured experiments in comparative coding again produced concordance in coding and highlighted differences in coding that stimulated researcher thought and debate. Armstrong states that in spite of debate about the philosophical assumptions that underlie exercises in inter-rater

reliability, in practice data does appear to speak in similar ways to different people (Armstrong et al. 1997). My results support this view, and also suggest the value of examining dissimilar coding. If I were to repeat these experiments I would try to get the coders together to debate the codes and themes produced rather than doing it on a one to one basis, and at a distance.

Peer review and audit

Peer review and audit usually refer to checks by supervisors on the research progress, analysis and findings. Peer auditors examine transcripts and examine the adequacy of which raw data has been reduced and analysed. This function was performed by PP at our regular meetings, although these tended to be informal meetings with advice rather than a detailed examination of coding and analysis. The exception to this was the experiments in inter-rater reliability as described above. The limiting factor in peer review audit was that participants had limited time to devote to this aspect of the research.

I also conducted a retrospective self audit of some of my data in my analysis chapter (Chapter 5.3.2). Four pieces of evidence were used to demonstrate an analysis audit trail. The first evidence was versions of the NUD*IST project folder that were saved in their entirety. The NUD*IST versions contained imported documents, command files, coding and category development, saved searches, and memos. The second piece of evidence was my reflective diary. The third piece of evidence was Inspiration maps. The final piece of evidence was notes, emails and summaries shared with my supervisors. These are retrospective pieces of evidence, and my construction of the truth of what happened, but I have tried to report these honestly.

External reliability

External reliability concerns the capacity of other researchers studying the same area to produce the same findings (LeCompte and Goetz 1982). The value of replicating a study has been questioned. The most celebrated example of this is Margaret Mead's work on Samoan adolescents (Mead 1971). Subsequent attempts to replicate this research several years later came to different conclusions. Similarly, Whyte in Street Corner Society was criticised after a later study of the same culture (Whyte 1981).

LeCompte and Goetz suggest five tactics for enhancing **external** reliability (Chapter 3.51). (LeCompte and Goetz 1982) The researcher should address five issues: their operational status during the research; sources of data; the social situations in which this was collected; they should detail theories involved in the research, particularly those that influenced coding; and give attention to methodological reporting. I have already addressed these issues in previous chapters, which are summarised in Table 10-7.

Table 10-7: Location of methods used to enhance external reliability in my thesis

Methods or tactics used to enhance external reliability	**Location in Thesis**
Operational status during the research	Chapters 1.6.1, 3.3.1, 3.3.2, 4.3, 7.3.1
Sources of data	Chapters 3.3.1, 3.3.2
The social situations in which data was collected	Chapters 3.3.1, 3.3.2, 4.3, 7.3.1
Theories involved in the research, particularly those that influenced coding;	Chapters 3.2, 7.3, 10.3.2
Methodological reporting	Chapters 3.3.1, 4.3, 5.31, 5.3.2, 5.4

10.3.4 Trustworthiness

As I mentioned earlier in this chapter (pages 207-208 and Table 10-2), Lincoln and Guba argue that establishing the trustworthiness of a research report is the essence of issues conventionally discussed as validity and reliability (Lincoln and Guba 1985). They propose four criteria for qualitative researchers that support the trustworthiness of a research account: credibility, transferability, dependability, and confirmability.

Credibility

Credibility is proposed as a replacement for internal validity. Through persistent observation, triangulation, the search for negative cases, showing interview transcripts and research reports to participants – respondent validation, prolonged time in the field, and exposing the research report to peer criticism the credibility of the research is established (see Chapter 3.5.2). Two of the most important elements I have applied are the search for negative cases and respondent validation.

Negative cases

An important feature of good qualitative research is examination of the data for "negative" cases, where the researcher's explanations appear to be contradicted by the evidence. In my study there are several examples where 'negative' data have modified the analysis. Most important were the opinions of patients about the value of receptionists. Most observations and many of the short interviews revealed positive views of receptionists, but a closer examination of this data revealed some negative views of receptionists, suggesting a more deeply rooted ambivalence about their dealings with receptionists. The findings from the long interviews, which sampled seven people who had complained about receptionists (Extreme sampling, Chapter 4.3.4), confirmed this underlying ambivalence. Despite voicing negative views of receptionists, all patients expressed at least some positive feelings towards receptionists. Including this contradictory or 'negative' data in the analysis gives a fuller and more complex view of patients' attitudes to receptionists.

The main way in which the search for negative cases was employed was in the 'day to day' analysis and manipulation of concepts in NUD*IST. If a behaviour, feature or idea was identified in the data, I would search the data set for contradictory evidence. For example, I was interested in the concept of professionals having 'favourites,' such as children when allocating appointments. I searched the dataset data for all occasions when children, were discussed, such as in the long interviews. This confirmed my view of professionals and patients treating children as 'more deserving of care' and appointments. There was, however, an exception to this as one receptionist did not feel this described her attitude or behaviour. I concluded that this single negative case did not detract from the majority of the data supporting my contention. It would have been interesting to observe this receptionist's behaviour with parents to see if she did what she said.

Respondent validation

I adopted two methods of member validation, informal discussion of a two-sided summary of my ideas with receptionists, managers and a doctor approximately three months into the research, and interviews with three patients and three receptionists from the long interviews who had viewed an eight page summary of the research and its key ideas (Appendix 9). The patients were chosen because I thought that their

previous contributions were particularly insightful, and the three professionals were all key informants in the practices. Two of these respondent interviews are discussed below.

A patient interview

This was a woman and single parent with three children under the age of 10 living in a run down council estate in Practice C's area. In contrast to the dilapidated external environment the house was warm and well decorated. The original long interview was completed on 14.12.98. The second interview was done on 2.11.99. My purpose was to follow the headings in my eight page summary of the research report and note her responses. She said that the summary was "interesting, and in a language that I could understand." The most striking finding, however, was that her responses were consistent with responses from the previous interview. For example, she maintained that if she needed to consult for her own problem (which she never disclosed) she would be prepared to wait to see her own doctor, but was not prepared to wait to consult with the children unless it was "something trivial." She expressed negative views about the receptionists and felt that they could learn a lot from other receptionists in the report. She advocated taking personal responsibility for care, "If you have help *[on the phone]* you can help yourself. You see people round here saying, 'I've been to see the doctor with this or that', and you think, well they could have managed themselves." She agreed that the patient strategies used to obtain an appointment were what she would use herself. "My first tactic is to be nice... I would ask nicely. If I didn't get satisfaction I would then threaten to call the doctor out. But only if it was serious." Her only change in attitude was about giving information to health care professionals. A nurse triage scheme had been introduced in the practice at the time I first visited it. Since our last meeting she had experienced giving information to the triage nurse rather the receptionist, which she found acceptable. Her only disagreement with my report was with my assertion that the elderly and children are seen as favourites by receptionists.

A receptionist interview

This respondent interview was with Practice A's manager. My plan in this interview was to work through the headings in my summary of the research, and test out areas of

uncertainty. For example, I postulated that doctors had the real power in the surgery in managing appointments, as recent research had suggested (Eisner and Britten 1999). She indicated that the receptionists and mangers were "in a bartering situation" with doctors, but that changes were usually initiated by receptionists. I also discussed the possibility of receptionists having an extended role like nurses as sorters or negotiators. She was uncomfortable with the concept of their being ritual elements to appointment making, because she felt that it demeaned the personal element of providing a service and "knowing patients." She also felt that there was too much focus on urgent appointments in the report. This respondent repeated views expressed in the long interview and in observations.

The four other respondent interviews followed a similar pattern to the two described here with agreement about most of the findings in my report. Only one new emphasis came from one patient and one receptionist; the issue of patient expectations. Both said that this was an issue in obtaining appointments. As one patient put it "People's expectations have been raised. It is an 'I want it now' world."

The patient respondent I have described had read the report and made notes in the margins. The receptionist had 'not had time to read it properly.' This is one of the limitations of respondent validation of textual material. You cannot rely on people to invest time on reading material so that they can be sufficiently critical to make the process successful, although most of my respondents appear to have read the report in detail. Also, the dynamics of the situation in choosing to interview people that you have seen before is that there is a 'relational context' where the concern may be for friendship rather than raising and reflecting on contentious issues (Murphy et al. 1998). I had certainly chosen these people because I had developed a relationship with them and felt that my rapport with them in this second interview would be good. None were chosen because of their contentious views or because they made me feel uncomfortable.

My feelings about experimenting with respondent validation echo those of Bloor. He says that it "is not a scientific test but a social event, constrained ... by the social dictates of polite conversation and shaped by the biographies and circumstances of the discussants" (Bloor 1997). It may not be a technique for validating findings, but it allowed me to meet with perceptive respondents to reflect on my analysis. It

encouraged me that my analysis struck a chord with others. I also had the opportunity to discuss areas of uncertainty and it produced new ideas to consider.

Transferability, dependability and confirmability

Transferability is advocated as a substitute for external validity. It is concerned with providing 'thick' descriptions that allow the reader to judge the applicability of the research. Only after reading my report will you be able to do that. Dependability is concerned with auditing the decisions made by the researcher in producing this report. Within NUD*IST I kept a record of memos about important decisions made in thinking about the research. These were also kept in my reflective diary, which was where my research experiences were contained: Examples of the process of audit are described in the chapter on analysis (Chapter 5.3.2). The main external source of audit of my thinking and decisions were Dr Pauline Pearson and Prof Chris Drinkwater. On a monthly basis I would present my findings and diagrams of my relationships between codes and groups of codes. NUD*IST allows an experienced user to explore the detail of coding and analysis. As none of my supervisors were experienced users this was not attempted. Clare Tagg, a NUD*IST consultant, did review the coding after three months for a whole day, and in particular encouraged me to move from descriptive coding to more conceptual coding to advance the study. In retrospect I could have involved an experienced user to audit the data collection and analysis.

Confirmability is suggested as an alternative to objectivity, but the emphasis is on reflection within the research account and with the triangulation exercises. These issues are discussed throughout the thesis, but particularly in Chapter 3.5 and Chapter 5.3.

10.4 Exploring data collection

Rigour of data collection is important so as to avoid the many potentially invalidating or contaminating factors which threaten to diminish the interpretability of the data from participant observation (McCall and Simmons 1969).

10.4.1 Patton's guidelines

I adopted Patton's ten guidelines for observational work (Patton 1990). These are similar to those proposed by other researchers such as Cresswell (Creswell 1998).

Guidelines 1 and 2:

"Be descriptive in taking fieldnotes. Capture participant's views in their own words."

My observations were dated, described the setting, who was present, and what social interactions and activities occurred. Throughout this thesis there are extracts of transcripts of my fieldnotes. Notes were very detailed with limited drawing of conclusions and avoidance of emotion laden terms such as "poor" or "uneasy". Direct quotations appeared in speech marks in the field notes as soon as they occurred or on a piece of scrap paper then written into the field notes as soon after that as possible. Quotations which I thought were accurate were between inverted commas. A data example illustrates some of these points:

> "A woman aged 40 years of about 16+ stone and 5'2" in height approached the reception hatch. She was dressed in a floral summer dress, which fell to mid calf, and wore sandals. Both legs were covered with stockinet bandages, between sandal and knee. She 'waddled' when she walked, as if her feet were on hot coals at each step. She appeared to be well known to the receptionist, "Right *[patient's name]*, go upstairs to the landing [where the nurse is]"..."
>
> Observation No 1, waiting room, Practice A

Guideline 3:

"Gather a variety of information from different settings."

Initially I spent my time in the waiting room and behind the reception counter, but I realised that it was also fruitful to record information from administrative areas and coffee rooms. The range of information recorded varied. The focus of recording was on the dynamics of appointment making, however I recorded the behaviour of patients waiting to see the doctor or nurse, conversations between drug representatives and patients in the waiting room, and personal concerns of the receptionists. Joint observations were made of the same events but from different observational viewpoints (Chapters 4.3.2 and 10.3.3).

Guideline 4:

"Cross validate and triangulate by gathering different forms of data – observations, interviews..."

Many observations were recorded but not verified in any way. Some observations were checked out with the receptionists and on two occasions with the patient. I have already emphasised the need for care in interpreting observations (Chapter 10.3.1). Further aspects of triangulation have been considered elsewhere (10.3.2).

Guideline 5:

"Select key informants with care... keep in mind that their perspectives are limited."

Most key informants came readily to mind as I spent time in the practices (Chapter 4.3.3). I had usually spent several weeks in the practices before I chose my key informant to interview. I had concerns about my first key informant in Practice A. Initially I felt that she was trying to put the practice in the best light, and trying to control my view of the practice. As I got to know her she relaxed, became more open about the work of the practice, and I realised that she had the most insight about reception working and appointment making in the practice.

Guideline 6:

"Be aware of and sensitive to the stages of fieldwork"

This involves building rapport on entry, alertness and discipline in the middle phase and conscientiousness of taking fieldnotes (Chapter 3.3.1). After the initial excitement of making detailed fieldnotes had evaporated I had to apply myself to concentrate on the task. Sometimes it became a chore and my concentration lapsed. My awareness of the phases of fieldwork is described in the methods chapter.

Guideline 7:

"Experience the situation as fully as possible, while maintaining an analytical perceptive grounded in the purpose of the fieldwork"

I think that I did that and became acquainted with the receptionists particularly Practices A and C. I did not feel over-involved in the practices and did not get involved

in local infighting. Indeed in Practice A I initially retained a distance from the receptionist, but this felt false and very uncomfortable, so I decided to become more involved in the personal lives of the staff and the work of the practice (Chapter 3.3.1).

