OUT-PATIENT ORGANIZATION

A SUCCESSFUL APPOINTMENTS SYSTEM IN A FRACTURE CLINIC

BY

F. S. A. DORAN, M.A., M.B., B.Chir., F.R.C.S.

Resident Casualty Officer, Manchester Royal Infirmary

The hospital system of this country is undergoing a process of readjustment to enable it to provide a service to the community which when judged by modern standards will be considered efficient. At present several bodies are striving to become the dominant power in our hospital system. All those responsible for the direction of medical opinion should be aware that a system is only likely to succeed, and endure, in practice if it is based on conclusions drawn from the practical experience of the personnel concerned.

The main object of the personnel of the hospitals must be to provide an efficient service. Howarth (1939) is correct in saying that "it has for a long time been a reproach that at the large London hospitals, in which very considerable numbers of out-patients are dealt with each day, the patients may have to wait, and indeed often do wait, many hours before their case is finally attended to." This disregard of the length of time a hospital out-patient is kept waiting is based upon the opinion that those who cannot pay with money must do so with their time. This is a short-sighted policy: the majority of hospitals are to-day dependent to some degree on contributory schemes, personal donations of their patients, and the efforts of their almoners.

Howarth described the appointments system employed in the ear, nose, and throat department of St. Thomas's Hospital. I understand that it worked satisfactorily before the war. Somewhat similar systems have been attempted at University College Hospital, the Royal Hospital, Sheffield, and the Manchester Jewish Hospital. In this article I describe an efficient method of organizing out-patients.

The Method Employed in the Fracture Clinic of Manchester Royal Infirmary

Type of Material.—The average number of fractures treated each year is about 2,500. The Table, which is constructed from the Infirmary Statistical Report for 1938, shows the number of fractures treated (2,573) and their types. In this clinic all fracture cases are treated as out-patients; in-patients are dealt with in another clinic. The clinic is held each morning except Thursday and Sunday. New fractures admitted to the hospital during the morning are radiographed and seen with their films at the end of the clinic. Reductions are not performed until 2 p.m. The majority of fractures do not need reduction, and at present the patients are kept waiting through poor x-ray facilities and a shortage of nurses who can apply plasters. Patients are given appointments for all attendances after their first.

The Basic Factor.—The basic factor in this system, as well as in the other systems mentioned, is the number of patients that can be seen each hour by the medical staff concerned. The staff in this clinic is one surgeon.

Size of the Appointments Groups.—The standard aimed at is to see each patient within half an hour of arrival; therefore the clinic has been divided into half-hourly groups. The optimum size for each group was found to be fifteen, and the maximum number that could be seen in half an hour was twenty. The plastic quality provided by working at a rate well within the maximum is essential. It means that up to five unexpected patients can be seen every half-hour without upsetting the system. A more exact and ambitious system is too brittle to survive in practice. Too much insistence cannot be placed on plasticity as the fundamental quality of success. The first appointment group is arranged for 9.15 a.m. and the others follow at half-hourly intervals.

Method of Giving Appointments.—Of several methods only one was efficient. The clerk must visit each patient with the surgeon and give the appointment under his supervision. The time, day, and date must all be written on the patient's appointments card. The patients' ingenuity destroyed all the other methods. Gaps will occur between the appointments groups,

wasting the time of the whole staff (surgical, nursing, and massage), unless the rule of filling all the 9.15 appointments before any are given for the later groups is strictly kept. This

Table showing Fracture Statistics for 1938 (2,573 Cases)

Face and Jaw	24
Clavicle	142
Scapula	20
Body	8
Neck	3
Glenoid	4
Acromion	5
Humerus:	
1. Upper end	103
2. Shaft	24
3. Lower end:	
(a) Supracondylar	63
(b) External condyle	30
(c) Internal epicondyle (not in joint)	38
(d) Internal condyle	3
Radius:	
1. Upper end	84
2. Shaft: Greenstick	124
Complete	16
3. Lower end:	
(a) Colles's	359
Smith's	1
(b) Epiphyseal separation	80
(c) Marginal or outer border	19
(d) Styloid process	48
Ulna:	
1. Upper end: coronoid	8
2. Shaft	24
3. Lower end	8
Radius and Ulna:	
1. Greenstick	132
2. Complete: simple	24
3. Monteggia	4
Carpus:	
1. Scaphoid	54
2. Carpal dislocations	3
3. Other carpal injuries	17
Metacarpals and Phalanges:	
Fractures: Simple	316
Bennett	17
Compound	27
Patella	26
Tibia:	
1. Upper end: Tibial spine	6
Epiphysis	9
2. Shaft: Simple	48
Lower end:	
Malleolus	16
(Post-marginal)	2
(Ant-marginal)	1
Fibula:	
1. Upper end	5
2. Shaft	19
3. Lower end (malleolus)	95
Tibia and Fibula (Shaft):	
Greenstick	6
Ankle-joint:	
External rotation type	47
Abduction type	8
Adduction type	4
Separation epiphysis	5
Foot:	
1. Astragalus	4
2. Os calcis	35
3. Other tarsal bones	22
4. Metatarsals and phalanges	223
Compound	15
Dislocations	
Temporo-mandibular	4
Upper Limb:	
Shoulder	76
Elbow:	
(a) Complete (i.e., both bones)	40
(b) Head of radius	2
Hand: Metacarpo-phalangeal	28
Interphalangeal	4
Radio-carpal dislocation	1

rule is waived only on the plea of serious transport difficulties—i.e., a patient living more than thirty miles away may be given an appointment for 10.45 even though earlier times are unfilled.

