PRACTICE OBSERVED

Organising a Practice

Changes in home visiting and night and weekend cover: the patient's view

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Changes in the work of general practitioners have included a substantial reduction in home visiting and a growing use of rota systems and deputising services for night and weekend cover. These are part of a series of changes that have been made to raise the quality, status, and morale in general practice.

Home visits

The growth in the private ownership of cars may reduce the need for doctors to visit patients in their own homes. Home visits take on average about three times as long as surgery consultations.[1] Thus, making cuts in home visits may be seen as a legitimate move towards making optimum use of the doctor's time. There is ample evidence of a decline in the amount of home visiting that general practitioners do,[2–4] though it still remains relatively high in Britain compared with other Western countries. Since much of the doctor's time has traditionally been spent in this way, what do patients think of this change? Are they aware that it has occurred? Is it an understandable and acceptable way of maximising the benefits of general practice, or is it inevitable but regrettable? Is it really a major cause of dissatisfaction? We try to answer these questions, drawing on data from interviews conducted in late 1977 with a random sample of over 1000 adults in south-west London and Surrey.[5]

Cartwright and Anderson[3] reported that in 1977 19% of adults had received one or more home visits in the previous year. This had fallen from 23% in 1964. The major decline, however, was in the number who received frequent visits: only 3% of patients had received five or more visits in the previous year, compared with 7% in 1964. In our research 17% had received one or more home visits in the preceding year, and 5% received three or more visits. We will discuss the public's perception of the doctor's willingness to visit their homes, focusing particularly on the effects that this change in policy has had on certain groups of people in the community.

The response that patients receive when they ask for a home visit is likely to be an important indication to them of the doctor's attitude. Nearly a fifth of our respondents who had asked for a home visit for themselves and half who had asked for one for a child had at least once been asked by the receptionist to attend the surgery instead. This does not mean that requests for visits were refused, and, indeed, half the adults and a third of the parents had insisted and obtained a home visit the last time that this occurred. Nevertheless, the patient may feel that the doctor is reluctant to come.

Despite policies to reduce home visiting most patients (89% of those who had asked for a home visit from their doctor and 67% of those who had not) thought that their doctor would come willingly if asked. Similar findings emerge from the recent study by the Office of Population, Census and Surveys[6]: 82% said that they thought it would be very easy or fairly easy to get a doctor to make a day-time call. In our study 20% qualified this perceived willingness by commenting that their doctor knew that they would not ask for a home visit unnecessarily, or that the doctor knew there was serious illness in the family. The fact that these qualifications were made spontaneously may indicate that many people are aware of the general tendency to reduce home visits and modify their requests accordingly. On the whole the public do not appear to feel that this change has seriously affected their health care. But behind the satisfactory overall picture there are some pockets of greater dissatisfaction.

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CHILDREN

One group which is especially affected by the reduction in home visiting is children. People with children were more likely to feel that the doctor was reluctant to visit or would not come (18% of parents with children under age 16, compared with 10% among a similar age group of adults without children). This finding is in part likely to be accounted for by the high proportion of parents, especially those aged under 35, who had been asked by the receptionist to take children to the surgery (table I). The study by the OPCS[6] provides further evidence that general practitioners are especially liable to tell parents to bring their children to the surgery when home visits are requested. Parents with small children face particular problems because they are often unable to assess accurately how bad a particular symptom is, and because a child's condition may deteriorate and improve so rapidly. Some parents appear to be happy to take their child to the surgery, but most are not. Sixty per cent of those who were asked to bring a child to the surgery had done so on the last occasion, but two-thirds reported that they were dissatisfied about this.

CAR OWNERSHIP

The reaction of parents—and others—to being asked to come to the surgery will depend in part on whether there is a car available in the household. Requests to come to the surgery may be acceptable if there is a car, but if there is not and the patient is really feeling unwell surgery attendance may be difficult or impossible. Our sample of patients was relatively well off, 72% having at least one car in the household compared with the national figure of 56%, in 1976.[7] There are strong relationships between social class and age and car ownership,[4] and those who are lower down the social scale and those who are elderly are therefore more likely to experience difficulty if the doctor is unwilling to make a home visit. It is possible that people with cars are more likely to be asked by the receptionist to go to the surgery. There was some evidence of this when children were concerned, with 52%, with cars compared to 40%, without cars having been asked to attend the surgery, but among adult patients the reverse was found (table I). These differences are small and not significant and they suggest that receptionists may not be discriminating about patients in terms of car ownership.