Guidelines 8 and 9:

"Clearly separate description from interpretation." And "report your own feelings thoughts and experiences"

This was highlighted in the fieldnotes. The fieldnotes contained my own feelings, reactions to experiences and reflections about the significance of what had occurred.

Guideline 10:

"Provide formative feedback as part of the verification process."

My initial reactions were presented to Practice A before I moved on to practice B.

Standardisation of data collection

A major limitation of observation and interviewing is non-standardisation of data collection. Two attempts were made at standardising data, during activity recording and the long interviews. Initially, the activity recorded consisted of writing a list of activities observed at the reception counter and in the waiting room. After a few sessions these were transposed to spreadsheets with categories of information such as repeat prescription ordering and collection, which were expanded to include new items with further data collection. These are examples of 'observational protocols' as advocated by Creswell. In Practices B and C these spreadsheets were limited to reception and waiting room activities because administrative sections were in other parts of the buildings, but significantly no new categories relating to reception activities emerged in the two later practices, suggesting that the spreadsheet accommodated all appointment activities. From the first interviews in Practice A a running order for the long interviews emerged. As far as possible the same questions were asked of the same people. This, however, was tempered by the need to persue lines of enquiry on the basis of data coming from previous interviews and analysis of observations.

10.5 Summary

In this chapter I questioned the quality of my research. I started with a discussion about how criteria for publishing qualitative research influenced my initial thinking on which methods to use that would enhance the quality of my research. I then examined how I applied criteria and terms such as objectivity, reliability, validity and trustworthiness. I described four experiments in comparing coding which aimed to enhance the reliability of coding and data interpretation. These experiments showed areas of common coding and areas of dissimilar coding, which stimulated researcher thought and debate. They also validated the observational skills of the main researcher (MG). Our results support the view of Armstrong that data speaks to different researchers in similar ways, and also suggest the value of examining dissimilar coding (Armstrong et al. 1997). I also examined how methods for data collection enhanced the quality of my research.

Chapter 11 : Discussion

"If the artist does not perfect a new vision in his process of doing, he acts mechanically and repeats some old model fixed like a blueprint in his mind." John Dewey, Art as Experience 1934 page 50 quoted in. (Strauss and Corbin 1998)

11.1 Introduction

This chapter examines the key findings and relates them to the research literature and health and social policy. I also present a model of appointment making and examine the implications of my findings.

11.2 The main findings of the study

1. **Patients and professionals define 'need' in relation to symptoms and signs of illness.** Sometimes this is used in the sense of care being imperative, at other times it means a request for care. Professionals, however, also define need in terms of their capacity to meet the demands of patients.

2. **Several patient factors act together to 'trigger' a consultation with the doctor.** These include factors such as a failure of self or medical care, anxieties about the duration of illness, previous illness experience, and concerns about specific symptoms and conditions, such as meningitis. Other trigger factors include disruption to employment and the need for a sick note, and disruption to family and social life.

3. **Patients and professionals share similar ideas about when to consult by an urgent or routine appointment.** Patients, however, prefer to consult urgently rather than wait, whereas professionals have ambivalent views about patient requests to be seen urgently, particularly for sick notes. Patients who wish to consult urgently, value seeing a competent doctor above seeing their usual doctor.

4. **Making an appointment is a complex social activity which depends on patient and family factors,** such as patients understanding of the organisation, and practice factors, such as the ease with which the patient can make an appointment.

5. **Making an appointment involves ritualistic behaviour of patients and receptionists.** At the heart of negotiating appointments is the process of legitimisation where practices enforce practice rules on appointment making. Receptionists judge the

authenticity of the patients request by soliciting information from patients, and using information volunteered in the negotiation. They also ask patients to judge the validity of their appointment request.

6. **Patients use strategies to negotiate appointments.** These include compromising their request, using advocates such as health visitors, chemists, and other doctors, trying to create a dialogue with the receptionist, alluding to ones social standing, being assertive, threatening to "call the doctor out", and exaggerating their condition. **Receptionists also use strategies** such as referring to other professionals and advocates, deferring appointments, being assertive, "fitting patients in", and reserving appointments for those that they think are at greatest need.

7. **Practice policy informs the work of receptionists** with responsibilities for making appointments. Most of these policies, or practice rules, are not written down but are widely understood by receptionists. In all three practices there were differences between the official practice policy and what receptionists did. These were most evident when receptionists asked for clinical information to judge the veracity of the patients request for an appointment. In two practices the official policy of not asking patients for clinical information was contradicted by unofficial policies where receptionists did. The unofficial policies were thought to be essential to the smooth running of the practices.

8. **Three categories of data demonstrate caring and uncaring interactions between receptionists and patients: valuing and helping behaviour; emotional involvement, and verbal and physical intimacy.**

9. All receptionists saw their main job as "helping people," and "giving a good service to the patient." **Caring receptionists treat patients with respect and deference.** A deferential approach enables the receptionist to control their negative feelings for the person and continue to help them. As well as responding to patients' requests, caring receptionists anticipate patients' needs or actively explore them.

10. **Some receptionists share patient's concerns and anxieties.** This emotional involvement appears to be rooted in familiarity and frequent association with patients, and tends to be with older people, and people with serious health problems. Receptionists can be distressed by their emotional involvement with patients.

11. Four types of verbal intimacy were observed: the use of first names; banter, joking; and the use of terms of endearment. Receptionists and patients commonly use first names. Patients addressed by their first names were more likely to be known to the receptionists than those who are addressed by their title. Banter and jokes are also made during interactions to lighten tense moments. Physical intimacy between patient and receptionist was rarely observed.

12. The uncaring receptionist does not value or help the patient and is not sensitive to their needs. They do not listen to patients concerns, and make the patients feel as if they are wasting the receptionist's time. The receptionist can also criticise, mistreat, ridicule or ignore the patient at the reception desk. The uncaring receptionist is emotionally distant from the patient and does not involve themselves in the patient's lives away from the surgery. Some receptionists were limited in their use of first names, did not joke with patients and had a flat affect. Their body language was 'closed,' and they did other tasks while the patient was speaking rather than making the patient the main focus of their attention.

11.3 Discussion of selected issues

I have selected what I think are the main issues raised by my results. The issues are health and illness behaviour, the process of negotiating an appointment, the notion of inappropriate consultations, and the concepts of caring and uncaring receptionists.

11.3.1 Health and illness behaviour

Symptoms of illness are common, but few patients consult a doctor. For example, in health diaries of women aged 20-44 symptoms were experienced every three days (Morrell and Wale 1976). In the same study Banks et al's showed that only one in 37 symptoms resulted in a consultation with a doctor (Banks et al. 1975). Most symptoms are managed by patients themselves.

Why patients seek professional help is complex. A recent study of patient decision making processes with symptoms of myocardial infarction showed that patients had difficulty recognising and evaluating symptoms, and the decision to seek help was a complex interaction of knowledge and experience, beliefs, emotions, and the context of the event (Pattenden et al. 2002). Ideas about symptoms, their significance, what

should be done about it, and whether a patient should consult are culturally determined (Fitzpatrick 1984). Mechanic in 1978 emphasised that whether or not patients consult a doctor depends not just on the illness itself, but also on how they and their family *respond* to that illness (Mechanic 1978). He listed 10 variables that act together to precipitate a consultation. Five of these variables appear explicitly in my analysis: visibility of signs and symptoms; the extent to which symptoms are perceived as serious; persistence of symptoms; the extent to which symptoms disrupt family, work and social activities; the availability of local resources. Some of these are considered now.

The perceived seriousness of symptoms is a potent trigger to consult a doctor. Parental anxiety about serious illness was recognised by Kai in his study of parent of pre-school children on Tyneside (Kai 1996). Two factors emerged that appeared to shape parents responses: their sense of personal control when faced with illness in their child and the perceived threat posed by an illness. My research shows that parents of small children *and* adults both have symptom anxiety, but about different conditions. For example, potent sources of anxiety for parents were symptoms of headache and visual phenomenon. Adults were also concerned about symptoms perceived as suggestive of meningitis and heart disease. These prompted fears about meningitis; these were perceived threats to health. This may be related to people's perceptions of illness as something outside of their control. Pill and Stott, in their interviews of working class mothers in Wales, found that illness was seen by more than half of the respondents as an external phenomenon: they had 'fatalistic' views of illness, which they felt might act as a bar to people accepting responsibility for their health (Pill and Stott 1982). It is interesting that Pattenden et al's study of symptoms of people who had previously had a heart attack showed that their previous experience did not increase consulting behaviour when they encountered similar symptoms in the future (Pattenden et al. 2002). Patients wanted to "put it (the heart attack) to the back of their minds and get on with life." They also did not want to be seen as consulting inappropriately, particularly if they had already experienced "false alarms." As we have seen in Chapter 6.6.2 patients are concerned not to waste the doctor's time.

Disruption to family life and to social activities was recognised by Zola as 'triggers' to consult (Zola 1973). Other more recent research has also emphasised disruption to work, social and family life as triggers to consultation (Punamaki 1995). My research

emphasis the importance that work occupies in deciding whether to consult. Patients were keen to minimise time off work and to protect family income by obtaining a sick note. There is a paradoxical relationship between work, service use and illness behaviour (Rogers and Elliott 1997). Symptoms can interfere with work and trigger consultation. On other occasion's loyalty and commitment to work may prevent consultation. Patients accommodate illness at least in the short-term in order to guard their work routines (Bloor 1985).

Before coming to the general practitioners the patient will have received care from on average two sources especially spouse, relative or friend, with home doctor books, chemists, nurses, and television making lesser contributions (Elliott-Binns 1986). More recently, an evaluation of three NHS Direct first wave sites found that 95 per cent of patients found the advice offered helpful (O'Caithain et al. 2000). My research confirms these findings. Patients used a variety of resources to support self care, including family advice, pharmacists, health visitors and nurses. Again patients in my study felt that there were limited practice resources to manage patient's requests. Patients articulated this as "not wanting to bother the doctor," and trying not to consult with 'trivial' problems.

11.3.2 Negotiations

Receptionists are the main controllers of access to care, however, patients also participate in the negotiation with strategies aimed at increasing their chances of getting an appointment.

Many patients dislike giving clinical information. Cartwright and Anderson suggested that asking for information about the patient's problem created a barrier to patient and doctor and discourage consulting (Cartwright and Anderson 1981). Some patients and receptionists felt that this was a necessary part of their job. Asking patients for information was thought by receptionists to be a necessary method for rationing limited resources (appointments) and sorting patients by directing them to resources other than appointments with the doctor. Without this pragmatic and flexible approach receptionists could not effectively sort patient's requests to see the doctor or nurse (Zimmerman 1973). 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" (Blau 1972). There is also considerable evidence

that receptionists covertly break practice rules, by soliciting clinical information from patients, and when allocating appointments. 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 (Eisner and Britten 1999).

11.3.3 Inappropriate demand

The relationship between need, supply (of health facilities), and demand (the expression of want) is complex and contested (Rogers et al. 1999). Of interest is the concept of 'inappropriate' demand from patients such as 'frequent attenders' (Rogers et al. 1999). In this 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 (Neal et al. 1998; Rogers et al. 1999; Stimson and Webb 1975). The label by professionals of inappropriate consulters can be seen as a socially constructed medical judgement that articulates doctors' negative feelings about patient behaviour.

11.3.4 Caring and uncaring

Our research reveals a number of categories and concept that show caring and non-caring in patient – receptionist relations.

Most previous research emphasises the technical functions of receptionists rather than their relationships with patients and professionals. For example, receptionists are gatekeepers to care (Arber and Sawyer 1985; Cartwright and Anderson 1981; Stimson and Webb 1975) and controllers of continuity of care and access (Arber and Sawyer 1982; Eisner and Britten 1999; Freeman 1989). Two large interview studies have examined patient's views of receptionists (Arber and Sawyer 1985; Cartwright and Anderson 1981). Arber portrays them as 'dragons behind the desk' and as obstacles to access (Arber and Sawyer 1985). Cartwright, however, showed that most patients felt

that receptionists did a good job, although they were unhappy with being asking why they wanted an appointment (Cartwright and Anderson 1981).

The uniqueness of my study is that it demonstrates that receptionists exhibit caring as well as uncaring behaviour. A recent survey of 119 receptionists showed that that they derive most satisfaction from their relationships with patients, rather than professionals (Eisner and Britten 1999). Receptionists do not operate only on an instrumental task based level, but also function at an expressive caring level where they manage psychosocial concerns.

Caring is an ill-defined concept. It is, however, a common subject of nursing research, where caring is usually seen as a synonym for giving physical nursing care (Halldorsdottir 1996). Two phenomenological analyses of nursing care contribute to a new understanding of the nature of caring. The first, by Riemen, identified three concepts to describe caring nurse - patient interactions (Riemen 1998). These were behaviour that makes the patient feel at ease, the patient being recognised and responded to as a unique individual, and physical contact between the nurse and the patient. The second analysis of caring by Halldorsdottir presents a model of professional caring composed of competence, caring, and connection (Halldorsdottir 1996). Competence refers to proficiency in undertaking physical tasks, making judgements, and educating people. Caring is about being sensitive to patients concerns. Connection involves several processes such as trust, respect and communication with the patient.

