

Home visits—the patient's viewpoint

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In New Zealand, where one of us trained and practised for a short period, 'list' sizes average almost 2,500 but are much higher in country areas, and home visiting by the general practitioner is rare. This study was stimulated when it became apparent that in the United Kingdom much more of the general practitioner's time and effort are spent on home visiting. As a Canadian practitioner on exchange has commented "In this area (house visits) English patients' demands and expectations, rather than needs, are met" (Sweeny, 1971).

The rural nature of New Zealand practice is unlikely to be a factor, since Scottish rural practices have a far greater visiting rate compared with English urban practices (Stevenson, 1964; Longmore, 1967; MacDonald and McLean, 1970). Other reasons for the phenomenon have been suggested, in particular 'tradition', and transport differences; and studies have shown that visiting can be substantially reduced in the United Kingdom by conscious effort (Marsh, 1968; Fry, 1969), and the greater use of ancillary staff (Smith and Mottram, 1967; Marsh, 1969; Hasler *et al.*, 1968; Hasler, 1972) and transport services (Seddon and Smith, 1966; Floyd, 1968; Lance, 1971).

Jacob (1963) listed some reasons for 'late' calls (requested after midday), and attempted to assess the personal characteristics of such patients by comparing them with those requesting visits before midday. He lists several reasons given for late requests in non-urgent cases.

A recent report (Lance, 1971) studies preferences for transport service or home visit in convalescent patients, and lists several reasons why patients prefer home visits. Other studies have analysed home visits by age, sex, social class and disease.

Apart from these, little has been reported of the factors involved in a patient's call for a visit, the reasons given for avoiding surgery consultation, and the patient's acceptance of alternative methods. This small survey attempts to assess these points, in a practice not yet providing transport assistance or ancillary staff for new home visits.

The practice

The study analyses home visits, resulting from new requests, made by two members of a six-man partnership working from a large central health centre (with attached nurse-midwives and health visitors) in a prosperous county town. There is very little domiciliary obstetrics. Within the partnership there is considerable overlap of the individual lists, but each doctor cares for roughly 2,250 patients. The practice has a radius of about five miles, and includes two small branch surgeries in outlying villages. The same area, population 43,000, is served by a total of 18 general practitioners.

Method

The first 100 patients requesting home visits by two doctors during a 15-day period were visited at home within two or three days of the doctor's call, and the patient or nearest relative interviewed. The interviewer, a newly arrived trainee, was medically qualified and known to very few of the patients. Calls initiated by the doctor were not included.

Basic information about the patient, distance from the base surgery, and transport and telephone services available, was obtained. The patient was asked to list reasons for requesting a visit rather than coming to the surgery; and the acceptability of alternative arrangements—ancillary staff, telephone consultations, or arranged transport—was assessed.

The opinions of the doctors, interviewer, and receptionist (when relevant), on the urgency and necessity of the call, and possible alternative arrangements, were also recorded.

Calls were classified into those thought to require action within two hours (urgent), from two to 24 hours (semi-urgent), or over 24 hours (non-urgent). The doctors estimated the time involved in each visit but these results were found to be inaccurate, and were excluded.

Results

During the scrutiny 100 new visits were performed. Including visits initiated by the doctors, the ratio of visits to surgery consultations averaged 1:3.5 (Table I). The sample showed a higher proportion of females, particularly amongst the elderly (Table II). Patients over 65 constituted 41 per cent of the sample, compared with a proportion of 12 per cent in the practice as a whole. Most patients lived less than three miles from the surgery (less than one mile, 23 per cent; one to two miles, 39 per cent; two to three miles, 28 per cent; three to six miles, ten per cent). There were three private patients and seven patients in small geriatric homes.

TABLE I
BASIC DATA

	<i>Dr A</i>	<i>Dr B</i>	<i>Total</i>
Survey period (days)	15	15½	
New home visits (survey cases)	49	51	100
Visits initiated by doctor	24	43	67
Surgery consultations	300	285	585
Home visits: surgery consultations	1:4	1:3	1:3.5

TABLE II
AGE AND SEX GROUPINGS (PERCENTAGES)

<i>Age (years)</i>	<i>Male</i>	<i>Female</i>
0-4	9	4
5-14	5	7
15-44	5	10
45-64	7	12
65 and over	8	33
Total	34%	66%
Practice sample	45%	55%

In comparing the two doctors, it was found that Dr B saw slightly more elderly patients, and tended to underestimate the urgency of calls compared with Dr A. In other respects the groups for each doctor were comparable.

