Home visits in general practice

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De auteur van deze bijdrage is huisarts in Exeter, een stad in het zuidoosten van Engeland, met bijna 100.000 inwoners. Hij is met twee andere huisartsen werkzaam in een groepspraktijk met ongeveer 6.500 patiënten. Daarnaast is hij als Senior Lecturer in-charge verbonden aan de afdeling huisartsgeneeskunde van het Postgraduate Medical Institute van de Universiteit van Exeter.

It was Hippocrates 2,000 years BC, who first noted that it was important for the physician to study man in his environment. Like many of his statements this still holds true today.
Until the eighteenth century care was always based on the home and even hospital care in the eighteenth century was seen as charity rather than as a desirable service in its own right for upper social classes. It was only with the development of the scientific revolution during the nineteenth century and increasingly in the twentieth century that the hospital became established as a central focus of medical care; only relatively recently has it become dominant *(Stevens)*.
In the United Kingdom in 1919 James Mackenzie, one of the father figures of British general practice, founded an institute in Scotland with the specific aim of studying ailments in relation to the environment (*Mair*).

General practice and the role of the hospital

Because the discipline of general practice is relatively new, family doctors throughout the world have had difficulty in defining the aspects and boundaries of our work. In the 1977 James Mackenzie Lecture I suggested that there were six fundamental components of general practitioner care: primary care, family care, domiciliary care, preventive care, and continuity of care, all leading to holistic or whole-person care. I suggested then that none of these are absolutely essential to general practice - all can be delegated either to a colleague in one of the other caring professions, or to a consultant - but that it is the unique blend of them all and particularly holistic care which makes our job a special discipline in its own right.
In clarifying the rising role of the hospital in medical care, it is possible to analyse the trend by a number of different parameters. In Britain, for example, it is possible to show not only an increasing real use of resources on hospital care, but despite recurrent statements by governments of both political persuasions a rising proportion of the spending on health services goes on hospital services. *The Compendium of Health Statistics* has shown in the United Kingdom a falling percentage of the health ,,cake'' being cut for general practice.
Nevertheless, at some time in the 1960s to the 1970s a fundamental realignment in the role of medicine especially hospital medicine, has ocurred simultaneously in Western Europe and the North American continent. This represents a loss of confidence in high technology medicine, a growing challenge by society and critics such as *Illich* and a rising reaction by governments throughout the world against the escalating costs of health services. Perhaps it has also been influenced by the rising morale and status of the generalist in medicine.

Home visiting in the United Kingdom

It is important to recognize the relatively sudden nature of the revolution in home visiting which is well documented in the United Kingdom. In the days of my grandfather who began practice in Exeter in 1895, and throughout the working life of my father who entered practice in 1932, home visiting formed a regular and substantial part of the work of a British family doctor. In 1962, the year in which I entered general practice, seventeen years ago this quarter, home visiting formed a quarter of the number of consultations nationally (*Social trends*). At the same time *Eimerl* and *Pearson* in a big survey showed that general practitioners at that time spent between 40 and 60 percent of their time on home visits.
Yet by the mid 1970s, within only about ten years, both the number and the proportion of consultations taking place in our patients' homes fell, and fell very suddenly. *Kuenssberg* showed that this was not just a European trend, but had occurred across Europe and the United States of America, and in Canada. Indeed when I visited some practices in Canada in 1976 I found some teaching units where home visits had virtually been abolished.
Despite my own interest in home visiting my own rates have been falling too and have been as follows:
1974 - 0.50 home visits per patient per year
1975 - 0.43 home visits per patient per year
1976 - 0.35 home visits per patient per year
1977 - 0.36 home visits per patient per year
I had thought that this was a falling trend, but I found with interest that my most recent figures for 1978 show a figure of 0.43.

The challenge has come from *Fry*, who reported that he had a rate of only 0.1 visits per patient per year. *Fry* has an above average number of patients for the United Kingdom, and so it was necessary to calculate what his rate would be if applied to a general practitioner with an average sized list which in Britain is currently about 2,300 patients. The answer for the average list came to less than one home visit per patient per day.
In the Mackenzie Lecture I asked the question ,,Are home visits going to increase? Should there now be a plateau, or should they fall? If so, should they fall to zero?'' The question in the Netherlands, the question in the United Kingdom is: ,,What is the role of home visiting, is the home visit going to go?''

The case against home visiting

The case against home visits is well known and is much the same in both our countries: a reduced role for bed rest, an increasing amount of time spent in traffic, an increasing value placed by doctors on their own time, and an exchange of roles between different members of the primary health care team, so that visits which were previously done by doctors are now being done by nurses and health visitors. An increasing number of patients have their own transport.

