MEDICAL PRACTICE

General Practice Observed

Survey of Home Visiting by General Practitioners in North-east England

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Summary

A total of 190 general practitioners in North-east England recorded the details of each home visit they made during a two-week period towards the end of 1969. Altogether 17,200 visits were made and these have been analysed. Two major points emerge: firstly, the extreme variation in visiting habits by general practitioners; and, secondly, the feeling that many home visits were unnecessary.

Introduction

As doctors have become more conscious of the need to audit their work before they analyse its content and its necessity there have been many reports of the change in the number of home visits. Most of the previous reports, however, dealt with relatively few practices, and hence the Practice Organization Committee of the North-East England Faculty of the Royal College of General Practitioners decided to survey the visiting habits of many general practitioners in their area, particularly to determine the amount of visiting taking place in North-east England, to analyse its clinical content, and to evaluate its necessity.

Method

Every Member and Associate of the Royal College of General Practitioners living in the North-East England Faculty (the counties of Northumberland, Durham, Cumberland, and the northern edge of North Yorkshire) were invited to take part in the survey. They were also asked to recruit colleagues who were not Members or Associates of the College who might be interested in taking part. In the event half of the participants were Members or Associates of the College and half were not.

Every visit that the participating doctors carried out from Monday to Friday during two consecutive weeks in 1969, 24-28 November and 1-5 December, was recorded on specially designed forms. This particular fortnight was chosen because it was thought to be a time of moderately heavy work load in general practice and not distorted by holiday periods or epidemics.

The form that was completed for each visit initially ascertained the main diagnosis for the visit and whether this was a new or a repeat visit. Subsequently diagnoses were coded according to the International Classification of Diseases. The time that new visits were requested was recorded, and if it was a repeat visit the interval since the last one was also ascertained. The time and place of the subsequent consultation, if any, were detailed and whether it was to be carried out by a doctor or a nurse. Questions were included to try to determine whether home visits were necessary, whether the patient was in bed, whether any clinical examination was performed beyond feeling the pulse, and whether the patient was sent to hospital.

Doctors were asked whether they thought the patient could have come to the surgery rather than request a visit at home after making allowance for any extenuating social circumstances. If the doctor thought that the patient could not have attended he was asked whether he could have come by a minibus collecting service. The doctor was asked to state whether the patient was on his regular chronic visiting list—namely, “a patient who had been visited for that condition for the past three months and was

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likely to be continued to be visited for the next three months." Finally, the patient's age, sex, and social class (Registrar General's classification) were ascertained.

Each doctor was asked to complete a profile of his practice which included his date of qualification, the number of his partners, and whether his practice was interested in operational activities, such as keeping work-load statistics, using age/sex registers, and employing nurses and secretaries. The use of an appointments system was also noted. The doctor was also asked to indicate in which area he worked (the areas being classified into four according to density of population). Finally, doctors were asked how many patients they saw in their surgery during the 10 days.

A total of 190 doctors completed the survey and 94 practices were represented. In 49 practices every member of the practice took part. The material collected was analysed as follows.

Overall Visiting Work Load

Altogether 17,204 home visits took place in the 10-day period, an average of 94 per doctor or nine per doctor per day; 8,599 (50%) were new acute visits, 5,232 (30%) were revisits for acute illness, and 3,373 (20%) were routine visits to patients on a chronic visiting list. On average, doctors made 45 new acute, 28 repeat acute, and 18 chronic visits in the 10-day period.

Repeat/New Visit Ratio.—The overall ratio of these was 0.94. Nevertheless, 29% of doctors had a ratio of 0.5 or less, 25% a ratio between 0.5 and 1.0, 24% a ratio between 1.0 and 1.6, and 22% of doctors had a ratio greater than 1.6.

Diagnostic Groups.—Respiratory infections accounted for half the new calls in general practice and over one-third of the total visiting work load (Table I). Over 10% of the total visiting work load was for diseases of the circulatory system.

