CLEVELAND LOCAL MEDICAL COMMITTEE

HOME VISITS BY GENERAL PRACTITIONERS

Introduction

The extent of visiting by British GPs is not repeated in any other European or North American country.

From the patients' point of view visiting is convenient; they may be blissfully unaware that domiciliary care in many cases impedes the provision of modern medicine. As far as the doctor is concerned they may well remain unsure as to where they stand in relation to their contractual obligation and might fear that to modify established patterns of visiting behaviour may render them at risk of criticism.

A number of attempts to define the reasons for visiting, or to establish guidelines, have been drawn up in the past including those by Staffordshire Local Medical Committee (1995) adapted by the Cleveland Local Medical Committee for the assistance of general practitioners in 1998. Those guidelines incorporated the views of the local CHCs and the Health Authority welcomed the initiative to clarify access to health care. This guidance was last revised and reissued in March 2004 and is now being circulated to practices and other interested parties to give practices a further opportunity to assess their ways of working.

In this advice, no distinction between "in hours" and "out of hours" has been made. The place of treatment is decided only on a patient's medical condition assessed in a reasonable way by a GP.

Throughout the development of this advice, the quality of medical care offered by general practitioners to their patients has been of paramount importance. The emphasis is that clinical effectiveness must, in some circumstances, take precedence over patient convenience.

Visiting and the New GP Contract

The circumstances when a practice is required to visit a patient are defined in Regulations[1]. A practice is required to attend a patient outside the surgery premises when:

(1) In the case of a patient whose medical condition is such that in the reasonable opinion of the contractor—
  (a) attendance on the patient is required; and
  (b) it would be inappropriate for him to attend at the practice premises

The contractor shall provide services to that patient at whichever is appropriate of the places set out in sub-paragraph (2).

(2) The places referred to in sub-paragraph (1) are—
  (a) the place recorded in the patient's medical records as being his last home address;
  (b) such other place as the contractor has informed the patient and the Primary Care Trust is the place where it has agreed to visit and treat the patient; or
  (c) Some other place in the contractor's practice area.

(3) Nothing in this paragraph prevents the contractor from—

[1] General Medical Services Contracts Regulations 2004, as amended, Schedule 6 para 3
Personal Medical Services Agreements Regulations 2004, as amended, Schedule 5 para 4
Alternative Provider Medical Services Directions (No2) Directions 2005 do not require attendance outside practise premises; contractors should look at their individual arrangements

(a) arranging for the referral of a patient without first seeing the patient, in a case where the medical condition of that patient makes that course of action appropriate; or
(b) Visiting the patient in circumstances where this paragraph does not place it under an obligation to do so.

The key phrase in this formal definition is "whose medical condition is such that in the reasonable opinion of the contractor". In practice this requires a GP to visit a patient at home when two conditions have been satisfied:

1. Does the patient have a medical condition which requires the doctor to see them
2. Is it inappropriate on medical grounds for the patient to attend at the practice premises

If both these are answered YES then the patient should be visited. There is no obligation on a GP to visit in circumstances where the patient's medical condition does not meet these conditions. The LMC will support any doctor who, having used reasonable opinion about a patient's medical condition, receives a complaint relating to a refusal to visit.

Alternatives to visiting and "voluntary" visits

A doctor may arrange for a patient to be referred to another NHS service without seeing the patient if the patient's condition makes that a reasonable alternative. An obvious use of this arrangement is for patients with chest pains, and the chest pain guidelines should be followed and an ambulance arranged rather than a visit undertaken. At other times a doctor may either admit a patient to hospital or make a referral to a community service without visiting them.

A doctor may choose to visit a patient when there is no requirement to do so.

Visits to nursing and residential homes

The status of a GPs patient living in a registered home, either nursing or residential, is no different to any other patient living at their own home. The requirement to visit a patient exists only when there is a reasonable medical reason for the visit and a reason, on medical grounds, why the patient cannot attend the surgery.

Registered homes often give many reasons for patients not being able to attend the practice premises. Many of a registered home's residents travel outside the home for social activities and, unless prevented from doing so by the condition requiring attention, these residents should be expected to attend surgery premises. The absence of staff to provide escorts, or lack of transport is not relevant and the judgement that a GP must make is whether or not the patient is fit to attend.

Preventing problems

As with most areas of complaint, lack of information and confusion about the service available makes a patient or their carer unhappy. Conversely complaints may be pre-empted by adequate information about the reasons home visits are undertaken, and the criteria on which the assessment is made.

The LMC recommends that practices inform all patients, using a combination of practice leaflets, and other publicity, how to request a visit, under what circumstances a visit is justified, and the criteria the practice uses in assessing any request for a visit.

Conclusion

Doctors should only undertake visits when they have made a reasonable opinion that a visit is required on medical grounds.

It is important that, as in all aspects of general practice, the advice is viewed as advice and that the circumstances of every request for a consultation are judged on its merits.

Practices are advised that proper training of reception staff and full, written, protocols for receptionists dealing with requests for access to the services of a practice should be in place.

