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Title: Patient burden during appointment-making telephone calls to GP practices

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Abstract

Objective: This study addresses, for the first time, the effectiveness of receptionists handling incoming calls from patients to access General Practice services.

Methods: It is a large-scale qualitative study of three services in the UK. Using conversation analysis, we identified the issue of ‘patient burden’, which we defined based on the trouble patients display pursuing service. We quantified instances of ‘patient burden’ using a coding scheme.

Results: We demonstrate how ‘patient burden’ unfolds in two phases of the telephone calls: (i) following an initial rejection of a patient’s request; and (ii) following a receptionist’s initiation of call closing. Our quantitative analysis shows that the three GP services differ in the frequency of ‘patient burden’ and reveals a correlation between the proportion of ‘patient burden’ and independent national satisfaction scores for these surgeries.

Conclusion: Unlike post-hoc surveys, our analysis of live calls identifies the communicative practices which may constitute patient (dis)satisfaction.

Practice Implications: Through establishing what receptionists handle well or less well in encounters with patients, we propose ways of improving such encounters through training or other forms of intervention.

1. Introduction

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

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

report is *how* this is done, in order to identify *what* makes some interactions (and GP services) more effective than others in dealing with patient access.

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

2. Methods

The dataset comprises recorded incoming telephone calls from patients to three General Practice surgeries in the UK, totalling 2780 calls. The recordings were anonymized digitally, in line with standard ethical practice when using recorded conversational data [19]. Consent was granted by the NHS for our evaluation of the data. 1,555 of the calls were transcribed verbatim and 447 of these were coded by the authors for numerous nominal categories. All of the transcripts containing target sequences were transcribed using the Jefferson [20] system for conversation analysis, which encodes prosodic, pacing and other phonetic information about the way talk is delivered. A glossary of transcription conventions is included in Appendix A. The data were analysed using conversation analysis (CA [21-22]). CA starts by repeatedly viewing or listening to recorded data, with the technical transcript. It proceeds to analyse systematically the activities that comprise the complete interaction; the way those activities are designed and how different designs lead to different outcomes. CA proceeds by exposing participants' tacit understanding of each preceding turn and of the action it comprised, rather than from analysts' *a priori* interpretations of what is happening [23].

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

We calculated the inter-rate reliability score using the Kappa score for nominal scores [24]. With Kappa scores varying between 0.69 and 0.95 and an overall score of 0.78, which is near

the ‘perfect agreement score’ of 0.81-1 [24], we regarded our coding as reliable. We compared our quantification of ‘patient burden’ with satisfactions scores from the same three surgeries found in the GP Patient Survey run on behalf of NHS England (<https://gp-patient.co.uk>). We used the January 2015 survey because of its temporal proximity to the data collection. We chose “X% describe their experience of making an appointment as good” and “X% find the receptionist at this surgery helpful” as the most relevant for comparison in our study.

3. Results

The analysis is divided into four sections: in sections 3.1-3.2 we summarise the phenomenon of patient burden in two phases of the calls; in section 3.3 we summarise our quantitative findings, and in 3.4 we provide instances of successful practice, where, for example, a doctor’s unavailability does not result in patient burden within the call.

3.1 Unmet request burden: Receptionist fails to initiate alternative offer

For this part of the analysis, we focus on the first turn following the receptionist’s response to a patient’s initial request. When a patient’s request is rejected, the call either progresses to a closing or an alternative way of meeting the request is proposed. In more than a third (37%) of calls where there are initial problems in meeting the patient’s request, no alternative offer/action is made by the receptionist following the non-granting. Eighteen, or 62%, of these calls were labelled as instances of patient burden; that is, where a lack of alternative action is treated as problematic by the patient (the non-patient burden cases were instances where an alternative was not relevant or not treated as absent by the patient). Below we explore two such instances. We have highlighted the moments in the interaction where the patient most clearly orients to interaction progress as absent or problematic.

In Table 1a the patient (P) calls to make an appointment.