Documentation of Appointments.—A very simple method is employed. It is exactly the same as that used in a theatre booking-office. In the appointments book a large square divided into twenty small squares is provided for each group, and when an appointment is made one of the small squares

TIME: 9.15				
/	/	/	/	/
X	X	X	X	X
L	L	L	L	L
E	E			

Diagram illustrating specimen from appointments book.

The first row shows the method of recording appointments. The second row shows how they are cross-checked when correctly kept. The third row shows how they are converted into Ls if the patient is late. The fourth row shows how an E is put into one of the five blank squares if the patient attends without an appointment.

is crossed off. Usually only fifteen of the twenty small squares are crossed off in each group (see above). If the appointment is correctly kept it is cross-checked and the patient complimented. Any arrival more than half an hour after the appointed time is considered as late and the corresponding small square is marked L. Such patients must be reprimanded when necessary. Patients who arrive without an appointment for that date are recorded in one of the five blank squares—i.e., E (extra). The accompanying diagram shows a specimen from the appointments book. In a clinic of this type there is no need to record either the names or the serial numbers of the patients. It wastes both clerks and time. Graph I shows that the great majority of the patients attend regularly if not punctually. The more elaborate system of recording names and numbers, as in the St. Thomas's method, is necessary, however, if the patients are to be followed up efficiently over a period of months after the conclusion of their active treatment.

GRAPH I.—Relation of total appointments made to total appointments kept (irrespective of punctuality).

Punctuality of Patients.—Graph I demonstrates that on only five days out of forty-four did the percentage of appointments kept fall below 80%, and it never fell below 70%. Graph II demonstrates that, during fourteen days of testing, the number of appointments correctly kept was between 72% and 91%. Graph III shows in real numbers the close relation between the total number of appointments given and the total number

GRAPH II.—Percentage of appointments correctly kept.

GRAPH III.—Relation of total appointments made to total attendances (from all sources) in real numbers.

of patients who attended. It shows how the number of patients who attend without appointments or on the wrong day almost exactly equals the number of appointments broken. Therefore the scheme as a whole is undisturbed. To check the patients' punctuality the appointments card is placed on the top of the notes for inspection by the surgeon.

Causes of Failure.—Nothing has been said on this subject in the descriptions of the schemes which I have examined. The problems that have presented themselves in this fracture clinic are grouped under five headings:

1. *No Appointment given to the Patient before leaving the Clinic.*—Due to neglect on the part of the medical and nursing staff; the patients' failing to call at the office to get an appointment on their way out; the office being shut (lunch-time, week-ends, and after 5 p.m. daily).

2. *Appointments given, but the Patients Misunderstanding Instructions.*—Due to deafness and mental deficiency or losing their appointment card.

3. *The Wrong Appointment Time given by Careless Medical Staff or Unauthorized Persons* (massage department, porters, women cleaners, other patients, and outside doctors).

4. *A Fresh Appointment not obtained at Each Attendance.*—This proved to be a real difficulty. The patients thought that once they had been given an appointment they were always to attend at that time on their subsequent visits.

5. A correct appointment given, but the patient arriving more than half an hour late or attending on the wrong day.

Local Facilities.—These vary considerably in each hospital, and it is therefore a waste of space to describe in detail the actual arrangements of this fracture clinic.

Additional Problems

New Patients.—The method which has been described proves that old patients can be organized in a practicable appointments scheme. The inclusion of new patients in the scheme, an attempt which Howarth (1939) did not make, might be achieved through the institution of an appointments office with a special telephone line and number which would be staffed by a clerk from 8 a.m. to 10 p.m.: this system has been put into practice by the Royal Sheffield Infirmary and Hospital and the Jessop Hospital for Women at Sheffield, and also by University College Hospital, London. (I have been unable to discover whether these schemes worked efficiently.) The following figures demonstrate that it is well worth while organizing the old patients alone, as in the last two years 70% of the attendances at the orthopaedic out-patient department of this hospital were those of old patients, and the chief clerk of the general office assures me that 50% of the attendances at the general surgical and medical out-patients clinics are also those of old patients. He showed me the figures for a representative month—i.e., November, 1941—to substantiate his statement.

The Teaching of Students.—The teaching of students must, as Howarth recognized, be carried out by a person not required for the routine work of the clinic. It is impossible to evolve an efficient system based on personnel that might take three-quarters of an hour's teaching on one case and only five minutes on the next one. As urgent cases are not out-patients, the teaching material should be selected the previous week by those carrying out the routine work, and brought up at a pre-arranged time for the teacher to take his class.

Conclusions

It is a short-sighted hospital policy to sustain an inefficient and out-of-date system in regard to out-patients.

An appointments scheme is practicable at least for old patients.

The advantages of an efficient appointments system are obvious so far as the patients are concerned. They are also great for the medical personnel for the following reasons: (a) The reputation of the personnel of the hospital is increased by association with an efficient system. (b) It enables medical personnel to know almost exactly at what time they will start and finish their work: this enables them to plan their other work accordingly.

The punctuality, and the determination of the medical personnel to succeed, are the corner-stones of the system.

Any system which is to succeed in practice must be plastic enough to absorb the considerable irregularities imposed on it by human nature.

Teaching must be performed by medical personnel not carrying out the routine work of the out-patients.

A practical efficient hospital system will only be evolved through the efforts of the medical and administrative personnel of the hospitals concerned.

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