Proper publicity should be available on the practice's criteria for dealing with requests for visits.

Background for changes to GP home visiting

Quality of medical care

- General practice has never been, and can never be, an emergency service along the lines of the police or ambulance. There is neither the manpower for this, nor the infrastructure e.g. communications, to work in this way. To try and work this way would inevitably harm other aspects of our work. We cannot provide an emergency response service when we are scrubbed-up providing minor surgery to our patients. Neither is it appropriate for a doctor to feel compelled to leave a busy pre-booked surgery to attend a patient at home, who it would seem may be suffering from a serious medical emergency. It is highly likely that the doctor will contribute little to the patient's care above and beyond that offered by the paramedics. Waiting for them to attend may well cause ultimate delay in hospital treatment and, in addition to all of this, the major disruption to many patients' timetable caused by the doctor leaving their surgery patients.

- A doctor's ability to properly assess and to treat a patient seen in their own home is often impaired by the far from ideal clinical situation of poor lighting, unhygienic conditions, and such simple difficulties as soft beds, making it impossible to palpate abdomens correctly.

- As technology moves on, sophisticated tests, treatments and equipment are being increasingly employed to improve care; much of this is not portable and thus not available on home visits.

- Speed of treatment is facilitated by restricting home visiting to those patients who really need it. Others are to be encouraged to attend properly equipped medical facilities where triage can take place, ensuring patients are seen quickly and those that need it, immediately.

- A change of patterns of care during evenings and nights from the traditional model where many GPs each see a few patients through the night at patients' homes, to a situation where fewer doctors see many patients in properly equipped and staffed centres, will result in many fewer patients being treated the following morning by tired, and some may say, less "safe" doctors.

Relationship to the out-of-hours arrangements

- GPs out of hours service involve the provision of out of hours primary health care centres, this change from the 'traditional' approach clearly only functions properly if the majority of patients attend the centres, rather than being visited at home.

International comparison

- No other country has adopted the visiting habits of British general practice.

Issues for the profession

- **Workload**: The workload of British general practitioners has increased greatly over recent years. It seems that it is set to rise further and unless GPs are allowed to deliver care in the most efficient way possible, the system seems likely to break down. If patients are seen at designated centres, rather than their own homes, then quite simply more patients can be attended to by a given number of clinicians.

- **Safety:** Doctors are particularly vulnerable to physical attack when home visiting; walking alone through inner city streets with a black bag containing heroin is far from safe for GPs of either sex.
- **Stress/Low Morale/Poor Recruitment**: Inappropriate demands for home visits are often quoted by GPs as a major source of dissatisfaction.
- **Medico-legal**: The current medico-legal climate is such that it is reasonable for a GP, with some justification, to have reservations about the prudence of making decisions based on an assessment made in the far from ideal clinical setting of a patient's home.

Financial

- **Cost:** Paying highly trained and expensive GPs to spend much of their time driving themselves from house to house makes little sense.

CLARIFICATION & EXAMPLES OF ADVICE IN ACTION

Situation where GP home visiting makes clinical sense and provides the best way to give a medical opinion

- The terminally ill
- The truly bed-bound patient for whom travel to premises by car would cause a deterioration in medical condition or unacceptable discomfort

Situations where, on occasions, visiting may be useful

- Where, after initial assessment over the telephone, a seriously ill patient may be helped by a GPs attendance to prepare them for travel to hospital. That is, where a GPs other commitments do not prevent them from arriving prior to the ambulance. Examples of such situations are:
- Myocardial infarction
- Severe shortness of breath
- Severe haemorrhage

It must be understood that if a GP is about to embark on a booked surgery and is informed that one of their patients is suffering from symptoms suggestive of an acute medical emergency, such as a myocardial infarction, the sensible approach will usually be to summon emergency paramedic ambulance and arrange admission to hospital rather than attending personally.

Situations where visiting is not usually required

- Common symptoms of childhood, fevers, cold, cough, earache, headache, diarrhoea/vomiting and most cases of abdominal pain. These patients are almost always well enough to travel by car. The old wives tale that it is unwise to take a child out with a fever is blatantly untrue. It is not a doctor's role to arrange such transport.
- Adults with common problems of cough, sore throat, flu, back pain, abdominal pain, are also readily transportable by car to a doctor's premises.
- Common problems in the elderly, such as poor mobility, joint pain, general malaise, would also be best treated by consultation at a doctor's premises. The exception to this would be in the truly bed-bound patient.

Request for medical care (usually by telephone)

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GP or other person trained in triage and backed by appropriate protocols
Can the problem be managed by telephone?

YES

GP Provides Advice
± prescription

NO

Could patient travel to the GP by car be reasonably expected to cause undue suffering or deterioration of the patient's condition?

NO

Ask the patient to attend at a timescale appropriate to the problem

YES

Is there reason to believe the condition is so acute/serious that immediate transfer to hospital is appropriate?

YES

Arrange ambulance transport and hospital admission.

If indicated and possible, GP may attend to prepare patient for transfer.

NO

GP arranges appropriately timed visit by GP or other member of PHCT