ELDERLY PATIENTS

In general, elderly people appear to be less affected by the reduction in home visiting, though we will consider chronically ill patients and housebound patients separately. As expected, older people were much more likely to have had a home visit during the preceding year. Forty per cent of all respondents who were visited three or more times were aged 75 or over. The older that people are the less likely they are to think that the doctor is unwilling to visit—only 5% of those over 65 thought that, compared with 15%, of those under 65 who had asked for a home visit. The OPCS study reports similar differences between age groups.[6] Receptionists were less likely to ask older people who had requested a home visit to come to the surgery—only 13% of those aged over 65 were asked (table I). Doctors and doctors' receptionists may well have a different attitude towards visiting elderly people, either because they think that elderly people will find it more difficult to get to the surgery or because fewer unnecessary requests for home visits are made as age increases. Among elderly people more home visits were reported to those who did not have a car in the household and to those who said that they would have difficulty getting to the surgery—so receptionists may be exercising some discretion when they deal with requests for home visits. Despite this perceived willingness to visit elderly patients, however, a note of caution may be sounded: more than half of those aged over 75 years in Cartwright and Anderson's study[3] and 45% of that age group in our sample had not received a visit from a general practitioner in the previous 12 months. Furthermore, since so many old people now live alone they do not benefit from the doctor's visits to other members of the household.

TABLE I—*Percentage of patients who were asked by the receptionist to come to the surgery when they had requested a home visit on one or more occasions, according to age and whether they owned a car*

	For a child under 16		For self	
	Percentage asked to come to the surgery	Total No	Percentage asked to come to the surgery	Total No
Age of respondent (years)				
Under 35	58	101	25	128
35–64	44	142	18	300
65 or over	—	—	13	130
		p < 0·05		p < 0·05
Is there a car in the household?				
Yes	52	199	17	386
No	40	42	22	167
	Not significant		Not significant	
Total	50	243	19	558

Note. Significance levels are intended only as a guide, since they were calculated on the assumption of a simple random sample, but the actual sample was selected from 50 wards.

CHRONICALLY ILL AND HOUSEBOUND PATIENTS

Not only are elderly patients more likely to live alone but with advancing age they are more likely to suffer illness or disabilities that render them housebound, though not all housebound people are elderly. As we have already mentioned, one of the main changes in home visiting has been the reduction in repeated visits, which suggests that chronically ill patients and housebound patients may now be receiving less attention from their general practitioners. In a study that one of us is doing there is evidence of a lack of contact between highly dependent elderly people and their general practitioners.[8] Sometimes the function of visiting the housebound regularly is taken over by health visitors or community nurses, and usually this is a satisfactory alternative. In our sample there were 32 housebound people, and most were elderly. Only six said that they were regularly visited by their doctor. We were told that the doctor generally "dropped in" while passing, which was very much appreciated. Three said said that they were taken to the doctor by relatives when necessary. Of the remainder a third lived alone, and over half had no transport in the household.

Emergency care—night and weekend work

There has been a definite change over the past 20 years in the management of requests for the doctor to visit when someone is ill either at night or during the weekend—"out-of-hours" visits. What are the patient's views about this aspect of rationalisation in general practice?

Although general practitioners continue to bear 24-hour responsibility for the patients on their list, the advent of group practice has made it possible for doctors to share the responsibility with their partners for night and weekend work. By 1970 up to 78%, of doctors in group practice operated a night rota system, and 71%, for weekends.[3] In addition, commercial deputising services have been developed to meet the demands of doctors to have a reasonable amount of time off duty. What little research there is suggests that these services have arisen in urban rather than rural areas and that single-handed doctors who cannot so easily arrange rota cover are more likely to use them, though in urban areas their use is not uncommon even in practices with three or more partners.[9] Cartwright and Anderson found that by 1977 44% of general practitioners were using deputising services

either occasionally or regularly, and this varied from 56% of those in single-handed practices to 31% in partnerships of five or more doctors.[3]

Newspaper reports have drawn attention recently to growing dissatisfaction with deputising services from both doctors and the public, and the use of these services has been cited as a major cause of discontent.[9] Little attempt has been made, however, to assess patients' acceptance of, or satisfaction with, either deputising services or rota systems.

One-third of respondents said that they had needed a doctor at night or during the weekend, either for themselves or for someone else in the family, during the past five years. We were asking respondents about events that had occurred up to five years previously, therefore our data must be treated with some caution, but only a fairly traumatic event leads most people to call the doctor out-of-hours. If emergency care had been given more than once during this period only the last occasion was asked about. Over a third (36%) had been visited by their own doctor and a further quarter by another doctor from their own practice. Only a small minority were visited by a general practitioner from a neighbouring practice (6%), but 22% had been visited by a deputising doctor. A further 9% had either spoken to a doctor on the phone or been unable to contact a doctor at all. As expected, having seen a deputising doctor was reported more often by patients attending single-handed doctors (35%) and partnerships of two or three doctors (31%) and least by patients attending large groups (12%) and health centres (15%). They were seen more often by patients in south-west London (45%) than in Surrey (9%).