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

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

Having requested an appointment (lines 3-4), the receptionist (R) checks which Friday P is referring to and then tells P that they are “fully booked” (line 9), thereby rejecting the patient’s request. An alternative offer is a relevant next action, and its continued absence becomes increasingly problematic for the patient and the progress of the call. First, at line 10, neither R nor P pursues an alternative. The gap of 1.6 seconds, about the standard maximum tolerance in telephone conversations before someone takes the floor again [25], is followed by P’s “Right.” (line 11), which displays recognition and ‘more to come’ [26]. In line 13, R seems to reiterate the non-granting (“fully booked”), thereby not adding anything new to the progress of the call. In line 14 P produces an “Okay,” followed by another gap (line 15), which again opens up space for R to initiate a next move. R responds with another “okay” (line 16), which at this stage implies closing relevance [28], before an alternative has even been attempted. The evidence that P is awaiting an alternative is found in line 18, where she does initiate an alternative inquiry, but in an audibly ‘stumbling’ manner. P’s “#uh-# o↑kay, uhm,” is produced in phonetically quite a disjunctive manner, with sudden pressure on the vocal folds (“#uh#”) followed by a marked raise in pitch (“o↑kay”). In overlap with P’s turn-initiation, and adding to its urgency, R makes a further move towards closing the call in line 19 with “thank you:”. In overlap, P pursues the possibility that another clinic, Flaxton, might have available appointments (lines 20-21). In this instance then, P pursues an alternative offer in the absence of any such initiative from R. The ‘burden’ of doing this is demonstrated by the manner in which P struggles to initiate and produce an alternative enquiry. This shows that P is not prepared to drive the service beyond the initial rejection, and expected R to have done so.

In Table 2, P makes a request to see a particular doctor, Dr. Warrington (lines 3-4).

Table 2

GP2-28: Patient pursues appointment with alternative doctor

1	R:	Hel↑lo:,
2		(0.3)
3	P:	Hello there, >just wondering if I can get an
4		appointment with Doctor< Warrington please.=
5	R:	=He’s on holiday at the momen:t,
6	P:	Oh:, wh- uh when ↑t _{il} ,
7		(0.4)
8	R:	Ooh not while we’re #(uh)# end of Oct <u>o</u> ber.
9		(0.3)
10	P:	↑Oh right,=>okay that’s a good holiday< in’t
11		it.
12	P:	.Hhh u:h:m,
13	R:	Hm hm ↑hm hm.
14	P:	.ptkhh anything with de Doctor de ↑C <u>o</u> urcy at
15		all?
16	R:	↑Mmm,
17	R:	((R talks to person in the background))
18	R:	°Just a moment°.
19		(10.9)
20	R:	No:,=I’ve not got anything with him at the
21		momen:t,
22		(2.5)
23	P:	Ri↑ght,
24		(1.1)
25	P:	U:h:m

26		(0.5)
27	P:	Doctor Grant[ham?]
28	R:	[Six]teenth of Oct <u>o</u> ber,=Doctor
29		de Courcy.
30		(0.7)
31	P:	Wi- sorry- s <u>o</u> rry?
32	R:	Sixte <u>e</u> nth of Oct <u>o</u> b[er,]
33	P:	[Tha]t suits me p <u>e</u> rfect.

The patient's (P) request is met with the reasons why it may not be grantable in the near future: the doctor is on holiday at the moment. P does not yet know how long the doctor is on holiday and whether he could be booked in for when the doctor is back. Or, alternatively, P might agree to see another doctor. These are opportunities that P himself pursues, first in line 6 and then in lines 14-15, by asking for possible appointments with a second doctor, Dr. de Courcy. While P so far does not display any trouble in pursuing an alternative (lines 14-15 do not alone constitute 'burden'), it is following R's second rejection (lines 20-21), that the (absent) alternative becomes problematic for P, who takes increasing responsibility to pursue such an alternative but is not quite sure how.

Following R's rejection in lines 20-21 ("No:;=I've not got anything with him at the moment;"), there is a long gap of 2.5 seconds, which is beyond the 'maximum silence' mentioned earlier [25]. P is the first one to talk next with a recognitional "Ri↑:ght," [26], produced with a sharp falling-rising intonation which might further enhance a sense that an ongoing action is not complete [27]. After another long gap of 1.1 seconds, P proceeds with an "u:h:m", followed by another gap (line 26), and then proposes a third doctor in line 27. In overlap, R gives a date and produces the name of the second doctor which was already mentioned by P in line 14, Dr. de Courcy (28-29). Apparently then, R has been searching for options all along, but the 'burden' for P is that, although R evidently pursues alternative appointments following line 21, R's actions are not hearable to P as pursuing alternatives. This is how P comes to push for a third alternative, and the process of getting there is not straightforward. The multiple long gaps and P's prolonged "u:h:m" shows that he attempts pushing forwards but struggles to do so. Eventually it emerges that P has been pushing an alternative trajectory in vain. This misalignment is observable in the gap of line 30 followed by P's repair initiation in line 31 ("wi- sorry- sorry?"): P did not expect R to have arrived at an offer already. R repeats the proposed date and P accepts this in line 33. But it is in the process of getting there that we have identified a 'burden' on P to drive the interaction forwards.