TABLE I—Percentage of Total and New Visits in Each Classified Category

I.C.D. Disease Category	Percentage of Total Visits	Percentage of New Visits
Respiratory diseases	37.6	49.4
Circulatory diseases	11.0	4.5
Nervous and special senses organs	6.7	5.1
Digestive system	6.4	7.8
Symptoms, senility and ill-defined	6.4	6.1
Infectious diseases	5.0	5.8
Bones and joint	4.85	3.4
Trauma	4.3	4.7
Neoplasms	3.2	0.8
Mental and emotional	2.9	2.7
Pregnancy	2.9	2.1
Genitourinary	2.7	2.7

Follow-up of New Visits for Respiratory Diseases.—Only 48% of the new visits carried out by doctors were followed up—18% in the surgery and 30% at home. The ratio of return to new visits in diagnostic groups is shown in Table II. Though respiratory diseases were by far the commonest cause of the doctor being called the revisiting ratio for respiratory diseases was almost the lowest. There were 4,340 new calls in this category but only 2,129 revisits were made. Only 23.6% of

TABLE II—Ratio of Return New Visits by Diagnosis

I.C.D. Disease Category	Return/New Visit Ratio
Neoplasms	7.0 : 1
Circulatory	3.7 : 1
Blood disorders	2.85 : 1
Congenital abnormalities	2.0 : 1
Bone and joint	1.77 : 1
Pregnancy, etc.	1.71 : 1
Nervous and special sense organs	1.56 : 1
Allergic, metabolic, etc.	1.22 : 1
Mental and emotional	1.07 : 1
Symptoms, senility and ill-defined	1.05 : 1
Genitourinary	0.96 : 1
Trauma	0.69 : 1
Infectious diseases	0.68 : 1
Digestive diseases	0.62 : 1
Respiratory	0.49 : 1
Diseases of early childhood	0.42 : 1

the 1,716 new cases of upper respiratory tract infection were revisited by the doctor. Of 1,042 cases of acute bronchitis 498 (47.8%) were revisited. Similarly, only 89 (20.5%) of 443 new cases of tonsillitis were revisited. Of the 89 new cases of pneumonia 49 (55%) were revisited on the next occasion by the doctor and 34 (38.2%) by the nurse.

Follow-up of New Visits for Circulatory and Other Diseases.—Patients with circulatory diseases were revisited more frequently. Of the 105 cases of coronary artery disease 55 (52%) were revisited by the doctor, though it is not known how many of these were acute new episodes. There were 681 new visits and 421 revisits for diseases of the digestive system, 267 being for cases of enteritis, of which 50 (18%) were revisited by the doctor. The commonest infectious disease was measles. Out of 134 cases 70 (52%) were revisited by the doctor and 49 (37%) by the nurse. Thirty new cases of infectious hepatitis out of a total of 40 were seen on the next visit by the doctor and six by the nurse. Few patients with the other infectious diseases were revisited to any extent. Most revisiting by the doctor was done on one of the three subsequent days. Thirty-six acute revisits (14%) were made on the same day, nine in cases of coronary artery disease, three in cases of asthma, and eight in cases of ill-defined conditions where there was probably some doubt about the diagnosis.

Day of the Week.—On Mondays general practitioners received 28% of their new calls; on Tuesday 19%, and on Wednesday, Thursday, and Friday either 18% or 17%. Twenty-three per cent. of the revisits in acute cases were on a Monday and the proportion fell to 19-17% for Tuesday, Wednesday, and Thursday though rose to 22% on a Friday, presumably to tidy up visiting work before the week-end. The figures for chronic calls for Monday to Friday were respectively 23%, 22%, 19%, 16%, and 17%, indicating that most chronic revisiting was done in the early part of the week and less towards the end of the week.

Effect of Age of Patient.—Though patients under 1 year constituted only 1.72% of the population, in fact 12% of new visits were done for this group (Table III). Patients aged 1-4 had

TABLE III—New Calls by Age of Patient

Age (Years)	Percentage of All New Visits	Percentage Population in Age Group
<1	12.21	1.72
1-4	11.09	6.96
5-14	17.26	15.98
15-44	21.74	39.31
45-64	18.12	24.41
≥65	19.48	11.62

twice as many visits as would have been expected from their frequency in the population. As expected, the over-65s represented 11% of the population and requested 20% of the new visits.

Timing of New Calls.—Eighty-two per cent. of new calls for family doctors were made between 8 and 10 a.m., and only 3% between 8 p.m. and 8 a.m. (Doctors using professional deputizing services at any time were excluded from this analysis.) Fifteen per cent. of the calls, however, were "late" in that they were made between 10 a.m. and 8 p.m. Infants and the over-65s accounted for a disproportionately high number of these calls and patients aged 15-44 the highest proportion of night calls (Table IV).