In addition to these two analyses ideas on interpersonal warmth provide a vocabulary to describe the caring element of professional relationships. Interpersonal warmth can be defined as, 'a cluster of concepts made up intimacy, relational closeness, bondedness, attachment and involvement's'. They are characterised by verbal and non-verbal elements, and are a ubiquitous part of emotional and relational lives (Anderson and Guerrero 1998).

Receptionists display professional competence, are sensitive to patients concerns, treat patients as individuals and connect with patients in treating them with respect and deference. Unlike nurses there are fewer opportunities for physical intimacy from behind the reception desk, and none on the telephone. Receptionist intimacy manifests itself verbally. The issue of how to address the patient is an interesting and complex

one. The use of first names could be seen as disrespectful, over familiar, or a reflection of the institutions policy of 'pseudo-friendliness.' It has also been documented that older patients prefer to be addressed as Mr. or Mrs. rather than by their first names (Charlton 1998). Our experience is that receptionists usually choose the most appropriate form of patient address, although first names are used more often with people that they are familiar with or emotionally involved with. By using a first or last name the receptionist treats the patient as an individual. This contrasts to the impersonal grunt, or command, 'Next patient through to room 12,' where the patient is nameless.

One criticism of my ideas about the 'caring' receptionist was about using the adjective 'caring' in relation to receptionists. It was felt that the concept of caring "was too rich a word...I want to resist the devaluation of the word caring, while preserving the underlying point that you are making about patients' positive experiences of receptionists." They suggested 'humanistic' and 'helpful' or 'unhelpful' as alternative terms. I believe that the concept of 'caring' is appropriate and consistent with established meanings. The Collins Concise dictionary gives three meanings to the word 'caring': "showing care or compassion;" "professional social or medical care;" and "the practice of providing care" (Collins 1989). 'Caring' includes the concept of *professional* medical or nursing care (this would include receptionists), compassion and intimacy, and the process of providing care.

We should re-formulate patient - receptionist interactions to include encounters that are characterised by valuing and helping the patient, emotional involvement and verbal and physical intimacy - the caring function. Recognising the receptionists as 'caring' might go someway to other professionals and patients valuing and affirming what receptionist do well to counterbalance what receptionists, and their practices, do badly.

11.4 Models of appointment making

In Chapter 2 I said that there was no consensus in the literature about the concept of access. Penchansky and Thomas, however, provided a theoretical framework for understanding access. They define it as "a concept representing the "fit" between the clients and the system" (Penchansky and Thomas 1981). Their concept is divided into several dimensions. (Chapter 2.2.2, Table 2.1) Those dimensions that apply to my

results are those of accommodation and acceptability. Accommodation is concerned with how supply resources are organised (such as appointment systems) to accept clients. Acceptability describes Attitudes of providers and clients to each other. For example, providers may be less willing to accommodate some types of clients. As we have seen in this chapter 11.2.3, 11.2 4, and 11.2.2 these dimensions show themselves in my results

Managing a patient's illness may involve several potential sources of advice and care, including self care, use of social networks, and informal and formal care such as pharmacists and general practice (Chapter 2.2.2).

Individual general practices manage patient demand and access by, setting aside appointments for 'extras', adjusting appointment length, triage by nurses of requests to see the doctor the 'same day,' so called 'advanced access,' better use of telephone consultations, and delegating doctor work to nurses (Chapter 2.3) (Brown and Armstrong 1995; Campbell 1992; Gallagher et al. 1998; Richards et al. 2002; Iliffe 2000; Kendrick and Kerry 1999; Oldham 2001). Practices have seen appointment making as a simple linear system which begins with the patient requesting an appointment and ends with the provision of one. The focus is on finding the right number and type of appointments to meet demand.

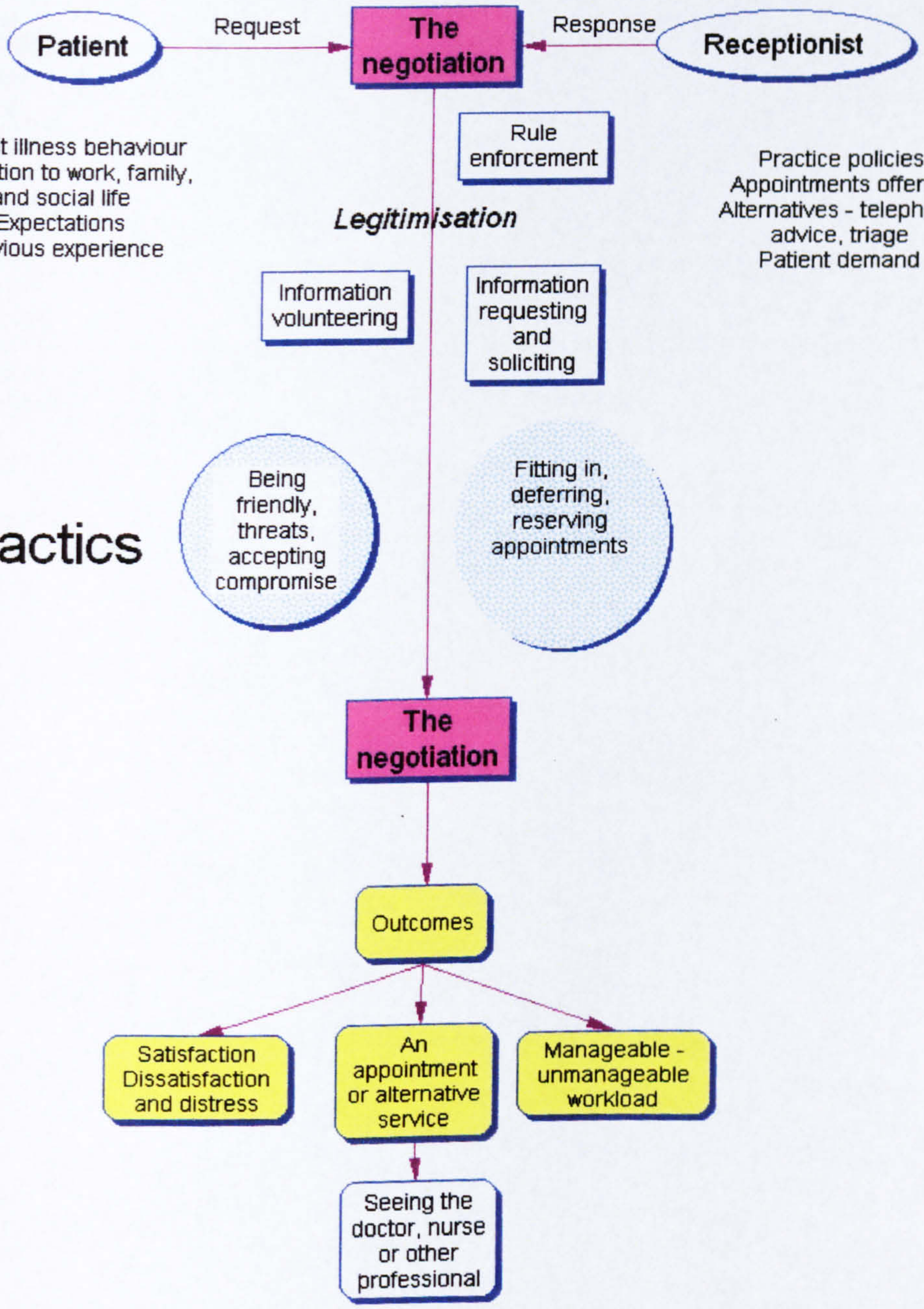
The challenge to this insular general practice approach to improving access is twofold; the advent of NHS Direct and government initiatives to foster 24 and 48 hour access (Health 2001; Pencheon 1998). These approaches accept that appointment making and demand management are complex systems with patient, professional, social and social policy contributions, and attempt to do something about it. In these cases NHS supports self care and triages patients requests, and 'advanced access' promotes a new theoretical and practical model of managing demand and access.

11.4.1 My model

A satisfactory outcome for the patient and the practice depends on the interplay of many factors including, patient illness behaviour (Scambler 1997), patients' expectations, receptionist actions and attitudes, appointment availability, and the process of negotiation. I have translated these factors into a model of appointment making (Figure 11-1). The focus of the model is on the patient and their negotiation

with the receptionist, but also integrates variables such as practice and social policy that provide the context in which negotiations occur. The model is limited because it is a two-dimensional representation of a complex activity.

Figure 11-1: A model of appointment making in general practice



11.5 Implementing my findings

In my thesis I argue that appointment making is as a complex activity that is affected by **three main areas:** patients' experiences of illness and seeking care; the culture and work of receptionists and general practices; and health and social policy. The receptionist is at the centre of this complexity. Current receptionist education and training emphasises the technical elements of receptionist work, such as using computers, rather than relationships with patients and professionals. I propose a 'new' receptionist curriculum, based on evidence in my thesis, which would improve the education and training of general practice receptionists.

11.5.1 A new receptionist curriculum

What would a new curriculum look like? I propose four new or improved elements.

1. 'Why patients want to see the doctor' - Patient illness behaviour

The journey of the patient from informal care to appropriating primary care resources is not part of receptionist training. But it is only by understanding how and why patients and their carers construct illness that receptionists can fully appreciate *why* patients want an appointment or other service. My curriculum would include, for example, discussion of patients' employment concerns, their perceptions of 'serious' symptoms, and use of informal and formal care. Although my finding are specific to general practice they need to be placed in the context of other theories and research exploring patient illness behaviour (Chapter 2). This would also form part of a new curriculum. It could be argued that receptionists already have this knowledge and apply it in their dealings with patients. Some experienced receptionists *may* have an intuitive understanding of the reasons why and how patients seek help, but most young receptionists do not.

A practial way of helping receptionists to appreciate patients' experiences would be by encouraging them to conduct case studies of people who come to see the doctor or nurse. These cases would serve as a basis for thinking about the patient's experience of illness, how they get help and how the practice manages that person. This approach to learning is used in undergraduate and postgraduate medical and nursing training.

2. 'How practice's work' – Practice culture

General practices are complex organisations with their own procedures, rules and norms, particulary for appointment making. Receptionist acquire knowledge of of how the practice works from their 'informal curriculum' by the process of apprentiship to more experienced receptionists.

Chapter 8 of my evidence details the *process* of patient-receptionist negotiations. It is a conceptual framework for teaching and learning the art of negotiating appointments and other services. It is specific to general practice and reflects what receptionists do in practice.

Other elements to a curriculum include learning about traditional and contemporary ways of managing demand and access. Receptionists complain about being isolated from decision making about appointment systems. If they were more knwledgable about ways of managing demand and improving access then they might be more able to engage doctors and managers in improving their services, and have a greater sense of ownership of the service that they provide.

Receptionists could also spend time training with doctors and nurses. This would foster better teamwork. A practical measure would be for receptionists to 'sit in' on consultations with doctors and nurses. This would give receptionists some insight into the dynamics of the consultation, would involve doctors and nurses with receptionist training and might foster better relations between professionals by breaking down barriers between receptionists and other health professionals. Indeed, receptionist doctors and nurses probably have overlapping learning and teaching needs.

3. Relations with patients

My conception of the caring and uncaring receptionist provides a foundation on which to develop training that fosters good relational skills. Again, my framework is based on patient and receptionist experiences and is specific to general practice. Receptionists need to know the charachteristicas of the caring receptionist and how the 'dragon behind the desk' behaves. This new element to the receptionists curriculum supplements modules on 'customer service' and 'managing the violent patient' which already form part of all certified receptionist training schemes.

4. 'The wider world' – Health and Social policy.

Increasingly general practices are directed by national initiatives, such as National Service Frameworks, many of which are aimed at improving service quality. It is important that receptionists understand local and national policies that affect their work.

The last words come from a practice manager who now organises receptionist training in a local Primary Care Trust (PCT).