While the first two examples show how 'patient burden' can be displayed implicitly, through absent actions and patients efforts to deal with them, Table 3 provides a more explicit display of 'burden'. P is phoning about a referral he has received to remove sutures from a surgery on his hand.

Table 3
GP1-100: Patient pursues alternative appointment date

1	R:	Good morning,=Limetown S <u>u</u> rgery: ,
2		(0.3)
3	P:	Oh hello,=.hh I've had a: (.) a: patient
4		dis <u>ch</u> arge summary from: u:m Keydale, where-
5		uh- you sent me to get uh: a lump removed
6		from me h <u>a</u> nd.
7	R:	Right,=

8 P: =>And it-< it says, ↑practice nurse
9 <referral, (.)hh for suture removal.>=
10 =.hh u::h- and I wondered if I could make an
11 appointment to come and see the (p-) (.)
12 practice nurse, to have uh(p-) u#:h# sutures
13 removed,=uh it says on the
14 seventh.=[that's tomorrow,]=
15 R: [°On:° (s::)]=
16 R: =seve#n:th.=em::# .hhh u::h:m- (0.4) <I've
17 got nothing> that I can book I'm
18 afraid,=we're fully boo:ked. hh .hh[hh]
19 P: [(Uh)]
20 R: U::[h : m :]
21 P: [What about] today:.
22 P: Later on, [Cos I] mean it's nearly as:
23 R: [#°uh°#]
24 (0.2)
25 P: [() (later on)]
26 R: [°Let's have a look° hh]
27 (4.8)
28 R: I've got nothing today I'm afraid either.=
29 P: =Shall I take 'em out mese:lf.

In lines 3-6, P starts referring to a letter he received from the hospital that conducted the operation. R does not display any form of recognition (line 7) of the patient or what is to be done, but instead treats P as having 'more to come' ('Right,'). P provides more background regarding what is written in the letter in lines 8-9. Seemingly R is not yet clear what P's enquiry is, and remains silent in line 10 while P moves into an explicit request: "and I wondered if I could make an appointment to come and see the (p-) (.) practice nurse, to have uh(p-) u#:h# sutures removed,". Note also how P further specifies his request in lines 13-14: the sutures are due to be removed on the seventh, which is the day following this call.

At line 16, R indicates that she is investigating available times for that day: note the prolonged sounds during and following the repeated "seve#n:th.". This is followed by an explicit *non-granting*: she cannot book P in because the diary for the next day is full. At this point, R might initiate an alternative offer (e.g., of an available time slot another day). R's "U::h:m:" in line 20 indicates that she might be heading towards further talk, but this is not recognised by P as initiating an alternative offer. Instead, P makes an alternative request, "What about today:." (21). Before R responds, P pushes back on the short notice with the increment "Later on," (22), followed by some qualification which seems to suggest that today is just about as good as the recommended date (tomorrow). R initiates a new search with "Let's have a look" plus silence (26-27), before responding with a second non-granting in line 28: "I've got nothing today I'm afraid either.". This time, P initiates a candidate offer/proposal for meeting his own request: "Shall I take 'em out mese:lf." (29), an ironic proposal that would make GP intervention irrelevant. This is, of course, P's point: by proposing to take the stitches out himself, P orients to the service as having failed to make a suitable offer when relevant. In other words, an alternative offer from the GP service is explicitly treated as absent, and problematically so, by the patient.

3.2 Call closing burden: Patient is not clear what the next action is

Towards the end of calls, the most common source of misalignment between patient and receptionist is that the receptionist initiates a call closing when the patient evidently does not regard the call as over. A closing sequence typically starts with “all right?”, “okay?”, or other items that seek to confirm that the patient’s query has been resolved. Being closing-implicative [28], such an item leaves the patient one more opportunity to raise concerns. In general, when the patients do raise further concerns, these are predominantly queries that seek to specify, or restate, the arrangements offered, and may thereby reveal that these were absent before. In more than half of the calls in our data, the receptionist does not restate or summarise the booking, and in 46 of all 447 calls (10%) the patient seeks clarify it after the receptionist has started closing the call. About two thirds of these were coded as instances of ‘patient burden’, as the patient displays trouble in their attempt to push back on the further closing of the call. We will see how this type of burden unfolds in Table 4, where P has requested a new prescription.