Telephone availability

Overall, only 30 per cent of patients had no telephone in the house, compared with a local percentage of 55 per cent for all homes (Table III). More homes of patients aged under five, and aged 15-44, lacked telephones (46 per cent and 40 per cent respectively), although numbers may not be significant.

The absence of a telephone has some bearing on requests for home visits, since a telephone conversation with the doctor would have been an acceptable alternative to 30 per cent of patients lacking a telephone, compared with only 8.5 per cent of those with a telephone. Furthermore, in the opinion of the doctor or interviewer 37 per cent of cases without a telephone could have been adequately dealt with by telephone, compared with 20 per cent of those possessing a telephone.

Transport availability

Many families had cars unavailable during much of the day, particularly families of patients

TABLE III
AVAILABILITY AND ACCESS TO TELEPHONE (PER CENT)

<i>Age</i>	0-4	5-14	15-44	45-64	65+	<i>Total</i>
Own telephone	7	10	9	14	30	70
Neighbour's or public 'phone						
access easy	4	1	2	2	8	17
access difficult	2	1	4	3	3	13
Percentage of age-group with no telephone	46	17	40	26	27	30

under 15. Also, as would be expected, more elderly patients had no transport or used taxis (Table IV).

TABLE IV
TRANSPORT AVAILABLE (PERCENTAGES)

<i>Age</i>	0-14	15-64	65+	<i>Total</i>
'Own' car at house				
generally available	6	15	10	31
unavailable during day	13	5	7	25
Other methods				
available easily	2	9	12	23
available with difficulty (or walk only)	4	3	5	12
No transport (or taxi only)	—	2	7	9
Total	25	34	41	100

Apart from a family car, other methods mentioned (some used several) were:

Bus	.. .. .	28%
Neighbour's or relative's car	.. .. .	25%
Walk (especially parents of under-fives)	.. .. .	19%
Taxi (mostly elderly)	.. .. .	13%

Further analysis of figures shows that in patients without a car, transport is generally acceptable as an alternative to home visits (Table V). This is so particularly in the under 65-age group.

TABLE V
ACCEPTABILITY TO PATIENTS OF TRANSPORT ASSISTANCE
(when considered by doctor or interviewer to be suitable for transportation)

	<i>Alternative transport acceptable</i>	<i>Not acceptable</i>	<i>Transport impracticable</i>
Own car at house	9 cases	22	25
Other methods or no transport	22	12	10

Illness and service required

Illnesses were classified into acute and chronic, and into major and minor conditions. Major episodes (19 per cent) were defined as those severe conditions requiring hospital admission or rapid therapy, or with a risk of fatal outcome, such as respiratory distress, severe pain, or cerebrovascular incident. Most major episodes concerned males, whereas females called for

more minor conditions (Table VI). Older patients called the doctor more often for chronic conditions.

TABLE VI
SEVERITY OF ILLNESS

	<i>Male</i>	<i>Female</i>	<i>Total</i>
Major episodes	12	7	19
Minor episodes	22	59	81

Our disease distribution was similar to that found in other surveys (Baker, 1966), but numbers were not enough for useful analysis.

It was of more relevance to classify the calls by service required. The majority of patients requested the visit to obtain diagnosis and a prescription, but with increasing age, a greater number of other reasons were given. For a few, medical procedures such as suture removal, injection, nasal packing, or ring-pessary changing, were required. For two men, the visit was requested only to obtain a sickness certificate. (Table VII).

TABLE VII
SERVICE REQUIRED
(some patients required more than one)

<i>Age</i>	0-14	15-64	65+	<i>Total</i>
Diagnosis and prescription	22	18	20	60
Diagnosis/prescription and other service	2	10	13	25
Reassurance	2	6	10	18
Prescription only	—	2	6	8
Sickness certificate	—	8	—	8
Admission (acute or geriatric)	—	1	6	7
Medical procedure	—	3	2	5
Other	—	1	2	3

Communication of request

Most requests were communicated by a relative or member of the household (43 per cent); the patient or parent (39 per cent), only 18 per cent were communicated by neighbours or others outside the house (four by ancillary staff). In two cases an apparent emergency was not communicated to the doctor as such; initial advice over the telephone would have been useful. In another case a petticoat hung from a window initiated the request for a visit.

A number of calls (14 per cent) came in after the time specified by the practice (08.30-10.30 hours), mostly from the parents of young children, and the elderly. The doctor took 23 per cent of calls; 16 per cent direct (usually at night) and seven per cent through the receptionist.

Urgency of call

The opinion of the patient or relative, the receptionist, and the doctor visiting, concerning the urgency of the call has, for comparison, been correlated with the view of the interviewer (Table VIII).