Eighty per cent said that they were satisfied with the medical attention they had received out-of-hours. On the surface this appears to be a high level of satisfaction, but it conceals some serious dissatisfaction. Two factors strongly influenced satisfaction: one was which doctor it was who came; the other was the length of time taken to answer the call. Another study[10] showed that deputising doctors took longer to answer calls than other doctors and that this was a major cause of dissatisfaction. In our study, however, a more complex situation emerged (tables II and III). The most satisfied patients were those who had been visited either by their own doctor (94%) or by another in their own practice (91%), and in both these cases over three-quarters

TABLE II—*Which doctor answered the out-of-hours call and how long before doctor arrived*

	Own doctor (%)	Partner (%)	Another GP (%)	Deputy doctor (%)	Total (%)
Within 20 min	46	41	33	16	36
20 min–1 hour	41	35	29	63	39
1–2 hr	5	15	19	22	13
2–3 hr	2	5	5	0	5
3–6 hr	3	2	14	0	5
6 hr	2	2	—	1	2
Total (%)	100	100	100	100	100
Total No	133	98	21	81	333
					p < 0·001

Note. The percentages in this table have been rounded and therefore do not necessarily sum to 100.

TABLE III—*Percentage of dissatisfied patients by which doctor took the out-of-hours call and the time taken to arrive*

	Own doctor (%)	Partner (%)	Another GP (%)	Deputy doctor (%)	Total (%)	No
Within 20 min	2	2	14	15	4	120
20–60 min	—	—	—	12	3	71
60 min–1·5 hr	3	6	—	39	15	74
1½–3 hr	17	27	25	65	42	45
3–6 hr	50	—	67	100	65	17
6 hr	100	100	—	100	100	6
Total (%)	6	8	19	42	20	333
Total No	133	98	21	81	333	

of the calls had been answered within an hour. Of the small percentage of calls that were taken by neighbouring general practitioners, 62% were answered within the hour and overall there was a high level of satisfaction (81%). Thus it seems that rota systems are on the whole acceptable to patients. Where a deputising system was used, although they did no worse in terms of time than neighbouring general practitioners, the level of satisfaction was much lower (58%). It was, in fact, clear that the likelihood of dissatisfaction rose far more sharply for deputising doctors than for anyone else.

Those who had not had emergency care were also asked who they thought would come if they asked for medical attention during the night or weekend, and whether or not they would be satisfied with this arrangement. Again, there was a statistically significant association between thinking that it would be a deputising doctor who would come and the expectation of being dissatisfied. It is interesting that people who had never had out-of-hours care had a higher expectation of satisfaction (92%)—whoever they thought would answer the call—than those who had actually received emergency medical care.

Since delay was clearly not the only cause of dissatisfaction with deputising services, we were concerned to discover from our respondents' comments why so many were dissatisfied. Several themes emerged: for some it was important to have a doctor whom they knew and trusted, and implied in this was that the doctor should know their past medical history and have access to their medical records; for others it was simply that they felt that the care from deputising doctors was less satisfactory, either because the lack of personal relationship led to a more careless attitude, or because the doctor who visited was too tired to do the job properly; thirdly, came the difficulty that some had had in getting in touch with a doctor—which seemed to be worse when a deputising service was used—and the need to make several phone calls, especially at night, must present particularly serious problems when there is no phone in the home; finally, there was dissatisfaction with deputising doctors who did not have a good command of the English language.

Discussion

Home visiting and the way in which night and weekend calls are dealt with are two aspects of the general practitioner's work that have undergone considerable changes over the past 15 to 20 years. Underlying both are several important issues. Cartwright and Anderson[3] commented that good general practice is less likely to exist when doctors do not see patients in their own homes. They said that the decline in home visiting has been accompanied by a fall in the proportion of patients who regarded their doctor as something of a personal friend. Certainly a unique part of the general practitioner's role is said to be that he or she alone knows the patient in the context of home and family, and that this background knowledge is important both for making an adequate diagnosis and for making decisions about treatment. A home visit is no guarantee that the doctor will retain this knowledge; but conversely, doctors who have never visited their patients' homes are less likely to be familiar with their backgrounds. There is some evidence from the United States, where the number of home visits is now negligible, that one of the advantages of a home-based consultation was that doctors learned more about the home and the family and were more confident in making a diagnosis and discharging patients from hospital, so that patients who were seen in their homes had on average a shorter period of medical surveillance.[11]