Table 4
GP1-12: Patient is not clear what the next action is

1	R:	.hh I'll ask #doctor Pin:kerman for you oka:y.
2		(0.2)
3	P:	Thank you,
4		(0.3)
5	R:	All RIGH:T,.
6	P:	uh:m (.) (d-) Do I need to:- #(r-) (.) (ruh-)# (r:)ring you
7		(b-) (.) back ag[ain ↓or.]
8	R:	[Yeah jus]t give us a ring t- probably
9		to↓morrow,=just to see if it's been ↓done.
10		(0.2)
11	P:	Okay.=Fine,=Thank you,=
12	R:	=Thank you.
13		(.)
14	P:	>Thank you,=Bye [bye,<
15	R:	[Bye]:.
16		(0.8)
17		((hang up))

In line 1, R makes an offer, “I’ll ask #doctor Pin:kerman for you oka:y.”, which P accepts in line 3 (“Thank you,”). Following this acceptance, R makes a more explicit move towards closing in line 5 with “All RIGH:T;.”. By producing “All RIGH:T;.” at this moment, R implies that, having met P’s request with an offer (line 1), no further matters are relevant to this call [29]. A confirmation from P is a highly projected next action, making it interactionally problematic to add more to the conversation. But this is what P sets out to do, as the implication of R’s offer, in terms of what to do next, is not clear to him. That this is problematic to P emerges in lines 6-7 when he asks whether he needs to call back: his turn is littered with false starts and other perturbations (e.g., the initial “uh:m” followed by the incomplete “Do I need to:-”, and several start-stop initiations of “ring”), suggesting he is not sure how to request this information. Once more, the burden is on the patient to find out what he needs to do to complete the service transaction.

We return now to the example from Table 1a, where it is evident that the receptionist’s initiation of closing occurs before any offer has been made, and that this causes problems for the patient.

Table 1b

GP3-14: Receptionist initiates closing after non-granting

9	R:	Uh I'm sorry we're fully <u>booked</u> on Friday.
10		(1.6)
11	P:	Right.
12		(0.3)
13	R:	(°() fully booked.°)
14	P:	<u>O</u> kay,
15		(0.3)
16	R:	<u>O</u> kay.
17		(0.4)
18	P:	Yeah, °uh:-°=o↑kay, [uhm,]
19	R:	[than]k yo[u:]
20	P:	[Is] it <u>w</u> orth me
21		<u>r</u> inging Flaxton.
22		(0.4)
23	R:	#Uh# I can see Fri:day, uh::, app <u>o</u> intments
24		<u>h</u> ere.
25		(1.0)
26	R:	U:h:,
27	P:	Hm:[:]
28	R:	[W]e're >fully booked< this Fri:day at
29		Flaxton I can see,=wi- we don't open
30		>Fri:[day aftern <u>o</u> on]ns< at Fl <u>a</u> xton
31	P:	[As well.]
32	R:	°It's just Friday mornings.°
33		(0.6)
34	P:	<u>O</u> h <u>r</u> ight, [o]kay.
35	R:	[°yeah.°]
36	R:	> <u>S</u> orry we're [fully booked<] there.
37	P:	[Th <u>a</u> nk you.]
38		(0.3)
39	R:	<u>O</u> kay.
40		(0.4)
41	P:	Th <u>a</u> ns.
42	R:	Thank yo[u.]
43	P:	[By]:[e.]
44	R:	[B]ye, bye.

R's "Okay." (line 14) is a first move towards closing [28], as it occurs at a sequential location where a response to the inquiry has been made, and no further concerns or enquiries have been raised by either party. As we saw earlier, P clearly does have further enquiries to make, and struggles to find a way to pursue them in line 18. The sense of urgency with which P pursues the alternative enquiry is evidence that P knows how a closing is imminent, and time is limited, especially as R proceeds on the closing trajectory with "thank you:" in line 19.

Evidently then, this is a premature closing, and problematic for P to push back on. Following P's alternative enquiry R also rejects this possibility (lines 28-30), and the call is then moved towards closing without any offers made to the patient.