We find that the doctor usually agrees, the receptionist is cautious, and the patient tends to overestimate the urgency, particularly with non-urgent calls. Overall in 58 per cent of calls all parties agreed on the degree of urgency.

Eleven patients (mainly elderly) would have found another partner unacceptable if their own practitioner had been unavailable; one even refused to admit the visiting doctor. Another patient specified the day of visit, to avoid being out when the doctor called.

TABLE VIII
URGENCY OF CALL—CORRELATION OF OPINIONS

	<i>Urgent</i> (under 2hrs)	<i>Semi urgent</i> (2–24hrs)	<i>Non urgent</i> (over 24hrs)	<i>Total</i> %
Researcher's opinion (number of patients)	10	51	39	100
Doctor disagrees	–	3	5	8
call more urgent	3	16	–	19
Receptionist disagrees	–	1	8	9
call more urgent	0	1	–	1
call less urgent	0	15	17	32
Receptionist doubtful	8	10	2	20
Receptionist not involved				
Patient or relative disagrees	–	3	10	13
call more urgent	0	1	–	1
call less urgent				
All agree (includes 'receptionist doubtful' cases)	7=70%	29=58%	22=55%	58

Patients' reasons for preferring a visit

Table IX shows that the primary reason given for surgery avoidance is usually a factor associated with the current illness.

TABLE IX
REASONS VISIT REQUESTED RATHER THAN SURGERY CONSULTATION (PERCENTAGE)

<i>Age</i>	<i>Primary reason</i>			<i>Other reasons</i>		
	0–65	65+	<i>Total</i>	0–65	65+	<i>Total</i>
Reasons associated with current illness	73	54	65	50	26	41
Other illness or disability or 'old age'	4	20	10	3	37	17
Lack of transport	13	17	15	30	37	32
Practice administration problems	8	–	5	10	5	8
Other reasons	2	9	5	25	29	27
	100	100	100			

These factors include fever or infectivity, pain, vomiting, deformity or disability; but usually the patient is just 'too ill' or 'in bed'. Occasional visits are due to 'panic calls', or on advice from other medical personnel (usually after hospital discharge).

It is of interest that 15 per cent give lack of transport as the primary reason, and a further 32 per cent list this as a secondary factor. Other reasons for requesting home visits are problems of practice administration (difficulty in obtaining an appointment, waiting time), parking problems, 'custom', 'too busy' or 'inconvenient', lack of a babysitter or accompanying person, risk of contracting infection, 'private patient', or bad weather.

Alternative arrangements

For the purposes of discussion, we have divided calls into those considered unnecessary (alternative arrangements practicable) by both doctor visiting and interviewer; those considered necessary by both (with existing ancillary services); and doubtful cases, usually those in which

the interviewer considered alternatives feasible (Table X). 'Necessary' visits include a few (eight per cent) who could have been dealt with by a specially trained ancillary worker as used by Smith and Mottram (1967) and Hasler *et al.* (1968) for first visits.

TABLE X

OTHER ARRANGEMENTS ACCEPTABLE TO PATIENT, AND CONSIDERED POSSIBLE BY DOCTOR AND INTERVIEWER (PER CENT)

	<i>Opinion of doctor/interviewer</i>			<i>Total</i>
	<i>Unnecessary visits (opinion of Dr and interviewer)</i>	<i>Doubtful necessity (interviewer's opinion only)</i>	<i>Necessary visits (with existing facilities)</i>	
TOTAL (per cent)	42	31	27	100
Male:Female ratio	10:32	11:20	13:14	34:66
Other possibilities acceptable to patient	38	16	8	62
Other possibilities not acceptable to patient	4 (all over 65)	15	19	38
ANCILLARY WORKER				
—acceptable to patient	28	13	7	48
—considered possible by doctor or interviewer	38	20	8	66
ALTERNATIVE TRANSPORT				
—acceptable to patient	25	6	—	31
—considered possible	39	27	—	66
TELEPHONE CONVERSATION WITH DOCTOR				
—acceptable to patient	15	4	1	20
—considered possible	17	8	—	25

Sometimes, ancillary staff were approved only if they could provide or arrange the appropriate sickness certificate or prescription.

A slightly lower proportion of the elderly (54 per cent) agreed to an alternative than in the under-65 age group (67 per cent), although some older patients were hesitant, and may have agreed with persuasion. Younger patients (71 per cent) were more likely to agree with the doctor-interviewer over the question of ancillary workers than the elderly (46 per cent). In a small number of the older patients, the suggestion of transport was rejected because of apparent overtones of 'charity'.