TABLE IV—Time of Day when New Visits were Requested (Percentage of Patients)

Age (Years)	8 to 10 a.m.	10 a.m. to 8 p.m.	8 p.m. to 8 a.m.
<1	78.16	18.08	3.74
1-4	85.74	11.86	2.40
5-14	87.29	11.17	1.54
15-44	80.86	14.92	4.22
45-64	82.33	14.84	2.83
≥65	80.04	16.34	3.62

Referral to a Nurse.—Fourteen per cent. of patients receiving acute visits and 17% of those receiving chronic visits were referred to a nurse for their next consultation. The respiratory diseases constituted the largest group of new cases referred to the nurse for the next visit, followed by measles (36.6%) and chickenpox (25%); the percentages for the 181 cases of acute suppurative otitis media and the "ill-defined" group of conditions were 15.7 and 15.2 respectively.

Admission to Hospital.—Of the 8,876 new calls received, including 277 new calls from chronic cases, 247 (2.8%) patients were admitted to hospital (Table V). Though highest in numbers,

TABLE V—Commonest Individual Diseases in Patients sent to Hospital direct from Visit

Disease	New Visit	Revisit	Total
Acute and chronic bronchitis and asthma	20	30	50
Coronary thrombosis	16	15	31
Pneumonia	21	6	27
Heart disease (not specified)	7	17	24
Cerebrovascular accident	14	19	33
Acute appendicitis	16		16
Gall bladder disease	6	2	8
Gastroenteritis	6	2	8
Peptic ulcer	3	2	5
Intestinal obstruction	4	1	5

proportionately few patients with respiratory diseases (1.25%) were sent to hospital. From new visits, digestive disorders (6%) and cardiovascular diseases (6%) were the categories requiring most frequent admission to hospital, while from repeat visits neoplasms had the highest proportional admission rate.

Chronic Work Load.—The commonest individual diagnoses for patients on the chronic visiting list (Table VI) were non-

TABLE VI—Commonest Disease Category, I.C.D.—Chronic Diseases

Disease Category	%
Circulatory	29.08
Nervous disease	12.27
Respiratory	11.02
Bone and joint	10.58
Neoplasms	10.52
Ill-defined and senility	7.14
Mental, etc.	3.67

specified diseases of the heart, myocardial degeneration, and chronic bronchitis. Of the total visits 631 (21.8%) were made less than seven days after the previous one, particularly to patients with neoplasms and respiratory diseases, compared with those with diseases of bone and joints or nervous diseases. A total of 576 cases (19.3%) were seen after seven days, 584 (20.2%) after 14 days, and 1,109 (38.2%) after a longer interval.

TABLE VII—New Calls from Patients who Could have Come to the Doctor by Age Group

Age (Years)	Total New Calls from Patients who Could have Come			Percentage who Could have Come
	Male	Female	Total	
<1 ..	179	208	387	55
1-4 ..	183	160	343	35
5-14 ..	289	244	533	35
15-44 ..	183	354	537	28
45-64 ..	134	206	340	21
≥65 ..	65	163	228	13

Effect of Social Class.—Patients of Social Class V had almost twice the number of visits that one would expect from the social class distribution for the area. Nevertheless, while the overall ratio of repeat to new visits was 0.94, for social class I it was 1.6 and for social class V it was 0.8.

Attendance/Visit Ratio.—The overall attendance/visit ratio was 3.04.

Effect of Area on Visiting Work Load

For analysis the region was divided into four types of area. Sixty-seven (35%) doctors worked in large urban areas (population of 200,000 or over), 39 (20.5%) worked in large towns (population between 50,000 and 200,000), 62 (33%) worked in small towns (population less than 50,000), while 22 (11.5%) worked in truly rural areas qualifying for a mileage allowance.

Overall Work Loads.—The rural doctor made an average of 73 visits in the 10-day period (Table VIII), doctors in medium

TABLE VIII—Average Number of Visits per Doctor by Area

Area	Type of Call			Total
	Acute		Chronic	
	New	Repeat		
Large urban	42.7	26.1	17.0	87.3
Small urban	51.0	23.9	9.3	85.6
Medium urban	50.0	32.5	19.3	103.4
Rural	29.6	24.6	18.0	73.0
Total	45.3	27.5	16.3	90.6

urban areas 103, and doctors in the conurbations and in small-sized towns about 86. Nevertheless, these figures have to be considered in relation to per thousand population for which the doctors are responsible. Thus the doctor in the country and in small towns made more visits per thousand patients on his list in the 10-day period than did the doctor in a medium town or a large conurbation (Table IX). For acute new calls, however,

TABLE IX—Average Number of Visits per Doctor per 1,000 Patients on List

Area	Type of Call			Total
	Acute		Chronic	
	New	Repeat		
Large urban	16.3	10.0	7.1	33.4
Medium urban	18.1	8.4	3.8	30.3
Small urban	20.0	13.0	8.4	41.3
Rural	15.7	12.9	9.9	38.3

there was little difference. It was his revisiting rate which made the country doctor and the doctor in the small town have a higher visiting rate per thousand population. The extra heavy chronic load in the country and in the small town also adds to the burden of these doctors.