3.3 Patient burden quantified: Comparing surgeries and correlating with patient satisfaction scores

Based on our qualitative and quantitative comparison of ‘patient burden’ between the three surgeries, we found that effective practice clustered in one service. GP3 had the lowest frequency of patient burden (15/150 or 10% of calls), followed by GP1 (28/149 or 19% of calls) and GP2 (46/148 or 31% calls). The overall difference between the GP services with regard to the number of patient burden calls is statistically significant at a 1% level, using a chi-square test ($X^2=16.337$, $df=2$, $p<0.001$).

When we compare our own findings with an independent measure of patient satisfaction from a national GP patient survey (see Methods), we found a negative correlation between the proportion of calls containing patient burden and percentage of patients who are satisfied (Figure 1). GP3 scores the highest of the three services (88% for “experience of making an appointment”; 97% for “finding the receptionist helpful”), followed by GP1 (82% for “experience of making an appointment”; 91% for “finding the receptionist helpful”) and GP2 (59% for “experience of making an appointment”; 82% for “finding the receptionist helpful”).

FIGURE 1 HERE

Figure 1. Satisfaction scores from the national GP patient survey, for the three surgeries studied. Comparing percentage of patients finding “experience of making appointment as good”, and “finding receptionist at the surgery helpful”, with proportion of calls containing patient burden within each surgery.

3.4 Examples of successful practice and reduced patient burden

It is not always straightforward for receptionists to make an alternative offer following rejection: there may be constraints on what can be offered and when. However, as we will see in the final two examples, there are ways of indicating that a relevant service is available, even if it turns out not to be exactly what the patient asked for.

In Table 5, the receptionist suggests the requested doctor is not available to pre-book during the current week (lines 5-6). In the immediate next turn space (line 7) she offers to look for appointments the week after. The patient accepts the offer in line 10. What makes this example different from earlier examples is that the receptionist initiates an alternative offer when faced with a request that proves difficult to meet.

Table 5

GP-143: Receptionist makes alternative offer following non-granting of request

1	R:	Good morning, =Limetown ↑Surgery, =
2	P:	=Good ↓morning, =↑Could I have an appointment to see
3		Doctor ↓<Wilkinson plea:se>¿=
4	R:	=.ptkhhh hh°uh:m° >#let me#< see when the next available
5		one is.=I don't think I've got anything ↓pre bookable
6		this wee:k¿
7	R:	.h[hh] ↑D'you want me to look for the week ↓after:¿
8	P:	[(uhum)]
9		(0.4)
10	P:	↑YES for tomorrow- uh- next week y[es,]

11	R:	[Y]eah?=#Let's °have
12		a loo:k:,°#

In Table 6, R offers to talk to the secretary that has been dealing with P's referral to a hospital (lines 1-2).

Table 6
GP3-111: Receptionist summarises next action

1	R:	.Hh ↑hiya Mister Sinclair, can you ↑leave it with me and I
2		will chase it for you,=the lady- the secretary's not in today,
3		.hhh
4	P:	That's [all]right.
5	R:	[A-]
6	R:	And I will try and find out what's happening for you and give
7		you a rin:g back is th[at alright.]
8	P:	[Ex cellent,]
9	R:	I[t will (be)] tomorrow before I get back
10	P:	[Wonderful,]
11	R:	to: you,
12	P:	Oh that's [absolutely fine, yes abs olutely.
13	R:	[Or the day after alright.]
14	R:	What's the best number to ring you on.

Unlike Tables 4 and 1b, what R does *not* do in line 6 is to initiate a closing. Instead she confirms what she already made explicit: she will find out what is happening. Furthermore, she makes specific two more things: first that she will call back (line 7), and second, that this will be in a given timescale (lines 9 and 13). This kind of specificity is commonly lacking in patient burden calls. P responds with “Excellent,” (8), “Wonderful,” (10) and “Oh that’s absolutely fine,” (12), indicating that this offer is more than satisfactory (see also [14] for endogenous cues to patient satisfaction).

4. Discussion and conclusion

4.1. Discussion

This paper has demonstrated, for the first time, how making a request of GP receptionists, such as to see a doctor, can involve a ‘burden’ on the patient to drive the interaction – and service – forwards (Section 3.1), or push back on premature closings (Section 3.2). We demonstrated how cues to (in)effective call handling within GP practices can be established endogenously, based on observable events in the interaction itself. First, in Section 3.1, we saw how patients pursue an alternative offer following an initial non-granting of their request. We showed that a sub-set of these cases, where the absence of an alternative offer was demonstrably problematic to the patient, can be regarded as instances of ‘patient burden’. In Section 3.2, we identified ‘patient burden’ towards the end of calls. In these cases, while receptionists treated the service transaction as complete, it was demonstrably unclear to patients what offer had been made or how to complete the service transaction. While future arrangements are commonly addressed in closing environments of telephone calls [28], our

analysis focused on how such a move can be a last opportunity to resolve an incomplete service transaction, which patients often displayed trouble in doing.