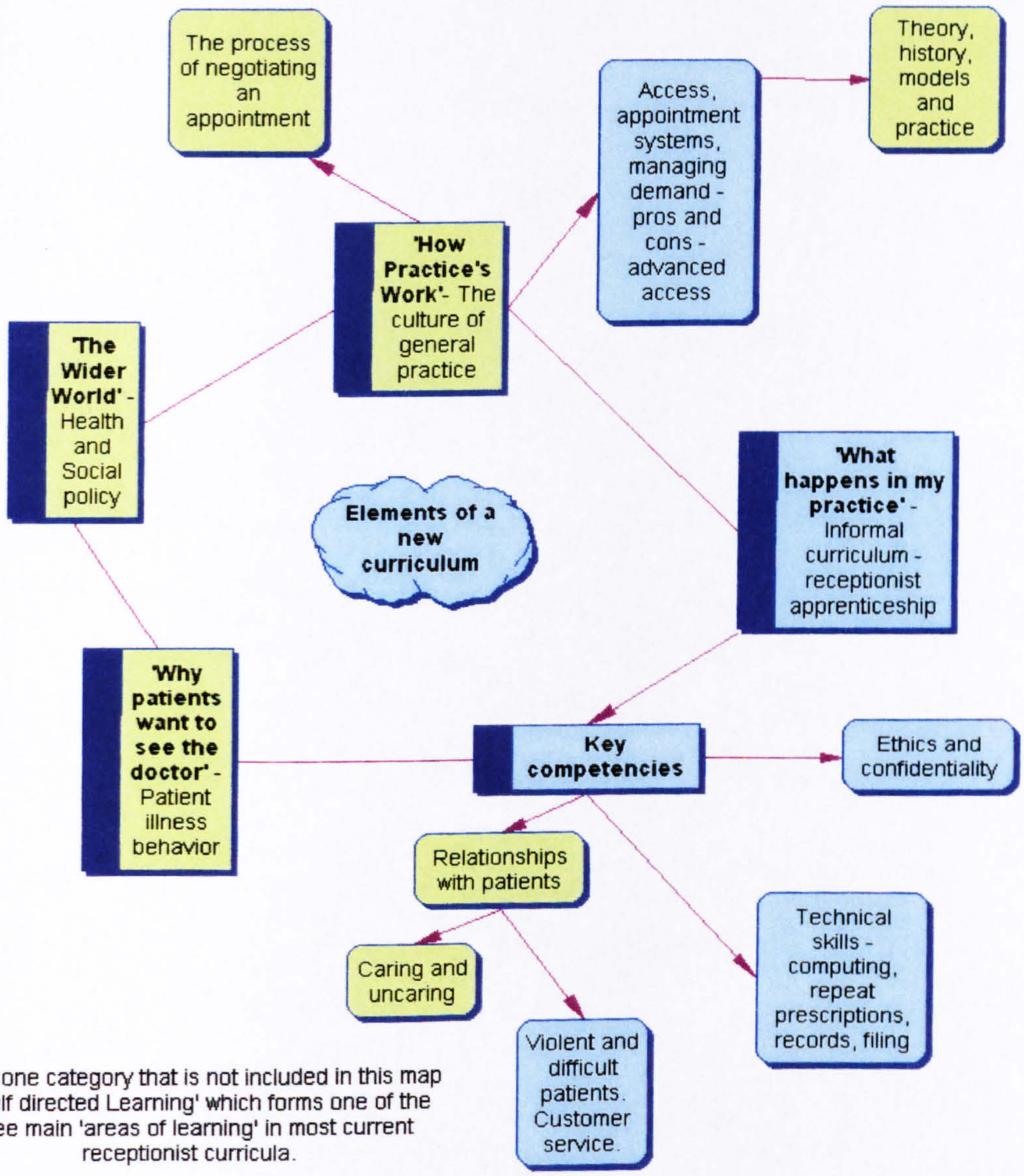
> "Receptionist training is better than it was before, but keen people now look to other sources of training to get what they want. Some PCTs, like mine, are very good and encourage training, but some are not - training varies a lot. You are very much left on your own."
>
> Practice manager interview Practice B, March 2003

Receptionists are crucial members of the practice team. Improving their relational skills alongside other competencies would do much to improve the experience of patients and the lot of receptionists.

Figure 11-2: Elements of the receptionists' curriculum.

Note 1: New and improves areas suggested by my research are in yellow; blue refers to subjects that already form part of receptionist education and training.

Note 2: Boxes indicated key learning modules



Note: one category that is not included in this map is 'Self directed Learning' which forms one of the three main 'areas of learning' in most current receptionist curricula.

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APPENDICES 262

Appendices

Appendix 1: Information sheet for research study: 'Patients' and professionals' views about making an appointment'

Introduction

Workload is increasing. Some practices still have difficulty providing a service, and this manifests itself to patients as difficulty in making an appointment.
Several factors affect a practice's ability to provide appointments. These include the number and type of personnel working in the practice, practice organisation, and the characteristics of doctors. Patients' ideas, past experiences of health care and social and psychological factors are also important.
The role of the receptionist in managing appointment requests is crucial. Only one study has systematically observed the work of receptionists. This focused on the receptionist's ability to offer appointments that maintain continuity of doctor care. It did not include patient observations, or examine how receptionists negotiate other demands such as urgent requests. A new approach to observing patients and receptionists may provide new insights into the important process of making an appointment.

What I want to research

- How patients and receptionists make appointments, especially when negotiating urgent appointments, and when the patient's first choice of doctor is not available.
- Patients' and professionals' views and experiences of managing appointment requests.

Why has your practice been approached?

I want to observe the work of up to five different practices. These include a group training practice, a small group practice with personal doctor lists, a large practice, a practice with five minute appointments, and a single handed practice.

What do I want to do in the practice?

A. Observe patients and receptionists making appointments

On the telephone or at the reception counter. The periods of observations in the five practices will be at different times of the day and week so as to cover the working week. Each practice waiting and reception areas will be observed at least twice. Patients will not be approached in the waiting room, but receptionists will be asked to clarify how they have handled calls or appointment requests. Hand-written and audiotaped notes will be made by me. My work will not interfere with the running of the practice.

B. Interview some patients and professionals

Approximately 2-4 short (30 minute) interviews with patients, receptionists and doctors, in each practice. The aim will be to explore issues raised by the observational work such as problems in making appointments.

Analysis

Transcribed field notes and interviews will be analysed to identify ideas and themes that are developed from the data to suggest theories that can be tested out by re-examining the texts.

What's in it for you?

- You will get feedback about my findings. Some will be general findings, others specific to the practice. The way in which I do this is negotiable, but I would welcome the opportunity to discuss my findings informally or formally. Individuals will not be identified in this feedback.
- It may be possible to suggest patient, professional and organisational factors that promote or hinder better service.

What's in it for me?

This research is the first part of a 4-year part-time doctorate examining the management of daytime need and demand in general practice. The results will be published in a peer-reviewed journal such as the BMJ.

Consent and confidentiality

Receptionists and other professionals

They will be able to choose not to be observed in the reception area if they are unhappy. Consent to interview will only be after the person is given a written and verbal explanation of the purpose of the project, and signs a consent form. These are appended.

Patients

A notice will be placed in the waiting room so that patients can choose not to be observed making appointments.
Consent to interview will be as for the receptionists.

I will identify myself as a researcher working at the University of Newcastle, where I am registered as a postgraduate student.

Ethical approval and support

Ethical approval granted by South Tyneside Local Ethical Committee on 7th of May 1988.
My supervisors are Dr Chris Drinkwater and Dr Pauline Pearson, both at the University of Newcastle upon Tyne.
Two awards from the British Medical Association fund my research.

Who am I?

- I am aged 42 and a GP in South Shields. For the past 4 years I have become interested in ways of reducing doctor workload, mainly by delegating work to nurses and by telephone triage. This research continues my interest.
- I am an experienced researcher and former RCGP Research Fellow (1978-79). I have also worked as a member of South Tyneside MAAG. I now lead one of the Northern and Yorkshire Research General Practices. But my main work is as a local GP trying to cope with increasing work and three teenagers – you know the story! My main research base is my practice and home in South Shields.

I can be contacted on

0191-4554621 or at Central Surgery, Gordon Street, South Shields, Tyne and Wear, NE34 4HX

Morris Gallagher

May 98

Appendix 2: Patients interview guide

Appointment making - general

I am interested in the experiences that you have had in making an appointment to see the doctor or nurse. Perhaps you could tell me about when you came to see the doctor today / yesterday?

- You made an appointment today. Could you tell me why?
- Or about the last time you made an appointment?
- Good or bad, positive or negative experiences. Appointment for you or other family member – parent, child, friend. How did you make an appointment today?

Do the receptionists ask for information when making an appt.? Do you volunteer information - under what circumstances? Patients offer information. Does that influence providing an appointment? In what circumstances?

Appointment making - meanings

What do you understand by the term urgent/ emergency, routine appointment? What type of things or reasons would you include (or exclude)? What kind of things would you say were urgent/routine? (Conditions, circumstances, problems, influences, be open).

Appointment making – lay care

? In what situations. Factors influencing consultation, transport, work, family

Appointment making – negotiating

I am interested in what ways you can influence the receptionist or someone else in the practice to give you an appointment – particularly if there is not obviously one available. Are there any tactics – try not to prompt.
Are there different ways of handling different receptionists?
Does your receptionist ask for information about the problem that you have? In what circumstances. How do you feel about that? Offer an appointment? Do you ask for information routinely? What ways do you have of helping the conversations along – encouraging, discouraging?
Nurses versus doctors versus receptionists. Ok for what?
How much **flexibility** do you have in offering appointments?
Is there a bureaucracy, system?

Attitudes to receptionists

What do you think about the role of receptionists - helpful, unhelpful, obstructive, and caring? Past experience good and bad
Previous conflicts with receptionists. Previous good experiences with receptionists.

Personal care

Is seeing the same doctors important? If so for which types of people

Discrimination

Do you feel discriminated towards?

Work as an issue

Triage

Barriers – problems or requests deflected (triage a barrier or help)

Waiting

What it is it like to be in the waiting room?

Feelings, activities, thoughts while waiting, rehearsal for the consultation, anxious relaxed, bored, adjectives, other people waiting, receptionist interactions.

Policy

Understand how things are organised?
What do you want? (In an ideal world). Is that achievable? How?

General

How well do you think the surgery manages **your needs?**
Do you think you know how the practice is organised for seeing the doctor or the nurse? Routine, urgent, repeats appt or home visits, or other services

Appendix 3: Professionals interview guide

Introduction

What does it feel like to be at the reception desk?

How well do you think the practice manages the **needs** of patients who wish to see the doctor or nurse?

Appointment making - meanings

What do you understand by the term urgent/routine appointment?
What type of things would you include or exclude. What kind of things would you say were urgent/routine (conditions, circumstances, influences - be open)?

Appointment making - policy

Who decides practice policy on appointments?

Is this an 'informal policy' or written down?

How was it achieved – formal or ad-hoc meetings, over a period of time, how reviewed? Is there guidance on flexibility – how much, in what circumstances, - are there limits? What influence do you have in deciding the policy on appointments?

Appointment making - negotiating

How much **flexibility** do you have in offering appointments? In what situations? With which patients?

There is debate about receptionists asking for information on the patient's condition before offering an appointment. Some receptionists do and some don't. In what circumstances would you ask for information?

Why open access appointment?

What ways of helping the conversations along – encouraging, discouraging?

Previous conflicts with patients.

Do you involve other member of the staff, such as GPs or practice nurses in managing people's requests to see the doctor or the nurse?

Eligibility of patients. Fees, threat of stigma (?), public's ignorance of the system, complexities of the system, personal predilections of the users and providers, deflecting to other agencies, and physical barriers.

What do you do when the patient is unhappy with your request?

Do you feel you have the training to manage negotiating appointment?

Discrimination

Do you have difficulty with certain groups of patients? What about children, working people, mid-life, old people, educated?

Personal care

Is seeing the same doctor important? If so for what type of people?

Appendix 4: Consensual notice for the waiting room

Today, a researcher from Newcastle University is in the waiting room. He is doing research into how easy or how difficult it is for patients to make an appointment with the doctor or nurse.

The doctors and staff of the practice have agreed to the researcher working in the practice.

If you feel very unhappy with the researcher being in the waiting room then please bring this to the attention of the receptionist.

Appendix 5: Interview information and consent sheets

Department of Primary Health Care

The Medical School

University of Newcastle upon Tyne

NE2 4HH

June 1998

Re: Research study on 'Patients and receptionists views about making an appointment'

Dear sir/madam

Sometimes people who want to see the doctor or nurse have difficulty in making an appointment. I am doing research to find out what problems patients and professionals have. I am interested in your own experiences.

I would like to talk to you about them. This will by an interview that will last about 30 minutes. Your comments will be recorded on tape. These will be typed for me to look at. Only my supervisors and I will see these records of your interview. They will not be given to anyone in your practice, including the doctors. You will not be identified in anyway in a final report of the research.

You will need to complete a form consenting to interview. However, you are free at any stage to withdraw from the interview and to have any tape recording to be erased.

I hope that this research will help practices to improve their appointment services.

Finally, thankyou for your help

Morris Gallagher

(Postgraduate researcher, Department of Primary Health Care, University of Newcastle upon Tyne)

Department of Primary Health Care
The Medical School
University of Newcastle upon Tyne
NE2 4HH
June 1998

Re; Research study, on 'Patients and receptionists views about making an appointment'

I agree to be interviewed, and for my comments to be used in this research.

I understand that the research is designed to add to medical knowledge.

I have read the explanatory sheet about the study. This is attached and I have had time to think about it.

Morris Gallagher has explained the nature of the research to me.

I have been told that I can withdraw my consent to interview at any stage, without giving a reason.

Date ... ...

Name ... ...

Signed ... ...

I can confirm that I have explained to the participant the nature of the study and have given adequate time to answer any questions concerning it.

Signed ... ... Date ... ...