Follow-up of Patients.—In medium urban areas 24% of the calls were followed up at home; the corresponding figures for small urban areas and the conurbations and country areas were 34% and about 30%. Conurbation doctors followed up 19% of their calls at the surgery, and country doctors 13%.

Timing of Calls.—Conurbation doctors had a slightly higher proportion of calls in the morning (82.6%) than the overall average (80.1%). They had a smaller percentage of calls between 10 a.m. and 8 p.m. (12.6% compared with an average of 14.4%) and the smallest proportion of night calls (2.7% compared with an average of 3.1%).

Diagnostic Groups.—In rural areas less respiratory disease but more circulatory disease was seen than in the urban areas. Relatively more visits were made to pregnant patients and confinements in the medium urban areas and least in the small towns, possibly reflecting the availability of obstetric units. Trauma was highest in the rural and small town areas compared with the larger urban areas. Rural practitioners revisited patients with infections and respiratory diseases more frequently than town doctors. Those in the medium urban areas revisited almost all patients less frequently than doctors in other areas.

Effect of Social Class.—The ratio of return to new visits for social class I was 2.2 in large urban areas and 1.4 in medium urban areas. In small urban and rural areas revisiting was almost equal throughout the social classes.

Need for Visiting.—Twenty-two per cent. of new visits by rural doctors were to patients whom the doctor thought could have visited the surgery, compared with 31% for medium urban area doctors and 24% for conurbation doctors. In only 9% of chronic visits did doctors think that the patient could have come to the surgery, but if a minibus had been available they thought that 45% could have come. The proportion was as high as 49% in rural areas and about 33% in towns.

Attendance/Visit Ratio.—Doctors in large urban areas had the lowest attendance/visit ratio at 2.86, while the ratio in medium urban areas, small towns, and rural areas were respectively 3.35, 3.02, and 3.17.

Size of Practice

Altogether 16 (8%) of the doctors were single handed and 34 (18%) worked in two-man practices. There were 62 (32.6%), 26 (13%), and 37 (19.5%) doctors respectively in practices of three, four, and five partners. The survey also included one partnership of six and one of seven doctors, all partners participating in the survey. There were two doctors from an eight-partner practice.

Overall Loads.—Though the total work load varied greatly with increasing size of practice, the few large practices in the survey make this increase perhaps a function of these particular practices rather than a general feature. Thus practices with one to four doctors made between 30 and 35 visits per thousand population, the six-man practice had a rate of 49, while the seven-man practice had a rate of only 25.

Follow-up of Patients.—The proportion of new acute calls followed up was much the same (48%) regardless of the size of practice, the exception being the six-man practice, for which the figure was 67%.

Timing of Calls.—Single-handed practices had both relatively more calls between 10 a.m. and 8 p.m. (17.3% compared with 14% overall) and more night calls (3.6% compared with 2.9%). Correct timing of calls thus improves in general with the size of the practice, though, again, the six-man practice was an exception, having 4.2% of its calls at night.

Age of Doctor

Of the 190 doctors 28 had been qualified for up to 10 years, 73 for 11 to 20 years, 68 for 21 to 30 years, and 21 for over 30 years.

Overall Visiting.—The group of doctors qualified more than 30 years did on average 10 more visits in the 10 days than did doctors in the other age groups (Table X). Older doctors got

TABLE X—Average Number of Calls per Doctor by Years of Qualification

No. of Years Qualified	Acute		Chronic	Total
	New	Repeat		
≤10	46.6	28.4	12.7	87.8
11-20	45.9	27.2	17.6	90.7
21-30	45.8	26.1	16.5	88.4
>30	39.5	32.3	28.9	100.7
Total	45.3	27.5	17.8	90.6

slightly fewer new calls in the 10-day period than their counterparts—40 compared with between 47 and 58 for those qualified less than 30 years. To some extent it is the high number of chronic visits that makes the older doctor visit more than his younger counterpart. It was found that older doctors care for older people, the older doctor having 40% of his work in the over-65 age group compared with 26% for younger doctors.