Our study provides tangible evidence of what drives receptionist-patient calls effectively. We do not argue that receptionists should necessarily offer patients exactly what they ask for, or pre-empt any potential issue in understanding or specification of an offer. Instead, the effective practices we have identified lie in ensuring that patients are clear about where the service encounter is heading, and that the receptionist is committed to driving this process. While interaction is a joint accomplishment, the participants do not always have access to the same knowledge and are not always equipped to assume equal roles and responsibilities. Such asymmetry has demonstrable consequences for how interactions unfold [30], and is fundamental to encounters between medical service and patients [31]. Similarly, patients and receptionists do not have equal access to, or rights to distribute, available appointments, and our paper has demonstrated that calls are more effective when receptionists hearably drive the process towards making and finalising an appointment or other arrangement with the GP service.

The three GP surgeries studied differed in the frequency of ‘patient burden’, a difference which correlated with satisfaction scores from an independent national GP patient survey. Although we cannot be certain that the satisfaction scores are *caused* by the poor practices reported here, what we have managed to identify are the kinds of constituent components that may comprise what patients have in mind, or feel but cannot specify, when they respond to the survey. The ability to demonstrate such patient perceptions gives a clearer understanding of ‘what patients want’ [15], which might very well have implications for patients’ decisions to visit A&E instead of phoning their GP, which remains an important topic for future study.

4.2. Conclusion

This paper shows that, in calls to their GP service, patients frequently drive the call forwards at times when one would expect receptionists to do so: therein lies the ‘patient burden’ as described in this paper. By analysing live encounters as they unfold, we can identify, endogenously, practices that may have a direct impact on patient satisfaction.

4.3. Practice Implications

Until this service evaluation, we knew that GP services differed in terms of patient satisfaction. But without analysing actual calls, how would one know what made the difference? What would one change in terms of receptionists’ behaviour, without knowing what works and what is less effective? Our findings suggest that, by correcting the patient burden problems identified we might very well increase patient satisfaction in lower-scoring surgeries. The study therefore provides the basis for an intervention via training, in which we would expect more positive responses to “experience of making an appointment” post training.

Our training solution is CARM, the ‘Conversation Analytic Role-play Method’, an approach to communication skills training based on conversation analytic evidence [18]. In the training, anonymized audio (and video) recordings are presented turn by turn, as they occur in real time. The difference between a professional being presented with these encounters in a workshop and ‘doing it live’ is that the interaction can stop at any time to address, in slow

motion, what has happened so far and what might (or should) happen next. Group discussions are then informed by the overall patterns we have discovered. Based on the findings presented, GP receptionists can be trained in how, and when, driving the call forwards is so important, and shown two key practices. First, while meeting a patient request with a rejection is often inevitable, what distinguishes (un)successful interactional practice is how such a rejection, or non-granting, is dealt with in terms of alternative offers. Second, summarising the arrangements of a booking (or any next action) towards the end of a call leads to smoother closing of the calls. Overall, receptionists can be trained to optimize their call handling, within the constraints and protocols of service procedures and offers, to achieve better outcomes for patients, as well as, presumably, their own job satisfaction.

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Appendix A. Transcription Conventions

The symbols used in this article are adapted from Gail Jefferson’s [20] transcribing conventions.

<u>Symbol</u>	<u>Definition</u>
.hh hh	Inhalations and exhalations, respectively
Spee::ch	Colon indicates a syllable that is drawn out
To-	Dash indicates a word has been cut off abruptly
<u>Very</u>	Underlining indicates stress or emphasis
(1.4)	Numbers in parentheses indicate length of pauses (in seconds)
.,¿?	Punctuation indicates intonation at the end of units of talk. Full stop stands for falling intonation, comma for flat intonation, reverse question mark for slight rise, question mark for sharp rise in intonation.
[yeah]	
[okay]	Square brackets represent overlapping talk
=	End of one turn and beginning of next begin with no gap/pause in between (usually a slight overlap if there is speaker change)
(words)	A guess at what might have been said if unclear
wo(h)rds	Within-speech breath-bursts (laughter)
WORD	Talk produced loudly in comparison with surrounding talk

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