Morris Gallagher

(Postgraduate researcher, Department of Primary Health Care, University of Newcastle upon Tyne)

Appendix 6: NUD*IST coding as of 08.10.98

Index or 'tree' of codes

(Key categories are highlighted in **bold**)

(1) Descriptive

(1 1) phase

(1 1 1) phase1

(1 1 2) phase2

(1 2) surgery

(1 2 1) A

(1 2 2) B

(1 3) type

(1 3 1) observation

(1 3 2) interview

(1 3 3) document

(1 4) interviewee

(1 4 1) patient

(1 4 2) receptionist

(1 4 3) practice nurse

(1 4 4) GP

(1 4 5) manager

(1 5) locations

(1 5 1) waiting room

(1 5 2) reception

(1 6) patients

(1 6 1) cases

(1 6 1 1) (Patient's name)

(1 6 2) gender

(1 6 2 1) female

(1 6 2 2) male

(1 6 3) age

(1 6 3 1) mid age

(1 6 3 2) teens

(1 6 3 3) >65

(1 6 3 4) child

(1 6 4) requester

(1 6 4 1) mother

(1 6 4 2) carer

(1 6 4 3) father

(1 6 5) problem

(1 6 5 1) leg ulcers

(1 6 5 2) pregnancy

(1 6 5 3) URTI

(1 6 5 4) earache

(1 6 5 5) dog bite

(1 6 5 6) stroke

(1 6 5 7) green spit

(1 6 5 8) UTI

(2) Interview topics

(2 1) training

(2 2) policy

(2 3) needs

(2 4) routine

(2 4 1) lack of appts

(2 4 1 1) easier urgent

(2 5) types

(2 5 1) child

(2 6) info

(2 7) flex

(2 8) urgent

(2 9) negotiation

(2 9 1) urgent

(2 10) home visit

(2 11) personal care

(2 12) preferences

(2 13) triage

(2 14) reason for making urgent appt

(2 14 4) patients

(2 14 4 1) patient judgements about illness

(2 14 4 1 2) beyond self care

(2 14 4 1 3) feeling bad

(2 14 4 1 8) deterioration

(2 14 4 1 10) treatment failure

(2 14 4 1 12) Parental judgment

(2 14 4 2) social convenience

(2 14 4 3) doctor good reason

(2 14 4 6) sick note

(2 14 4 7) organisational factors

(2 14 4 7 1) anything

(2 14 4 7 2) previous use of service

(2 14 4 7 5) surgery not busy

(2 14 4 7 14) lack routine appts

(2 14 4 7 15) wait too long routine

(2 14 4 7 16) certainty seen

(2 14 4 9) Family advice

(2 14 4 11) referred by other doc

(2 14 4 13) employment concerns

(2 14 4 17) child

(2 14 4 17 1) uncertainty about illness

(2 14 4 19) illness worries

(2 14 4 19 7) reassurance

(2 14 4 19 18) worrying symptom

(2 14 5) receptionists and others

(2 14 5 1) condition judgement

(2 14 5 1 1) condition worse

(2 14 5 2) no routines

(2 14 5 3) can't wait until tomorrow

(2 14 5 4) patient persistence

(2 14 5 5) patient asked re defn urgency

(2 14 5 6) can't wait - time

(2 14 5 7) decision passed to patient

(2 14 5 8) helping patient define urgency

(2 14 5 9) protect urgents

(2 14 5 10) persuasion

(2 14 5 11) new offer

(2 14 5 12) fit them in

(2 14 5 13) guidance role

(2 14 5 14) limit urgents

(2 14 5 15) tactic talking to control appts

(2 14 5 16) judge tone of voice

(2 14 5 17) work issues

(2 14 5 18) meaning

(2 14 5 19) offer when routine requested

(2 14 5 20) nurse use

(2 14 5 21) conflict

(2 14 5 22) dependence

(2 14 5 23) stress

(2 14 5 24) educate

(2 15) past

(2 15 1) positive

(2 16) reasons for making a routine appt

(2 16 2) receptionist and others

(2 16 2 1) condition

(2 16 2 2) duration

(2 16 2 3) refusal urgent

(2 16 3) patients

(2 16 3 1) unimportant in comparison to urgent

(2 17) the system

(2 17 1) doctor protective

(2 18) conflict

(2 19) prof perspect making urgent appt

(2 19 1) child

(2 19 2) elderly

(2 19 3) knowing patient

(2 19 4) asking info

(2 19 5) misusers of the system

(3) comments

(3 1) relations

(3 2) personal care

(4) conceptual

(4 1) appointments (Note: classified as a category on page 105)

(4 1 1) repeat

(4 1 2) urgent

(4 1 3) routine

(4 1 4) home visit

(4 1 5) registering

(4 1 6) notes

(4 1 6 1) repeat

(4 1 6 2) urgent

(4 1 6 3) routine

(4 1 6 4) home visit

(4 1 6 5) registering

(4 2) negotiations

(4 2 1) beginnings

(4 2 2) middles

(4 2 3) closure

(4 2 4) checking

(4 2 5) choice

(4 2 6) deferred

(4 2 7) flexibility

(4 2 8) commun info

(4 2 9) message

(4 2 10) conflict

(4 3) relationship

(4 4) attitudes pro

(4 4 1) disapproval

(4 4 2) approval

(4 5) attitudes pat

(4 5 1) disapproval

(4 5 2) approval

(4 6) reasons for making an urgent appt

(4 6 1) child

(4 6 2) receptionist deciding yea or nay

(4 6 3) chesty

(4 6 4) non worrying condition

(4 6 5) worrying symptom

(4 7) waiting (Note: classified as a category on page 105)

(4 8) discretion

(4 9) information

(4 9 1) offered

(4 9 2) requested

(4 10) training

(4 10 1) apprentiship

(4 11) discrimination

(4 11 1) young people

(4 11 2) elderly

(4 12) rationing

(4 13) personal care

(4 14) typology wait (Note linked to category of waiting (4.7))

(4 14 1) foot tap

(4 14 2) poster exam

(4 14 3) leaflet exam

(4 14 4) nail bite

(4 14 5) eye contact

(4 14 6) restless

(4 14 7) magazines

(4 14 8) recep check

(4 14 9) watch TV

(4 14 10) coupling

(4 14 10 1) mirror movements

(4 14 10 2) affection

(4 14 11) conversing

(4 14 12) pacing

(4 14 13) smokes

(4 14 14) talking

(4 14 15) coughing

(4 14 16) clothes fiddle

(100) new documents

Appendix 7: 'Final' tree of themes, categories and codes for project 021101

Index or 'tree' of codes

(Key categories or themes are highlighted in **bold**)

(1) Descriptive

(1 1) phase

(1 1 1) phase1

(1 1 2) phase2

(1 2) surgery

(1 2 1) A

(1 2 2) B

(1 2 3) C

(1 3) type

(1 3 1) observation

(1 3 2) interview

(1 3 3) document

(1 4) interviewee

(1 4 1) patient

(1 4 2) receptionist

(1 4 3) practice nurse

(1 4 4) GP

(1 4 5) manager

(1 5) locations

(1 5 1) waiting room

(1 5 2) reception

(1 5 3) coffee

(1 5 4) admin

(1 6) patients

(1 6 1) cases

(1 6 1 1) (Patient's name)

(1 6 2) gender

(1 6 2 1) female

(1 6 2 2) male

(1 6 3) age

(1 6 4) requester

(1 6 4 1) mother

(1 6 4 2) carer

(1 6 4 3) father

(1 6 5) complainer

(1 6 6) 16-65

(1 6 7) complimentor

(1 6 8) waiter

(1 6 9) >65

(1 6 10) parents

(1 6 11) 65

(1 7) appointments

(1 7 1) repeat

(1 7 2) urgent

(1 7 3) routine

(1 7 4) home visit

(1 7 5) results

(1 7 7) registering

(1 7 8) prescription

(2) Policies

(3) comments

(5)FOCUS-access appt making

(5 1) Causal issues

(5 1 1) concepts of appt types

(5 1 1 1) Urgent-emergency

(5 1 1 2) routine

(5 1 1 3) home visits

(5 1 1 4) something in middle

(5 1 2) need and demand

(5 1 3) organisational factors

(5 1 3 1) social convenience

(5 1 3 2) previous use of service

(5 1 3 4) lack of appts

(5 1 3 5) easier urgent

(5 1 3 16) certainty seen

(5 1 4) Pt illness behaviour

(5 1 4 1) lasted a long time

(5 1 4 2) failure of care

(5 1 4 2 2) failure of self care

(5 1 4 2 10) failure of medical treatment

(5 1 4 3) disruption - fam, soc, wrk

(5 1 4 4) previous experience of condition

(5 1 4 7) can't wait

(5 1 4 9) Family advice

(5 1 4 11) referred by other doc

(5 1 4 12) Parental-child judge

(5 1 4 13) employment concerns

(5 1 4 19) illness worries

(5 1 4 19 1) uncertainty about illness

(5 1 4 19 2) feel bad

(5 1 4 19 7) reassurance

(5 1 4 19 8) deterioration

(5 1 4 19 18) worrying symptom

(5 1 13) personal care

(5 2) Negotiating access

(5 2 1) Caring-discord

(5 2 1) engagement

(5 2 1 3) caring

(5 2 1 3 3) knows person and PMH

(5 2 1 3 5) intimacy

(5 2 1 3 6) joking

(5 2 1 3 7) first names

(5 2 1 3 8) non-verbal

(5 2 1 3 9) asking after

(5 2 1 3 10) terms of endearment

(5 2 1 3 11) helps

(5 2 1 4) discordant

(5 2 1 4 1) appt disagreement

(5 2 1 4 2) other

(5 2 1 4 3) Tetchy testers

(5 2 3) Discrimination-favourites

(5 2 3 1) disliked

(5 2 3 2) favourites

(5 2 5) Tactics

(5 2 5 1) patient tactics

(5 2 5 1 1) persistence

(5 2 5 1 2) verbal tactics

(5 2 5 1 3) using status

(5 2 5 1 4) deferral

(5 2 5 1 5) recruiting help

(5 2 5 1 6) creating dialogue

(5 2 5 1 7) being assertive

(5 2 5 1 8) threatening doctor out

(5 2 5 1 9) aggressive

(5 2 5 1 10) exaggerating

(5 2 5 1 11) using alternative

(5 2 5 7) receptionist tactics

(5 2 5 7 1) acceptance

(5 2 5 7 2) offer cancellation

(5 2 5 7 3) deferral

(5 2 5 7 4) alternative

(5 2 5 7 5) fitting in

(5 2 5 7 6) Being assertive

(5 2 5 7 7) listening

(5 2 5 7 8) manipulating appt

(5 2 5 7 9) advocate

(5 2 5 7 12) verbal messages

(5 2 5 7 16) protect appointments

(5 2 6) The ritual

(5 2 6 1) Openings

(5 2 6 2) hold on

(5 2 6 3) refusal of appt

(5 2 6 4) unusual requests

(5 2 6 5) offers

(5 2 6 6) checking

(5 2 6 7) Closure

(5 2 6 7 1) confirmation

(5 2 6 7 2) Farewells

(5 2 6 8) giving directions

(5 2 7) Legitimising- sentry

(5 2 7 1) rule enforcement

(5 2 7 1 1) deferral

(5 2 7 1 2) refusal

(5 2 7 1 3) re-directing

(5 2 7 1 4) checking

(5 2 7 1 5) telling off

(5 2 7 1 6) discretionary power

(5 2 7 1 8) policy issues

(5 2 7 5) info exchange

(5 2 7 5 10) volunteering

(5 2 7 5 11) requesting

(5 2 7 13) judgements

(5 2 7 13 1) self assess urgent

(5 2 7 13 2) recep condition

(5 2 8) receptionist attitudes

(5 3) Waiting

(5 3 1)Displacement activities

(5 3 2) Comforting

(5 3 3) socialising

(5 3 4) Orchestration

(5 3 5) off stage

(5 3 6) entry and exits

(5 3 7) feelings

(5 3 7 1) boredom

(5 3 7 2) agitated

(5 3 7 3) anger

(5 3 7 4) negative

(5 3 7 5) afraid

(5 3 8) rehearsal

(6) Reflective diary

(7) Investigations and papers

(7 1) waiting paper

(7 1 1) intro

(7 1 2) methods

(7 1 3) practice differences

(7 1 4) results

(7 1 4 1) demographics

(7 1 4 1 12) Index Search205

(7 1 4 2) displacement activities

(7 2) Recep-pat interactions

(7 2 1) intro

(7 2 2) methods

(7 2 3) practice differences

(7 2 3 1) caring v surgery

(7 2 4) results

(7 2 4 1) open coding

(7 2 4 2) Terms of endearment

(7 2 4 3) analysis in general

(7 2 4 3 3) Index Search195

(100) new documents

Appendix 8: Transcribing guidelines

Observations

All separate observations must have a Header (Not in the header Word section, just at the top of the page) that includes the practice (A, B, etc), site, date and time – all in the one line (E.g. *Practice A, 27.07.98, reception area, 9.15-10.30 a.m.) These should be preceded by an * as the first character.

The second paragraph of each section should repeat this text minus the * as this can be searched.

All transcribing of participants names should be converted to a descriptive term, plus a colon. The choice is '**patient:, receptionist:, practice nurse:, health visitor:, manager:, doctor:, district nurse:**'. The only one that should be kept is '**Morris:**' The other researcher Val Elsy should be converted to '**researcher 2:**'. Another researcher would become '**researcher 3:**'. (Do not do in bold text; I have only done it here to display the wording that I would like to use consistently.) Discuss others with me.

'Morris:' should precede sections of text with notes and comments by me so that this text can be searched on the computer. Comments will be kept for researcher insights.

If there are *long paragraphs* (more than 5 or 6 lines) these should be split into two, with the beginning of the second paragraph identifying the person speaking, or commenting or notes.

Coding convention

" "	Double quotation marks	verbatim quotes
' '	Single quotation marks	paraphrases
( )	Parentheses	encloses contextual data and/ or interpretation
< >	Angle brackets	emic ideas
____	Solid line	partitions time

Interviews

Each interview Header (Not in the header Word section, just at the top of the page) that includes the practice (A, B, etc), person, venue, date and time – all in the one line (E.g. *Practice A, receptionist, GP common room, 27.07.98., 2100 hrs.) These should be preceded by an * as the first character.

The second paragraph of each section should repeat this text minus the * as this can be searched.

Try and reproduce **everything** that is on the tape i.e., pauses, laughter, anger, incomplete conversations, noises, faltering speech ... ...

Each person's text should be preceded by their descriptive code e.g. Morris:

As above, if there are *long paragraphs* (more than 5 or 6 lines) these should be split into two, with the beginning of the second paragraph identifying the person speaking, or commenting or notes.