In addition to the insights gained by the doctor when he or she knows the patient's home circumstances, background, and family, the patient's feelings about the doctor's care and concern are enhanced. Cartwright and Anderson[3] reported that the number of home visits received by patients was clearly related to general satisfaction with care and also, independently, to a number of other indicators of a satisfactory doctor-patient relationship—such as the ability to talk easily to the doctor and a readiness to discuss a personal problem. In our study patients who felt their own doctor was willing to make home visits reported better communication with their doctor, felt that the doctor was more concerned about them, and had greater confidence in their doctor.

When someone is sufficiently ill to require medical attention outside normal surgery hours this generally implies more serious illness and greater anxiety and for that reason people particularly want to see their own doctor, whom they know and trust, or a doctor from their own practice, who at least will not be totally unfamiliar. This may go some way to explaining the high level of dissatisfaction with deputising doctors. Patients would certainly see it as showing more interest and concern if out-of-hours calls were dealt with by colleagues with whom their doctor communicated regularly and in whom the doctor had confidence.

A related issue is the need for continuity in primary medical care. So far as home visits were concerned, another partner in the practice was usually acceptable to patients, in part because of the anticipated communication between doctors and also because they often knew the partner already. This, and the high level of satisfaction expressed with rota systems for out-of-hours care, counteracts Williams's[5] assertion that in large group practices patients may be no better acquainted with some of the partners than they would be with an unknown deputising doctor. He was, however, talking about groups with as many as 12 doctors as envisaged in the Todd Report,[12] whereas most large groups remain at five or six doctors. The growth of group practice has not eliminated the demand for deputising services, and in large urban areas where such services exist they are used fairly extensively by group practices. The public are somewhat resentful when doctors in large practices resort to using deputising services, since they are well aware that one of the benefits of group practice is that the partners should be able to cover for each other during the night and at weekends.

In a series of in-depth interviews with a subsample of our respondents several issues recurred. Patients were aware that the doctor needed a reasonable amount of time off duty and undisturbed nights and weekends, and they recognised that some reduction in home visiting had been inevitable. Many said that they were very well aware that doctors are extremely busy, and said that they would not ask for a home visit unless they felt it was really essential. In contrast to these views, there are claims in the medical press that a high proportion of calls both during the day and out-of-hours are not "necessary,"[13–15] and it has been suggested that demands for home visits may arise from unrealistic expectations rather than because of "genuine need."[16] The problem for the patient is to make an accurate assessment of the severity and urgency of the symptoms which he or she or a member of the family is experiencing. Parents of young children in particular reported problems in this respect—being uncertain about what symptoms constituted a legitimate reason for consulting the doctor and in being unable to assess severity. Similar findings have been reported elsewhere.[17]

Other sources of anxiety for respondents were about who made the decisions regarding home visits and out-of-hours visits. People were unhappy when they thought that "urgency" or "need" was being assessed by a receptionist, because she is not thought to have the necessary medical knowledge. We have discussed elsewhere[18] that in larger practices and health centres receptionists may impose regulations more rigidly and are more likely to ask patients to come to the surgery when they want a home visit. Similarly, for out-of-hours care all incoming calls may be routed through a telephone operator who will have no knowledge of the patient, and even though the operator's function may only be to inform the doctor of the call, patients may still perceive this as a barrier. Finally, a doctor's knowledge of a patient and the confidence that a visit would be requested only if necessary may be important in assessing the need for an out-of-hours visit and the severity of the illness. The deputising doctor has no such knowledge to help him or her and some respondents claimed that deputies had been overready to minimise the severity and not give effective treatment.

Conclusion

Our research shows that so far as home visiting is concerned the general level of satisfaction remains high, though there are some groups such as people without cars and parents with young children who are more adversely affected. All concerned may need to consider whether the policy of reducing home visits is being applied with sufficient flexibility. On the other hand, it is clear that some discrimination is used because elderly people on the whole seem to have less difficulty in obtaining home visits. Patients who are chronically ill or housebound may be suffering from a reduction in the number of repeat or regular visits from their doctor.

The use of rota systems—either of doctors in a practice or of those from neighbouring practices—for night and weekend cover seems to be generally acceptable though satisfaction is strongly related to the time taken to answer the call. The use of deputising services leads to much greater dissatisfaction, irrespective of waiting time.

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