Revisiting.—Doctors qualified less than 30 years had an overall revisit/new visit ratio of 0.88, whereas for those qualified more than 30 years the ratio was 1.47. In acute visits the ratio for older doctors was still higher (0.82) compared with that for

younger doctors (0.59). Nevertheless, doctors of all age groups revisited patients with infectious diseases at about the same rate.

Timing of Calls.—The older doctors in this survey did just as many late visits and night visits as younger doctors.

Follow-up.—Doctors qualified less than 10 years followed up about 30% of the patients at home, compared with 40% for doctors qualified over 20 years. The younger doctors, however, followed up 21% of the patients in the surgery, compared with only 13% for doctors qualified over 30 years.

Diagnostic Groups.—The clinical content of visiting varied according to the length of time qualified. The older doctor (qualified over 30 years) saw relatively fewer patients with respiratory and infectious diseases and relatively more diseases of circulation, neoplasia, and diseases of bone and joint. The younger doctors (qualified less than 10 years) did more obstetrics and saw more patients with mental and emotional disorders.

Effect of Social Class.—The tendency for more revisiting of social class I is increased with the length of qualification of the doctor. Thus the return/new visit ratio for doctors qualified up to 10 years was the same throughout the social classes (0.8). The figures for social class I increased to 2.7 and went down to 1.0 in social class V for doctors qualified more than 30 years.

Attendance/Visit Ratio.—This ratio tended to decrease with age. Doctors qualified more than 40 years had an attendance/visit ratio of 1.09, increasing to 3.05 for those qualified less than 10 years.

Need for Visiting.—Twenty-eight per cent. of patients receiving new visits from younger doctors were thought able to come to the surgery compared with 23% for older doctors. Younger doctors, however, thought that only 9% having revisits could have come to the surgery compared with 12% for older doctors. Younger doctors thought that 33% of all patients revisited could have come to the surgery by minibus compared with 18% for older doctors.

Interest in Practice Organization

Doctors who appeared to be interested in their operational activities defined above were compared with those who were apparently not interested. There were few differences between the two groups and, if anything, the trend suggested that the former had the higher visiting work load and did repeat visits more often. There was nothing to suggest that the doctors interested operationally got fewer new calls or that patients were more willing to attend surgery. Moreover, these doctors followed up relatively more (32%) of their patients at home than the other group (23%). They also admitted more patients to hospital than the other group. There was no difference in the two groups in the proportion followed up in the surgery.

Use of Appointments System

We found no evidence that an appointments system helped to reduce the visiting work load. Doctors with an appointments system received more new calls than those without (48 compared with 41). Paradoxically, doctors with appointment systems followed up about 31% of their new calls at home compared with 26% for those without these systems. There was no difference between the two groups in the follow-up rate at the surgery.

Discussion

Home visiting is one of the corner-stones on which British general practice has been built. It is one of the factors which has differentiated general practice in Britain from that in North America and many parts of the continent of Europe. We believe

here that it is important for the general practitioner to have personal knowledge of the patient's home, where many of the dramatic episodes in general practice are encountered. Nevertheless, the need for visiting at the British level has been challenged,¹ and in the past few years it has been greatly reduced.²⁻⁴ This trend will probably continue, though most general practitioners would agree that a change to transatlantic patterns would be undesirable.

One of the main values of this survey has been to elucidate visiting patterns of many general practitioners in North-east England. Each participating doctor has been sent an analysis of his own particular visiting figures and the average figures for doctors working in areas similar to his own. Thus each doctor has been able to assess his own figures against the norm for his own area, and this has probably been one of the most important educational features of the survey.

EFFECTS OF DOCTOR'S HABITS

One fact stands out from this survey. There is a wide variation in the visiting habits of different doctors, even among different doctors working in the same practice—from as many as 80 visits per thousand patients in the 10-day period to fewer than 10. It was also obvious that a high total visiting work load largely depended on the revisiting rate to either acute or chronic patients. Thirty per cent. of the doctors who took part had a revisiting rate three times that of the 28% of doctors who were at the other end of the spectrum. Undoubtedly some doctors can diagnose more quickly and accurately and predict with greater confidence than others. Others revisit more often because of uncertainty, and probably some doctors are more susceptible to what they consider to be their patients' expectations than are others. Nevertheless, the doctor who wishes to reduce his visiting work load should certainly reconsider just how much he is doing. Perhaps on every occasion he decides to pay a revisit to a patient he should ask himself why.