27.7.98

Appendix 9: Summary of research findings given to patients and professionals

Making an appointment: a research study in three practices

Summary

Here is a summary of some of my research. I welcome feedback and criticism. Is my account of what happens when you make an appointment accurate? Does it ring true, or have I got it wrong? It is however, more likely that you will disagree with or not understand some areas. You may also want to make comments about the presentation of this information.

Write, ring, or send notes to me, Morris Gallagher, at Stanhope Parade Health Centre, Gordon Street, South Shields, NE33 4JP

0191 4554621

Morris.Gallagher@ncl.ac.uk

This paper is written as a supplement to face to face discussion with patients and professionals. It will not be possible to do this with everyone.

Introduction

Patient access to health care is important. In general practice, problems of need, supply and demand focus on patient difficulties in making appointments.

My *aims* were

To observe appointment negotiations in general practice, especially urgent requests

To investigate patients and professionals' experiences of negotiating appointments, and how these were influenced by practice policy.

The practices

The research was conducted in three practices on Tyneside. These were a single-handed GP practice with three receptionists and 1,700 patients, a three-doctor practice

with five receptionists and 4,600 patients, and a seven-doctor practice with five receptionists and 10,500 patients.

What I did

Between May 1998 and September 1999 I studied appointment making by observing in the waiting room, the reception area, and in administrative areas, and by long patient and professional interviews.

Forty-two patients were interviewed. These included 12 people attending an 'open access' surgery, parents of young children, middle-aged people, the elderly, and people who complained about appointments or who complimented the receptionists. Interviews were conducted in the patients' home within 72 hours of a visit to the surgery to see the doctor.

Seven receptionists, two general practitioners, two practice managers and a practice nurse were also interviewed.

I examined the typed observation notes and interviews, to identify ideas (concepts) or groups of ideas. These ideas and their relations were accepted, changed or rejected by examining earlier information and during later data collection and analysis. Analysis was conducted throughout the project.

What I discovered

Eight appointment activities were identified; requests for 'routine', 'urgent' or 'emergency' appointments and for home visits, registering for an appointment, changing a previously booked appointment, telephone calls to verify or resolve queries, and directing the patient to a consulting room.

Why do patients consult?

These reasons apply to routine appointments, urgent appointments, and home visit requests, on the phone or at the reception counter.

Patients' judgements about their illness:

- The condition has lasted a long time – 'too long.'
- Deterioration in condition.

- Parental worries and uncertainties about child's symptoms, such as headache and fever, and reassurance that this is not a serious illness such as meningitis.
- Worrying symptoms. Adults and children e.g. chest pain.
- Failure of self-care (e.g. over the counter medicines and preparations) and medical care (previous treatment from GP or other doctor).

Disruption of family, social and work activities. E.g. no sleep due to vomiting and stomach pain.

Persuaded to consult by another family member

Recommended to consult by other agency, such as hospital, heath visitor or NHS Direct.

Previous experience of conditions suggests that they should consult.

Employment concerns – not losing time and money, appointment fitting in with work, and need for sick notes.

Patients felt that they were good judges of when to consult and what kind of appointment to request.

Organisational factors that affect consulting:

- Lack of appointments
- I have to wait too long for an appointment, so I want an appointment now
- I can't wait
- Convenience – "easier for me to attend urgently."

Past experience of a service – influences future use of appointments.

Certainty of being seen sooner.

Some patients use alternative sources of help such as health visitors or pharmacists, "rather than bother the doctor."

These patient and organisational factors act together to result in the patient consulting, and requesting a particular type of appointment – routine, urgent, or home visit. For example, a man with back pain for one week developed increased pain in the leg,

preventing work and affecting sleep. Painkillers did not help. His sister suggested that this could be something serious. He wanted to be seen within 24 hours. He was offered an appointment in three days, but insisted on a same day appointment, which he attended.

B. The ritual process of appointment making

Appointment making is characterised by a number of recurring or ritual elements. These include openings, offers, confirmations and closures. These are offers of time, day, doctor, nurse, routine or urgent appointment. There may be multiple offers and refusals, until the patient receives, declines, or (rarely) is refused, an appointment.

Openings

The opening request comes from the receptionist or patient. Usually this is a spoken request. At the reception desk openings are more diverse, than on the phone, because of the opportunities for non-verbal communication. The patient would be invited to speak by non-verbal cues such as the receptionist looking up from the computer or reception counter, and smiling or giving a questioning look to the patient. Patient openings vary. These can be jokes or requests for services such as repeat prescriptions, and appointments. Appointment requests are usually specific about day, time, problem, or type of appointment.

Requests and offers

At the heart of appointment making are requests and offers. These are offers of time, day, doctor, nurse, routine or urgent appointment. Sometimes a request by the patient or an offer by the receptionist is agreed immediately. Usually there are one or more offers, before closure.

Confirmation and closure

Confirmation of requests occurs for almost all patients. Usually there are brief verbal or non-verbal exchanges supplemented by the receptionist giving an appointment card to the patient. On the telephone the receptionist confirms the day, date and time of the appointment, and the name of the doctor or nurse. For patient registrations the interaction sometimes terminates with the receptionist directing the patient to sit in a subsidiary waiting area.

Some patients are **refused** appointments. Usually these are urgent appointments where the receptionist judges that the patients' problem does not merit an appointment.

Differences between practices

Sometimes patients on the telephone would be **asked to wait,** before their request is dealt with. This was a feature of one practice where the counter receptionist also dealt with telephone appointment requests. This is a tactic for managing competing appointment demands.

In another surgery, there was a limit to the number of repeat appointments. When these were 'full' patients were **put off** and told to "ring back next week."

The large practices have two or three or more people making appointments. There is a 'house style' to openings and confirmations; receptionists repeatedly use the same form of words, particularly on the telephone. In contrast, the small practice usually has only one receptionist making appointments at a time. Their openings and confirmings are less stereotypical, and language use less formal.

This difference may be due to the specialisation of tasks in the larger practices. For example, in one of the larger practices two receptionists take face to face and telephone appointment requests from behind the reception counter. There is another team of two receptionists who staff the reception counter. The deputy manager also works behind the reception counter on Mondays, and leads both teams. Other receptionists do not get involved in appointment making, and have their own tasks, such as taking repeat prescription queries on the telephone or data management. In the largest practice, five receptionists rotate their day on the reception counter and at other times take telephone appointment requests. In both of these practices the receptionist wear colour co-ordinated uniforms and the receptionists project an air of efficiency and professionalism. The receptionist is exposed to the patients as both have reception counters. In the small practice, however, the receptionists have numerous other tasks including appointment making, they wear their own clothes rather than a uniform (at least in the first year of my involvement), and the impression given at the small reception hatch is one of informality rather than professionalism.

Specialisation, professionalisation, and the ritual nature of appointment making have a number of benefits. They may ensure that negotiating skills are vested in the most able people in the practice, assuming that they have been chosen for their ability to

negotiate with patients. It also ensures a consistency and formality of process that is inoffensive to patients, and that essential items in the communication process are not missed and are easily brought to mind because they are routine. The disadvantages are that negotiations may lack spontaneity and variability, and the receptionist may appear bureaucratic, unapproachable or even offensive.

C. Patient access

Most patients expect to have difficulty in making an appointment for the doctor, day, or time of their choice;

> "She (the receptionist) said, 'The first appointment is next week.' And I said, 'You haven't any appointments left at all for this week? None whatsoever?' And she said, 'No, none whatsoever.' ...I must admit I thought 'Here we go again.' I just said 'Right okay next Monday,' and put the phone down."
>
> Long interview, middle-aged woman

Waiting several days was not unusual, even when the patient wanted to be seen within one or two days. Several patients felt that they did not have difficulty seeing the doctor. All of these were over 65, and felt that they had a good relationship with the receptionists, which made it easier for them to get appointments.

Several patients found it difficult to reconcile appointment difficulties with an apparent increase in the numbers of doctors and nurses working in the surgeries. The commonest explanation for this was that the practice had "too many patients" (five interviews). There was sympathy for the doctor who was seen as "working flat out" doing a "difficult job".

Doctors and receptionists were also stressed in managing patient demand that was sometimes thought to be overwhelming, "The demand. It's too much...Its not possible to satisfy Joe Public", even though they felt they were trying their best.

All of the practices treated the issue of access to the surgery as important. The two larger practices had experimented with open access surgery, and daytime telephone triage with some success.

Approving appointment requests

Approving patient requests is a crucial function of appointment negotiations. It is the process by which receptionists give ***appointments in accordance with established and informal practice rules,*** and includes judgements about the ***genuineness*** of the condition. It occurs with all appointment making, and not simply urgent requests, and may be explicit or implied within the patient – receptionist encounter.

Three main tactics are used to approve appointment requests

- ❖ Enforcing practice appointment rules.
- ❖ Exchanging information about the patient's problem.
- ❖ Asking the patients to judge the urgency of their problem.

Receptionists enforce practice rules about appointment availability. Usually this is by a statement to the patient such as, "You can't do that", or, "That's not the practice policy." Some patients deliberately test practice appointment rules and availability. The smaller practice was more likely than the others to enforce practice appointment rules.

Volunteering information

Many patients feel that giving the receptionist information about their problem provides evidence that helps their requests to be approved. They want to demonstrate that the problem is worthy of an appointment, and is not trivial and inappropriate.

> "I think it 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."
>
> Long interview, mother of three

> "I automatically give it (information) because it is difficult to get appointments. I always have done. I have got a little boy that's got cerebral palsy. He has a lot of complications, and like you really do have to tell them - in great detail."
>
> Long interview, mother of two

> "Well, sometimes, you know, I have had to like really push it, you know. I'd have to like say that my chest's bad, my asthma."

Adult, interview

Requesting information

Receptionists feel that requesting clinical information enables them to allocate practice resources better. They can identify people who they feel need to be seen urgently, or offer alternatives to appointments, such as nurse appointments or telephone consultations with a professional.

The doctor and receptionists in the small practice accepted the need to request information. In the larger practices the patient was asked to judge whether the problem "can wait" or "is it urgent", and urgent appointment requests were directed to a triage nurse. Although the official policies in these large practices were not to ask the patient about their condition, most receptionists did, at least some of the time, solicit information to inform decision-making. Tactics used including a welcoming manner on the telephone and creating gaps in the phone or face to face consultation for the patient to fill with information. A discussion about the authenticity of the problem might then occur.

Patients had ambivalent feelings about being asked for information. Some saw it as a 'sorting role', - "I mean they couldn't just bring anybody in willy-nilly". Several patients felt that assessment by the nurse or doctor, however, would be preferable. Two patients felt unhappy that a nurse should be involved in triaging calls, one of whom complained to the practice.

> "... you have got to tell them the symptoms, exactly what's wrong with you. Which I don't think is right because as I say they are not qualified to make a judgement on what's wrong with you."

Interview, woman

Other tactics for getting an appointment

Patient tactics include

- Persistence.
- Use of advisors or 'helpers' such as a health visitor.

- ❖ Returning to the reception desk, to another receptionist.
- ❖ Alluding to ones social standing.
- ❖ Threatening to "call the doctor out."
- ❖ Exaggerating the condition or lying about it.
- ❖ 'Being friendly.'
- ❖ All are seen as a legitimate tactics to overcome receptionist reluctance to give appointments.

Receptionist's tactics include

- ❖ Referral to a district nurse, or health visitor.
- ❖ Using advocates (doctor or receptionist).
- ❖ Being assertive.
- ❖ "Fitting in" patients.
- ❖ Reserving appointments for 'needy' and favourite patients.
- ❖ They also display considerable listening and verbal skills to gauge the nature and urgency of the patient's problem.

Favourites and misusers.

Receptionists have three groups of favourites, the elderly, children, and 'friends.' Older people were felt to "deserve a different service", and that "you would do more for them." Children were seen by some, but not all, receptionists, and all patients, as vulnerable and unable to articulate their needs - 'you can't tell what's wrong with them', and more deserving of appointments than other patients.

Receptionists see patients who disobey appointment rules, allocated patients, and drug users as 'misusers' of the system. Young people are viewed as being particularly demanding and undeserving.

The distinction between the groups is important, as receptionists are more likely to give an appointment or other service to favourites. Few patients felt discriminated against.

Documents and practice policies

Only one practice had a written policy for organising, but not negotiating appointments. Most rules were passed down in an apprenticeship fashion. Receptionists felt that they had some input into how appointments were provided, but usually the doctors had the first and last word

D. Dissatisfaction and disagreements about appointments

Patients are dissatisfied with four areas

- Appointment making
- Receptionists' behaviour
- The doctor-patient consultation
- Length of waiting time in the waiting room

Dissatisfaction with appointment making occurs when there is a mismatch between what the patient wants and what the receptionist offers.

Most patients find the process of negotiating an appointment frustrating and stressful. Patients feel that receptionists do not acknowledge their requests or distress, and that their primary function is to "get me off the phone" and protect practice appointments. Patients felt this dissatisfaction even when their requests had been granted.

Discord is a feature of all appointment types, but the most striking cases come from the long interviews and are associated with urgent appointment requests.

I rarely observed disagreements. Most negative responses at the reception desk or on the phone were about lack of appointment availability, such as "That's not acceptable", "I could be dead (by the time I have an appointment)!" or facial expressions indicating displeasure. In contrast, patient dissatisfaction and ambivalence to with appointment making was mentioned in a half of the 26 long interviews.