As general practitioners' practices become better equipped, the case for bringing the patient to the services, whether nurses or equipment, becomes stronger. All these pressures are set within a framework of knowing that at the very least a home visit will always take twice as long as a consultation in the surgery. In Exeter, for example, I am able to see eight patients an hour in the consulting room, but only four an hour in their homes.

The case against home visiting can be summed up as the more economical use of services especially equipment and staff.

The case for home visiting

There is, however, a stronger case for home visiting than has previously been put. It is first necessary to examine the tradition of medical education which in the past has centered firmly on the basis of pathology. Yet the Birmingham Research Unit of the British Royal College of General Practitioners showed as early as 1958 that in half the cases at that time the general practitioner simply did not have an intellectually convincing *pathological* basis for diagnosis. In every other consultation the *behaviour* of the patient was either the dominant or at least the major reason for the consultation or the diagnosis.

I should like to tell you a story which happened to me many years ago when I first became interested in teaching. An undergraduate medical student from a famous teaching hospital came to see a little girl with me at home in Exeter. He took a thorough history, carried out a meticulously correct examination and recommended an appropriate treatment which I was pleased to prescribe. When I took him to see the little girl at home three days later he was pained to discover that she was no better at all! In seeking the causes of such a state of affairs he listed lengthy pathological complications, eventually ending with tropical diseases! When I asked his course of action he said he would give powerful drugs by injection, but he did not know why the child was no better. Subsequently, I asked him to look behind the clock on the mantlepiece, and when he did he found that the prescription that we had written together three days ago was still there!

I think that little story illustrates something about the nature of general practice both in Britain and in the Netherlands. General practice is as much about behaviour as it is about pathology, and the physical sign of the prescription behind the clock may be as relevant to the understanding of the child's progress as elucidating a physical sign in the chest. One of the underrated skills of general practitioners for many years has been the accurate assessment of the capability of a household to care for one of its sick members which is indeed one of the stated objectives for the vocational training scheme in the University of Exeter.

In short, looking behind the clock is part of our job.

The behavioural sciences

A study of many of the behavioural sciences suggests that valuable insights can be obtained by general practitioners who are prepared to consider their patients' problems within a framework of the behavioural sciences. In anthropology, for example, it is already well established that it is always necessary to study the behaviour of animals in their natural habitat and that studies in zoos, although important, are limited. Top class naturalists work in the field. Who are we to say that the same is not true for man?

Significance of social class. I was most impressed when I first learnt of the change in infant mortality among babies born in social classes five and one. In the mid 1930s the death rate of babies under the age of one in England was about 80 per thousand for social class five, and only about 40 per thousand for social class one.

Twenty years further on after a series of unprecedented revolutions in health care in our countries one would expect great differences. They came. Those twenty years saw the introduction of antibiotics, none of which were available in the mid-1930s, but which were readily available at the stroke of a pen for every general practitioner in Europe in the 1950s. Simultaneously in my country a free comprehensive National Health Service was introduced which made free general practitioner and specialist care available to every woman and child in the country. Yet another fundamental revolution was the introduction of specialist paediatricians and obstetricians, neither of whom were available in Exeter in the 1930s, both of whom were well established in the mid-1950s, and finally came a bloodtransfusion-service as well as an understanding of the importance of antenatal care. All became available in those twenty years.

Yet what do we find? The infant mortality rate in social class five in the 1950s was about 40, and social class one had fallen to only 20. The 2:1 ratio had persisted in spite all those revolutions and furthermore, a further look at those figures is of interest. It appears that it was as safe to have a baby in Exeter delivered at home by a general practitioner who gave the mother little or no antenatal care, who had no antibiotics, no blood transfusion service, no paediatrician or obstetrician to call upon, as it was to have a baby for a social class five mother twenty years later even with antibiotics, blood services, obstetricians and paediatricians all readily available.

I learnt then and I know now that figures like these underline the importance for all of us of the educational and behavioural aspects in medical care. If such factors have such dramatic effects on the deaths of babies, how much more are they likely to have on illness?

Territory. In all behavioural sciences territory emerges as a topic of immense importance, and it was first discussed in relation to general practice by *Hodgkin* in his Mackenzie Lecture. All the evidence suggests that animals behave differently on their own territory. Surely as the domiciliary doctors we of all doctors should be prepared to stand up and say that we know that children behave very differently at home - as most mothers tell us almost every day in our consulting rooms! There is no better place to observe relationships, no better place to observe patterns of behaviour which are increasingly recognized to be associated with and increasingly to cause ill health.

Behavioural causes of morbidity and mortality. Lalonde showed as a government minister that the principal

causes of both death and disease in Canada at that time are primarily behavioural. It follows inevitably that the greatest need, the greatest action to counter the mass of death and disease must be by behaviour.