Table X shows more unnecessary calls among females (particularly in the elderly, one male to 17 females). Overall, at least 42 per cent of visits were considered unnecessary, and 62 per cent of patients approved of one or more alternative arrangements. These results are mirrored in the various possibilities agreed. Ancillary staff (usually nurses) were the most popular alternative amongst patients, although doctors and interviewer considered transport to the surgery equally useful. A smaller number would have been happy with a telephone conversation with the doctor.

If several possibilities were acceptable to the patient, as in about half of those agreeing to alternative arrangements, usually the nurse or health visitor were preferred to transport or a telephone conversation.

Several said they were not willing to use transport to the surgery if provided, and yet used

taxis, neighbours, or hospital transport willingly for other reasons. One elderly lady refused the offer of transport "I'm not bad enough for that".

Ancillary workers thought to be appropriate by the doctor or interviewer in each case (sometimes more than one per case) were:

Nurse	..	..	..	..	29 cases
Nurse specially trained in first visits	..			..	21 "
Health Visitor	..	..	..	..	10 "
Midwife	..	..	..	..	2 "
Social worker or voluntary worker	..			..	3 "

It was apparent that several patients disliked the idea of a nurse because they felt she was socially or professionally inferior to the doctor.

Almost one third of visits otherwise considered necessary were felt by the interviewer to be suitable for a specially trained nurse, leaving a hard core of only 19 per cent of cases who definitely required a visit by the doctor.

Discussion

Although the short period of the survey was thought to be representative of the practice as a whole, our numbers are small, with no control group, and the practice serves a non-industrial population. Interviewing, however, was conducted by a single uninvolved observer, thus largely avoiding inter-observer error. The ratio of home visits to surgery consultations (1:3.5) fell near the United Kingdom average of recent years, and well within the national range of between 1:12 and 1.5:1 (Lees and Cooper, 1963; Royal College of General Practitioners, 1970; Lance, 1971). The efficiency of practice communications and appointment systems are factors influencing demand for home visiting, and the survey exposed some defects in our own organisation, a few requests for visits being a direct result of appointment or communication difficulties.

Classification

In classifying home visits by disease, and by urgency, we found similar difficulties to those of other workers. In many cases, although the disease was classifiable, the call was primarily requested for a service. Jacob (1963) has classified calls into emergencies, urgencies and non-urgent cases, depending on the presenting disease or symptom. Although most of our cases fell into one of these categories, we developed a new classification based on the time within which the doctor was required. This allowed easy comparison between the opinions of the doctors and patients about the urgency of the case. Jacob found that 69 per cent of calls (after 12 noon only) were for 'non-urgent' conditions, and Hardman (1966) using the same classification reached similar conclusions. Using our criteria only about 40 per cent of calls were 'non-urgent' (could wait for 24 hours), but this figure becomes 90 per cent if two hours is taken as the time within which 'urgent' cases should be seen.

Telephones

Although more of our sample possessed telephones than the local average, this may merely reflect the age-group or social class of those preferring home visits. Further figures suggested that absence of a telephone does lead to more home visits. The Post Office, however, forecasts 95 per cent telephone coverage of households by 1991, effectively eliminating this factor in home visiting. Our figures suggest that in approximately one quarter of home visit requests, telephone advice from the doctor would have sufficed.

An impression was gained during the survey that if all telephone requests for visits were referred to doctors, the saving in time and effort would amply justify the extra trouble involved, since many calls can be dealt with immediately, and the urgency and suitability for transport or ancillary workers can be assessed. A nurse-receptionist, even specially trained, is unable, on her own responsibility, to suggest alternatives to many of the patients requesting visits.

Transport

Lack of suitable transport was a more important factor than lack of telephones in the demand for home visitation. By asking if organised transport to the surgery would have been acceptable,

it was found that in 31 per cent of patients transport was a major factor, and 15 per cent of patients gave lack of transport as the primary reason for requesting a visit. In recent transport experiments (Lance, 1971) in which only about one half of the patients were offered transport, it was found that 60 per cent accepted this offer.

In assessing the justification for a particular visit it is difficult to be objective. Thorpe (1965) considered that 26 per cent of his visited patients 'could have attended the surgery'. In this study the visiting doctors considered 39 per cent were able to visit the surgery, and the interviewer felt that a further 27 per cent could have come. Thorpe also assessed 16 per cent of home visits as being an 'abuse of services'.