How do we explain the difference between the observations and interviews? Patients may have been inhibited from expressing their feelings because of my presence, or

have suppressed negative feelings. This latter assertion is supported by indirect evidence from observing receptionist. Receptionists are professional in dealing with difficult patients in the public setting of the reception counter, and generally do not show irritation. In contrast, however, receptionists make critical comments privately 'backstage' out of earshot of the patient in the about difficult patients. There is a cathartic aspect to this. The public setting similarly discourages patients from demonstrating their true feelings which are articulated to me in the privacy of an interview. Other explanations for the frequent stories of discord from the interviews are that I sought them, and while these incidents are probably uncommon, they are remembered and articulated by patients because they have been important negative experiences.

E. The receptionist as a caring person

There is a popular feeling that the receptionist is a 'dragon at the desk', who's main job is to control appointments, 'protect the doctors', and someone whom patients have to fight their way past (like George and the dragon).

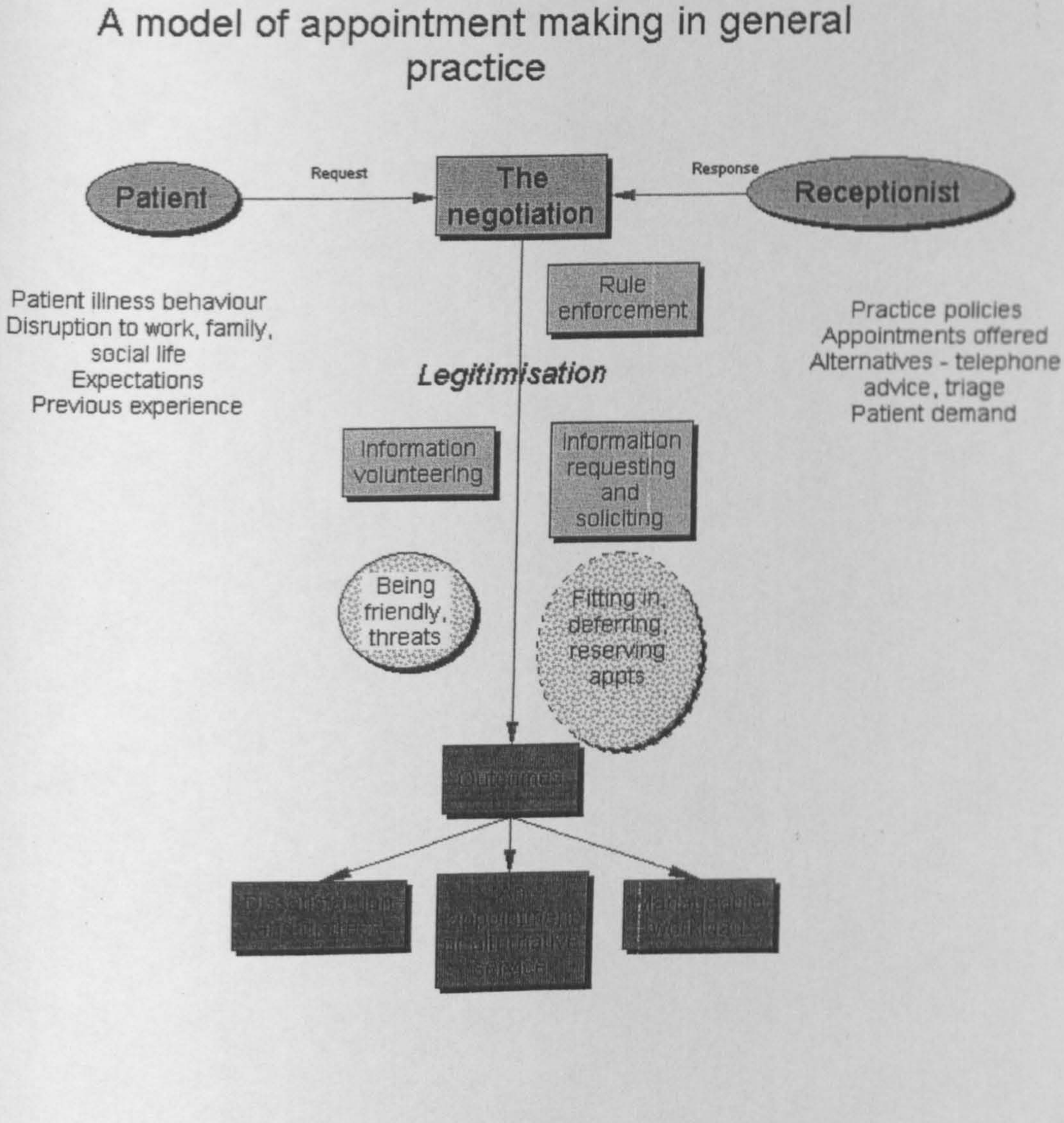
Most receptionist-patient encounters are emotionally neutral, and emotions are hidden and not displayed. I observed few episodes of discord and many more examples of warmth and generosity by receptionists and patients at the reception counter. Dissatisfaction with receptionists was evident in half of the long interviews. Usually this was about a 'bad experience, and patients knew who were helpful and unhelpful receptionists. A helpful receptionist was characterised by patients as someone who smiled and made eye contact, who listened to their request, and who offered a menu of options if an appointment was not available.

The evidence for this caring function are joking, the use of terms of endearment, expressions of concern, and physical intimacy, such as touching. This was more evident with patients that they knew well from their frequent visits to the surgery. This may have something to do with their role as women and carers in families caring for children and old people; their caring skills are being transported to the work setting.

We need to re-formulate receptionist/patient behaviour to include encounters that are characterised by caring, warmth and intimacy: the 'saintly' function.

What do you think?

F. A model of appointment making



Appendix 10: Summary of facts and figures about Practices A, B and C, and my practice 1998-1999

Practice	A	B	C	My practice
Contract	GMS.	GMS.	GMS.	PMS.
GP Training	No.	No.	No.	Yes.
Population	1,700	6,500	10,500	11,000
%>65 yrs age	17.0	* Not disclosed	15.5	20.5
%deprived	14.6	* Not disclosed	6.7	9.6
Site	House.	Health centre.	Health centre.	Health Centre.
Doctors	1 and one surgery every 2 wk.	3 full time.	4 full time, 3 part time.	6 f/t. 1p/t. 1 salaried f/t.
Practice Nurses	1, 20 hrs.	2 f/t.	4 part time, 111 hours.	1 f/t, 4 p/t.
District Nurses	1	3 and 1 support worker.	1 full time, 4 part time.	3 full time and one support worker.
Health Visitors	1	1 and 1 nursery nurse.	1 part time.	2 f/t and a support worker.
Midwife	1 and half hrs.	1	4 hrs	6 hrs.
Managers	1, 26 hrs.	1	1 full time 1 part time.	3 (one half time).
Receptionists	3, (24, 24 and 10 and half hrs).	5	6 full time and 4 part time.	8
Secretaries and Admin	A receptionist does this work.	1 sec. 2 admin.	2 part time.	3
Dietician	2 hrs.	2 hrs.	3 hours a fortnight.	3 hrs a wk.
Appointment waiting time	3 days.	2-5 days.	3 days.	7-21 days.
Modes of managing demand	Spaces for 'extras' at end of surgeries.	'Open access' clinic - urgent's. Nurse triage visits	Nurse telephone triage of same day requests.	Telephone triage of urgent. Telephone results line.

Appendix 11: Key, and activity record for Surgery A reception area

Key

Call pt: Receptionist or doctor calls patient in waiting room through to doctors or nurses consulting rooms.

Appointment requests at reception counter

Reg: Patient comes to the reception desk to register their appointment with the doctor or nurse.

New: A 'new' appointment request.

Repeat: A follow up, return or repeat appointment.

Urg: An urgent or emergency appointment request

Query: Queries taken at the reception desk, results of investigations, and requesting a doctor's letter, urine samples etc.

Appointment requests on phone

New: A 'new' appointment request.

Repeat: A follow up, return or repeat appointment.

Urg: An urgent or emergency appointment request.

Other phone calls

Internal: From or to doctor or nurse.

Results: Usually from patients, sometimes initiated by receptionist.

Others: Calls to and from drug rep, neighbouring doctor.

RP -Repeat prescriptions

Counter: Repeat prescriptions requests and collections at the reception counter.

Phone: Repeat prescriptions requests taken by phone.

HV-Home visit request

Reception: Request for home visits taken at the reception counter.

Tel: Requests for home visits taken on the telephone

Computer tasks

Reg: Registration

Presc: Repeat prescription ordering and printing

Other: Putting on new patients, smear results

Typing: Of hospital referral letters

Filing: Extraction, replacement of patient records, including making up surgery lists and use of tracer cards

Com: Episodes of talking or discussion about patients, appointment availability. Includes 'social communication' by visitors e.g. nurses and couriers

Admin: Administrative requests that are not classified in any other way. Commonly this includes opening letters **Other:** Activities such as making coffee

Appendix 11: (continued) Activity record for Surgery A reception area

Date	Day	Time	Appt requests at reception counter					Other activities		
			Reg	New	Repeat	Urg	HV	Call pt	Query	RP
08.06.98	Mon	9.00 am	3	1	1		3	1		2
11.06.98	Thur	9.30 am	3	2	1			2	3	4
19.06.98	Fri	9.15 am	1	1	2			3	2	2
29.06.98	Mon	9.15 am	2		1	1	1	2		
02.07.98	Thur	9.45 am	4		3			2		2
06.07.98	Mon	9.45 am	3		3		1	2		5
Total			**16**	**4**	**11**	**1**	**5**	**12**	**5**	**15**
			37					**32**		

Date	Day	Time	Appt requests on phone				**Other phone calls**			
			New	Repeat	Urg	Tel	Internal	Results	Others	RP
08.06.98	Mon	9.00 am	3	1	2		1		2	6
11.06.98	Thur	9.30 am	1				1		1	1
19.06.98	Fri	9.15 am				1		1	1	7
29.06.98	Mon	9.15 am	3	2		1			2	1
02.07.98	Thur	9.45 am	1						1	
06.07.98	Mon	9.45 am	2	1		1			4	
Total			**10**	**4**	**2**	**3**	**2**	**1**	**11**	**15**
			19				**14**			**15**

Appendix 11: (continued 2) Activity record for Surgery A reception area

Date	Day	Time	Computer tasks			Filing	Com	Admin	Other
			Reg	Presc	Other				
08.06.98	Mon	9.00 am	4	3		3	2	2	1
11.06.98	Thur	9.30 am	1	3	2	20	4	6	2
19.06.98	Fri	9.15 am		3	4	16	2	3	1
29.06.98	Mon	9.15 am	2	4	4	11	3		
02.07.98	Thur	9.45 am				9		8	1
06.07.98	Mon	9.45 am		6	3	9		8	1
Total			7	19	13	68	11	27	6
			39			68	44		
Total all activities			268						

Appendix 12: Activity record for waiting room areas of Practices A, B and C

Part I: Waiting room activity records (Practice A and B)

Surgery A											
Reception counter											
Date	**Day**	**Time**	**Appointment activities**					**Other activities**			
			Reg	New	Repeat	Urg	HVDesk	RP	Query	Others	Call Pt
08.06.98	**Mon**	**9.00 am**	3	1	1		3	2		2	1
11.06.98	**Thur**	**9.30 am**	3	2	1			4	3	1	2
19.06.98	**Fri**	**9.15 am**	1	1	2			2	2	1	3
29.06.98	**Mon**	**9.15 am**	2		1	1	1			2	2
02.07.98	**Thur**	**9.45 am**	4		3			2		1	2
06.07.98	**Mon**	**9.45 am**	3		3		1	5		4	2
Total			**16**	**4**	**11**	**1**	**5**	**15**	**5**	**11**	**11**
Waiting room											
04.06.98	**Thur**	**8.50 am**	7		3			2	1	3	
04.06.98	**Thur**	**9.20 am**	1		1			3		1	
04.06.98	**Thur**	**9.50 am**	7		2			5			2
05.06.98	**Fri**	**3.45 pm**	2					3		1	2
05.06.98	**Fri**	**4.15 pm**	2								2
05.06.98	**Fri**	**4.45 pm**	2								
08.06.98	**Mon**	**10.45 am**			1						
Total			**21**		**7**			**13**	**1**	**5**	
Surgery B											
Waiting room											
12.07.98	**Mon**	**10.50 am**	1	6				5		4	3
07.09.98	**Mon**	**10.15 am**	4	4	2			2			1
10.09.98	**Thur**	**3.30 pm**	7					4			6
14.09.98	**Mon**	**9.50 am**	8	4	1	2	1	5	3	5	
Total			**20**	**14**	**3**	**2**	**1**	**17**	**3**	**9**	**10**

Continued on next page

Part I: Waiting room activity records (Practice C)

Continued from previous page

Surgery C											
Waiting room											
Date		**Day**	**Time**	**Appointment activities**					**Other activities**		
				Regn	New	Repeat	Urg	HVDesk	RP	Query	Call pt
11.11.98	Wed	11.35 am	9	2	2			1	7	9	1
11.01.99	Mon	10.50 am	11	1				4	1	3	
11.01.99	Mon	11.20 am	8	2				10	4		
12.01.99	Tues	1.50 pm	2	3				10			2
Behind reception counter											
14.11.98	Mon	8.35 am	9	4				3		4	5
14.11.98	Mon	9.05 am	8	3		1		5	1	4	3
Total			**47**	**15**	**2**	**1**	**0**	**33**	**13**	**19**	**11**

Key

Appointment requests at reception counter

Reg: Patient comes to the reception desk to register their appointment with the doctor or nurse.