The home is the battle ground, the home is the boundary, where the transition from health to illhealth and back again takes place. The home is where we have our most important relationships, and where most of us spend most of our lives.

As early as 1960 *Hodgkin* in a classic study showed that the prevalence of upper respiratory tract infections was statistically significantly greater in his patients living in caravans that living in houses. Other studies, including *Fanning* and *Richman*, confirm this finding in the United Kingdom.

Serious physical diseases

Most of the arguments in favour of home visiting have in the past lain in the realm of the psycho-social aspects of medicine, in the so-called behavioural sciences. General practice, however, will always stand on the two legs of both the behavioural and the pathological sciences. Quite apart from the numerous and powerful arguments in favour of the behavioural sciences, and the behavioural aspects of medicine, there is growing evidence in the United Kingdom that in the management of a physical diseases the home has unrealised potential for care.

The trend in terminal care has in recent years been steadily away from the home; my country has accepted the taboo on death. I believe that the proportion of patients who will die at home may yet turn again; certainly in my own practice it is becoming much more common for patients with cancer to be cared for and to die at home.

As far as home deliveries are concerned the Netherlands have a distinguished record, and one of the highest proportions of home deliveries taking place anywhere in Europe, with a remarkably low perinatal mortality rate. In my country home deliveries have fallen so far that now far less then five per cent occur at home at all.

Nevertheless, in another aspect of care the British general practitioner may be able to offer colleagues in the Netherlands a wider perspective in medical care. I understand that in the Netherlands it is usual for patients with myocardial infarction to be admitted immediately to hospital, and that large numbers are admitted even for chest pain which has not been confirmed as a coronary thrombosis.

I would like to draw attention to an interesting article by *Mather et al.* This was important because it was the follow-up of a previous study by Mather, a specialist physician in Bristol in the West of England, which examined in great detail, and for the first time in the United Kingdom the results of a prospective randomly selected home-versus-hospital care for proven myocardial infarction.

The trial was concerned only with men under the age of 70 because of the obvious social difficulties in admitting women to hospital. The hospital care when provided invariably involved 48 hours in a coronary care unit with full and intensive cardiac monitoring. The diagnosis in each case was proven beyond doubt by changes in both enzymes and domiciliary electrocardiagrams, and was confirmed by a research registrar.

Practitioners participating selected from sealed envelopes on a random basis home versus hospital admission policy. At 28 days the death rate in the home was 12 per cent, and the death rate in the hospital was 14 per cent. By 330 days, i.e. almost a year, the death rate in the home was 20 per cent and the death rate in the hospital was 27 per cent. Furthermore, in the group of men aged over 60 there was a statistically significant advantage in being cared for at home. In all, the relative increased risk of having one's coronary thrombosis treated in hospital rather than at home, at least for a man resident in the south west of England, is 1.35 to 1.

The explanations are not yet clear. There is good evidence that in hospital intensive cardiac monitoring can reduce the death rate by detecting and treating arrhythmias. What, however, is becoming increasingly suggested in the United Kingdom is that the move to hospital, and the emotional distress of intensive monitoring, may in itself initiate more episodes than occur at home; furthermore, that the emotional strain may actually, and apparently does, outweigh the other benefits of hospital care. Other studies have since confirmed these findings (*Colling*).

There are enormous and tremendous professional issues involved. This study is carried out only just in time because even by the mid-1960s it was becoming clear by convention that a growing number of hospital doctors and many general practitioners were beginning to assume that in some way coronaries were better cared for in hospital.

Findings like these challenge all of us as family doctors to remain flexible and tolerant to new ideas, even when those new ideas are old ideas coming back! It has been said that one of the most important capacities which we must instil into our vocational trainees is an open-mindedness and a readiness to accept change in the light of new evidence.

Conclusion

In conclusion I would like to suggest that the tradition of home visiting, so strong in the Netherlands and in the United Kingdom, may be an even more important part of general practice than has previously been recognized.

For the future, I believe there is an urgent need for us to work together in collective studies; to begin to evaluate for the first time in our discipline the tangible advantages which can be obtained from home visiting. These will have to be demonstrated by prospective randomly-selected trials which will seek to identify, first of all the information gained, secondly the value to patients including their attitudes and comfort, and thirdly comparative outcomes, like *Mather's* study. Only in this way will it be possible to build up a scientific basis of modern general practice.

In my Mackenzie Lecture I suggested that the scientific advance of miniaturization would give new opportunities and new challenges for us and our successors in the home in the future. I said then and I believe now that machines at which today we merely marvel will become the everyday tools of the general practitioner of tomorrow. Portable electrocardiagrams and miniature peak flow machines will be seen as but the beginning. Mini-computers are coming.