Ancillary workers

Ancillary workers were in many cases an acceptable alternative for first visits, although as Hasler (1972) has shown, special training for the nurse would be required if she is to be fully used in this way. In at least 38 per cent of our cases, an ancillary worker was considered by the doctors to be a satisfactory alternative, and if specially trained nurses were available, up to 66 per cent of calls could have been dealt with in this way. Pinsent (1964) felt that in 48 per cent of home visits, the skills of a nurse would have been sufficient; and Smith and Mottram (1967), and Hasler (1972) use ancillary workers for about one third of new calls. In an area of doctor shortage, full use of ancillary workers would therefore apparently save one half to two thirds of doctors' visiting time. Many practitioners, however, feel that this would deprive them of an important part of the function of a family doctor; but an initial personal conversation with the patient or relative over the telephone, with close daily collaboration with the other health team members, should avoid this sense of loss of contact by both patient and doctor.

On the other hand, there will always be a few house calls thought necessary for fuller assessment or adequate management, and practitioners must be careful to avoid losing this privilege of home visiting.

The study confirmed an opinion that many people still call the doctor to the home through long-established custom, and that a simple but widespread change in attitude would perhaps be the most effective means of reducing time spent on visits. There appeared to be a lack of awareness among many patients of the time and effort involved in a home visit.

Sex differences

Other findings not yet fully documented or explained are the surprising sex difference in *severity* of the presenting illness, and in the *incidence* of home visiting. This latter phenomenon has also been commented on by Lees and Cooper (1963) and Morrell *et al.* (1970), although Scott and McVie (1962), Baker (1966) and Rider *et al.* (1969) in different areas, have shown that home visiting rates per patient are similar in both sexes except in the 15-44 age group (where obstetrics may be a factor). Our female preponderance (66 per cent) is much greater than would be expected by practice sex distribution (55 per cent female) and obstetrics is not a significant factor.

Other findings in this study were those expected, or were in agreement with other work.

Conclusions

Many practitioners enjoy the traditional house visiting, and maintain that in this way they gain a unique insight into the lives and homes of their patients.

However, home visits take two to four times as long as surgery consultations, and involve about 40-50 per cent of doctors' working time (Royal College of General Practitioners, 1970, Lance, 1971). It appears that there is now general agreement that it is of greater overall benefit to the patient if he is dealt with at the surgery, or by other health-team workers, allowing the doctor to use the time saved in more profitable ways, and to be more often available for genuine emergencies.

With the worldwide shortage of doctors, and the emergence of the integrated health team, it is even more essential for general practitioners to look closely at the ways in which non-essential time consuming activities can be curtailed.

Many and varied are the reasons given by patients for requesting home visits. Only too often the patient was able to visit the chemist, shops, or outpatient departments, yet under the

same circumstances the doctor was expected to travel to the house and provide prescriptions, certificates, or reassurance or diagnose and treat under difficult conditions.

To allow a maximum reduction in home visiting, we feel that it is essential to have efficient practice organisation, specially trained ancillary staff, a well-run appointments system, good communications (including direct telephone access to the doctor), transport assistance, and perhaps most important, an active scheme designed to make individual patients, and the general public fully aware of the changing attitudes and the reasons behind them.

In the opinion of Thorpe (1965), Hardman (1966) and other workers, many home visits performed in the United Kingdom involve patients with non-urgent conditions, who could have travelled to the surgery, or been assessed by a nurse. We have confirmed this view, and shown that, in general, such patients are themselves agreeable to alternative methods.

Some of our results cannot be considered statistically significant, but we perhaps explore in greater detail than other workers the opinions and motivation of the patients or relatives themselves; and some points emerge which might encourage further thought and research, or stimulate individual practitioners to re-examine the use of their time.

Summary

One hundred patients were interviewed after being visited by one of two general practitioners in response to new requests. Visits to females were more common, less necessary, and for more minor conditions. There was general agreement about the urgency of a call in 58 per cent of cases; although the receptionist was usually cautious, and the patients often overestimated the urgency.

Patients were classified by 'service' required rather than presenting complaint, and an attempt was made to assess factors preventing surgery attendance. Apart from reasons associated with the presenting illness, the main factors in the demand for visits were lack of transport, disability or old age, and defects in practice administration. Other reasons were listed, and 'custom', and lack of telephone, were also thought to be significant factors.

As an alternative to home visits, up to one quarter of calls could have been dealt with by telephone; up to two thirds could have been transported to the surgery; and up to two thirds could have been initially assessed or managed by ancillary workers. One or more alternative arrangements were acceptable to 62 per cent of patients.

It was considered that more efficient use of the doctor's time by using alternatives to home visiting would be practicable, acceptable to patients, and to the benefit of both patient and doctor.

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