New: A 'new' appointment request.

Repeat: A follow up, return or repeat appointment.

Urg: An urgent or emergency appointment request

Query: Queries taken at the reception desk, results of investigations, and requesting a doctor's letter, urine samples etc.

Other: Activities such as nurse, drug re, postman, courier, delivery person

Call pt: Receptionist or doctor calls patient in waiting room through to doctors or nurses consulting rooms.

RP -Repeat prescriptions

Reception: Request for home visits taken at the reception counter.

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The British Journal of General Practice

'We might consider having nothing further to do with happiness ...'

Alan Munro, page 594

Follow the yellow brick road: starting an MD

Like Dorothy (her of the whirlwind and Toto the dog) I have started on a path that will take me to a new and uncertain prospect. For her it was Oz, for me it is to complete my MD.

I am in the first year of a part-time MD. My thesis is about patient and receptionist negotiations. The research approach is qualitative. The path to register for my degree has not been smooth, but I suspect that this is a common experience.

It is estimated that only 4% of theses come from general practice,[1] and the numbers may even be falling.[2] In specialties such as medicine, an MD is an established career move,[3] but in general practice the reasons for doing an MD are more diverse, and the obstacles greater. The main problems are lack of protected time and lack of money.[2]

Most Regional Health Authorities (RHAs) and the RCGP advertise research fellowships to fund time off. I obtained funding to employ a locum through the Northern and Yorkshire RHA research practices scheme, which is supervised by NoReN.

Finding and choosing a supervisor is crucial and you will need to negotiate this with your local MD advisor. If you are lucky your supervisor will become your advisor, mentor, and friend. I spoke to and interviewed many people about potential supervisors, including postgraduate students. People were surprisingly open about their experiences, although sometimes you had to read between the lines. These efforts built up a short-list of potential supervisors. I also had a 'trial run' in seeking their counsel about my ideas in the nine months before registering. I chose two supervisors from the same department who had worked together. I have not been disappointed.

Formal training for the degree is now compulsory in many universities. You can also choose modules aimed at increasing your knowledge in an area of interest. Practice and family support are also important: an MD is a major emotional as well as academic commitment. The opportunities to manage anxiety and uncertainty are legion. There are anxieties about supervisors, funding, grant applications, time off from the practice, and of course, the research itself. Don't believe people when they say you only need to do a couple of hours' work a week — it needs a lot of work.

Be prepared for obstacles. Not everyone thinks that your idea is innovative. But the knocks are good training for later on when you have to justify your thesis. I had some difficulties in obtaining approval for the qualitative methodology. I was surprised that even senior academics were inexperienced in this methodology, and I am sure that I would have had fewer problems doing a randomized controlled trial.

The Wizard of Oz is a parable about self-discovery and self-realization. That is a good description of doing a postgraduate degree. There is industry and perspiration, but also times of discovery and elation when it all seems worthwhile. I hope to have more of these moments.

Morris Gallagher

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contents

The Back Pages...

Myths and dragons

The conventional image of the receptionist as a dragon guarding the GP's gate dies hard. But MORRIS GALLAGHER's *study paints a very different picture*

Getting to see your GP can be a battle. At least that is my experience after spending 16 months observing receptionists in three practices on Tyneside, and interviewing a number of patients and healthcare professionals. As one patient said: "I expect to be told that there's no appointments available. Time and time again this is the kind of thing that happens."

On the other side of the divide, the doctor is also feeling the strain. "The demand is too much," said a GP waiting to see patients at an "open access" surgery for patients with urgent problems. "I've had the experience of going into the waiting room to see an enormous queue of people waiting for me. It's like a scene from Warner Brothers and the Titanic."

And between patient and doctor is the arbiter of access to care – the much-maligned receptionist. A receptionist with 13 years' experience commented on her predicament: "Patients are getting more demanding now than ever. It's more stressful for the receptionist, trying to fit patients in."

What these comments don't illustrate is the dynamic nature of patient/receptionist interactions when making an appointment.

A tense encounter I observed at the reception desk is more revealing. A young man in his 20s approaches the reception desk. He says he's already rung to say he'd be late. The receptionist looks at the computer screen, and says she will see the doctor. Then in an aside to me: "They're 'druggies' so will need medication. Got to check it out with the doctor."

After he has been waiting 20 minutes the receptionist calls him to the desk and explains that the doctor cannot see him today, but will leave a prescription after 2 o'clock, and see him next Friday. The receptionist turns her attention to the computer. The patient picks up a scrap of paper from the desk. "Don't worry," says the receptionist, "I'll write the appointment out for you. Is that time all right?"

She looks at him fully – giving eye contact. He fiddles with the paper. He asks the time again and looks blankly into space. The receptionist says: "So, after 2 o'clock your prescription will be ready and doctor will see you next week."

She holds eye contact with patient. The patient's face is unexpressive, and his eyes glazed. He breathes heavily, takes the appointment slip and walks haltingly to the door.

The receptionist says: "Phew! I thought he might have created. He's always late, sometimes 20 minutes, but today one hour and 10 minutes. I don't think he knows what the time is most of the time. It's a shame."

Despite the central role receptionists have as gatekeepers to care, the current debate on managing health service demand ignores their contribution. They are a Cinderella group who don't have the power and prestige of managers, doctors and nurses. As a researcher and GP I was interested in whether their role had changed in the past few years, especially with increased telephone working and the advent of nurse triage.

Managing patient access

Despite the problems of managing patient access and difficult patients, all receptionists saw their main job as "giving a good service to the patient" and "helping people". This tallies with research that shows receptionists derive most satisfaction from helping patients, and in their relationships with patients rather than colleagues.[1]

My experience of talking to receptionists indicates most do not feel appreciated by doctors, and feel other professionals have little understanding of the responsibilities of their work.

Receptionists have many contacts with patients on the telephone and face to face. The most important is sorting

patients' requests for appointments. If the practice has lots of available appointments then the patient may get the service they want. If the practice has a chronic or short-term lack of appointments then the receptionists will become more involved in rationing access to care and appointments.

Most receptionists are skilled at managing patients' requests, but the quality of help and advice given can vary a lot. A parent of three young children illustrated the difference between help and hindrance. "The first receptionist I spoke to has a really good manner about her that makes you feel you are not wasting their time. But there is another lady there who is extremely abrupt. I hate having to talk to her because she manages to annoy you without even saying anything."

Patients see creating a dialogue with the receptionist as an important feature in requesting practice services, particularly if their first choice is unavailable. Unfortunately, these negotiations favour the articulate and able patient, and disadvantage those with poor verbal and social skills.

Previous research has labelled receptionists as "dragons at the gate", and as barriers to accessing care.[2,3] Both receptionists and patients dislike this role as rationers of services, but some doctors are clearly happy to accept it, believing: "It is the maligned receptionist who creates order out of the chaos of limitless demand."[4] As one GP said: "I think to some degree they are protecting the GP because there is a limit to manageable workloads. They are aware of whatever rules the individual GP lays down as their manageable workload."

Most appointments I observed were made on the telephone rather than at the reception counter. I also saw the impact of telephone triage on receptionist working. Same day requests to see the doctor are now sorted by nurses, not receptionists, for instance, and this seems to be welcomed. However, this has not eliminated the need for receptionists to manage routine appointment requests, or face to face negotiations at the reception desk, when the nurse is not available.

SPL

Why are we waiting? The receptionist's role is becoming increasingly stressful

The future receptionist

Will the receptionist continue to have a key role as a gatekeeper to GP services? Many of their problems appear the result of their position as rationer of resources, and the public perception that they are still dragons. But they have considerable strengths, such as their commitment to serving patients, relational skills and adaptability to changing circumstances.

At the same time there are potential threats to their position from inside and outside general practice. External to general practice has been the growth of the new technology, particularly NHS Direct and nurse telephone triage. Receptionists could be replaced with a centralised booking service where anyone can arrange an appointment with any practice, by telephone or computer, from their home, business or newsagents. And if you can't wait, they'll transfer you to a triage nurse who can give advice, or arrange for you to see a nurse or a GP at any practice or at a nearby walk-in centre.

Within practices, nurses could be used to triage patient telephone calls or acute patients visiting without an appointment. We found this approach consistently reduced acute doctor workload by over 50% over a three-year period, with 84% of patients being satisfied with the service.[5,6]

Another threat comes from NHS Direct. But telephone access to care is by its nature impersonal, and it seems unlikely this will ever replace the personal patient/receptionist interaction. I witnessed many examples of receptionists caring for patients, particularly the elderly and those who visited the surgery frequently. Moreover, appointment making is only one part of receptionist working. They are still engaged in other activities within practices, such as filing, data management, and providing administrative support.

So these apparent threats to their way of working can also be seen as an opportunity to redefine receptionists' traditional role. They could take a more active and explicit role in sorting patients' requests – like triage nurses. A change of name to a more user friendly title might help. They could also benefit from negotiation skills training. Receptionists, like nurses, should be recognised as managers of patient demand who are effectively graduating access to doctors.

Receptionists have an important role in general practice that is largely unacknowledged by policy makers. We could make more of their abilities and commitment. They can and must adapt to a culture where there are many providers of primary care linked electronically. This can only be a good thing for patients, doctors and, of course, receptionists. RM

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

Morris Gallagher, Pauline Pearson, Chris Drinkwater and Joy Guy

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

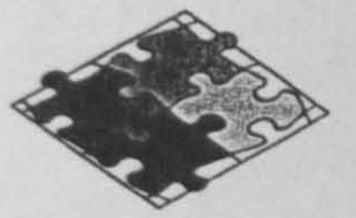
Settings and subjects

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]

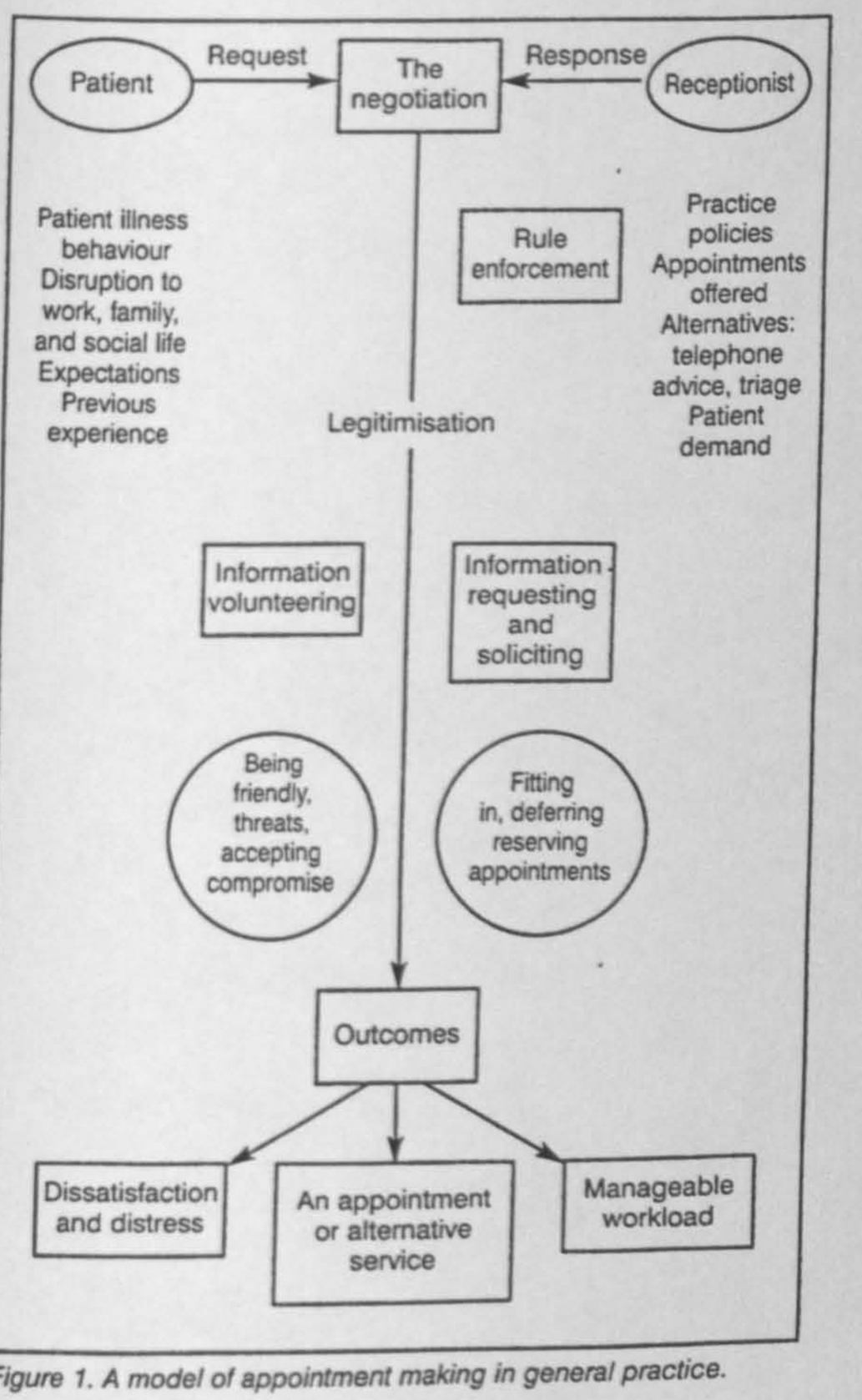


Figure 1. A model of appointment making in general practice.

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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