I am confident that the dangers of abolishing home visiting as has so nearly happened in the North American continent can yet be resisted in Europe. Working in our patients' homes has been one of our greatest privileges: it may yet prove one of our greatest strengths in the years to come.

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Nota Bene

Depressieve toestanden bij ouderen kunnen bedriegelijk gelijken op dementiële beelden. (Stelling bij het proefschrift Een vorm van systematiek in de verpleeghuisgeneeskunde, J. Trommel, Groningen 1979).

Der Hausbesuch in Deutschland

PROF. DR. K. SCHIFFNER

Zoals ook elders het geval is, daalt in Duitsland bij een stijgend aantal verrichtingen het aandeel van de huisbezoeken, zij het dat op het platteland de visites nog altijd een belangrijk deel van de dagtaak van de huisarts in beslag nemen. De auteur, docent in de huisartsgeneeskunde aan de Universiteit van Tübbingen, acht het huisbezoek een wezenlijk deel van de taak van de huisarts: ,,Ihr musst ans Krankbett gehen, denn nur dort könnt Ihr etwas von der Krankheit lernen''.

Der Hausarzt in Deutschland

Der Begriff ,,Hausbesuch'' ist automatisch mit dem Begriff ,,Hausarzt'' in Verbindung zu bringen. Dieser Letztere bedeutet in Holland etwas anderes als bei uns. Zur Begriffsklärung ist Folgendes zu sagen: Bis zum Jahre 1970 entsprach dem holländischen ,,Huisarts'' in Deutschland der praktische Arzt. Diese Bezeichnung konnte sich jeder approbierte Arzt mit der Niederlassung zulegen. Für die Behandlung von Kassenpatienten waren vorher 18 Monate Vertreter- oder Assistentenzeit in Krankenhäusern und bei einem freipraktizierenden Kassenarzt erforderlich.
1970 wurde die Allgemeinmedizin durch die Weiterbildungsordnung zu einem eigenen Fach so wie andere Spezialfächer. Dieser Arzt für Allgemeinmedizin braucht eine vierjährige Weiterbildung nach Studienabschluß mit festgelegten Zeiten für Innere Medizin und Chirurgie und einer mindestens vierteljährlichen Weiterbildungszeit bei einem Allgemeinarzt.
Die Weiterbildung dieser Allgemeinärzte, die den früheren Praktiker ablösen sollen, stößt auf Schwierigkeiten. Dies deshalb, weil für die weit über den Bedarf hinausgehende Zahl der Medizinstudenten in Deutschland bei einer gleichzeitigen Reduzierung von Assistentenstellen an den Krankenhäusern die nötigen Weiterbildungsstellen fehlen. Wir haben bei einem Ersatzbedarf von 6 bis 7.000 Ärzten jährlich zur Zeit. Studentenzahlen von 12-13.000.
Ab 1980 gibt es nach den Bestimmungen der Europäischen Gemeinschaft keine Verpflichtung zu einer Krankenhaustätigkeit vor der Niederlassung mehr. Es besteht daher die Gefahr, daß sich junge Ärzte ohne oder mit nur sehr kurzdauernder Krankenhaustätigkeit gleich nach Erhalt der Approbation niederlassen, da die entsprechenden Weiterbildungsstellen fehlen. Dies bedeutet, daß sie auch zur Behandlung von Kassenpatienten zugelassen werden müssen, da ein Rechtsanspruch auf Zulassung besteht.
Dazu kommt eine weitere Tatsache. In den letzten Jahren haben sich eine große Zahl junger Ärzte zu Internisten weitergebildet. Diese Zahl übersteigt bei weitem sowohl den Bedarf der Krankenhäuser an Internisten als auch den Bedarf der freien Praxis an dieser Arztgruppe, soweit man darunter konsiliarisch tätige Fachärzte versteht. Ich muß noch ergänzen, daß in Deutschland die ambulante Versorgung sowohl von Allgemeinpraktikern als auch von Fachärzten duchgeführt wird, letztere also nicht nur an Krankenhäusern tätig sind. Die große Zahl von Internisten hat nun zur Zeit an Stelle der aufgrund ihrer Altersschichtung ausscheidenden Praktiker Hausarztfunktionen übernommen. Ähnliches gilt für die Kinderärzte für deren Arbeitsbereich. So faßt man unter dem Begriff ,,Hausarzt'' in Deutschland die Allgemeinpraktiker, sowie die hausärztlich tätigen Internisten und Kinderärzte zusammen.

Entwicklung der Hausbesuche

Frühere Hausarztgenerationen haben ihre Tätigkeit weitgehend in Form von