One factor that certainly influenced visiting habits was the age of the doctor. The older doctors did more visiting,¹⁻⁵ particularly acute revisits and chronic revisits. They also saw relatively fewer patients in the surgery. No doubt attitude played some part, but the older doctors saw relatively more older patients and this probably had a much greater influence. The older doctor did not revisit patients with infectious diseases more frequently than the younger ones but his revisiting rates to those with respiratory and cardiac conditions were greater. It is more difficult to predict accurately the outcome of an episode of respiratory disease in an older patient; consequently more revisits are necessary. Unlike the survey in South Wales⁵ we found that the older doctors did their share of late calls and night work.

Another factor which appeared to influence visiting was the situation of the practice. Doctors in small towns and rural areas did more visiting per thousand patients than doctors in large towns and conurbations. Both Wright⁶ and Williams⁵ found similar patterns. The visiting figures for the medium-sized towns were probably influenced by one large practice of seven doctors, all of whom took part in the survey and visited similarly. The small-town doctor received more new calls and also made more return visits than his colleagues in large urban areas. This suggests that attitude was playing some part. Perhaps the serious traffic problems of large urban areas have not yet reached small towns and accordingly doctors visit more readily and easily. Rural practitioners too had a high acute and chronic revisiting rate, but this no doubt reflects the problems of transport in rural areas. Nevertheless, the number of new calls per thousand patients in rural areas was not much less than in urban areas and the late call rate was actually higher, which discounts to some extent the popular image of the co-operative, long-suffering countryman.

Visiting tended to increase the larger the group; this applied

particularly to visits initiated by patients. The larger the practice the greater area it covers, and this may well cause patients who live toward the periphery of the area to request visits rather than attend surgery. The additional facilities that one would expect in large group practice premises did not appear to attract patients to them in the North-east of England. The Royal Commission on Medical Education⁷ predicted the formation of groups of up to 12 doctors, and health centres on an even larger scale are now planned. Unless regular and cheap transport is available it is probably doubtful whether these centres will reduce the visiting work load. On the other hand, the larger the practice the smaller the percentage of late calls received, so the discipline associated with group practice does appear to influence patients to request visits earlier.

One of the proclaimed advantages of an appointments system is the beneficial effect it has on reducing the visiting work load.^{1-4,6} This was not found to be the case in this survey. Patient-initiated visits per thousand patients on the list were identical in practices with or without appointment systems. The revisiting rate was found to be actually higher in practices with an appointments system. Nor did the doctor feel that this facility should have influenced the patient, for those with appointment systems felt that fewer of the patients should have come to the surgery than did those without such a system. Probably the reduction of visiting work load previously noted in practices that had adopted an appointments system is a concurrent and not a consequential phenomenon and has occurred in practices without such a system to a similar degree.

The effects of the social class of the patient on visiting proved most interesting. Social class V required twice as much visiting as its size in the community should have warranted, whereas social class III required considerably less. No doubt inadequate transport and social difficulties are greater in social class V, resulting in a lower threshold at which visits are requested. Paradoxically, the revisiting rate of social class I patients was highest, and the ratio fell steadily through the social classes. Similarly, a higher proportion of non-chronic patients in social class I could have come to the surgery than in social class V—again a gradient through the social classes. This no doubt reflects the better transport facilities in social class I and also their reluctance to use these. Possibly the reduced revisiting of social class V was to some extent due to the reduced level of complaint producing more trivia, but this cannot be the whole story for in that case social class III would have been revisited more frequently than social class I. It seems more than likely that the doctor revisits most frequently those patients with whom he identifies. This was more evident among older doctors than younger ones and among town doctors rather than rural ones.

Patients of social class V also made a greater percentage of late calls and night calls than the other classes. Hence probably the doctor with a higher proportion of patients of social class V has to contend not only with the higher demands for visits but also with relatively more of them at inconvenient times.

Eimerl and Pearson¹ showed what every general practitioner knows—that Monday is a busy day. This survey once again underlined that both patient-initiated and doctor-initiated visits and surgery consultations decreased as the week wore on, with a slight increase on Fridays. Patient-initiated demand is understandably high on a Monday, presumably reflecting some protection of the doctor over the week-end, but it is difficult to explain the doctor's insistence on doing more revisiting and chronic visits early in the week if he is trying to level out his work load through the working week.

NECESSITY OF VISITING

Some visiting appeared to be unnecessary. Much of it was for relatively trivial conditions, and in as many as 70% of acute new calls revisits were not made. Over 25% of the requests for visits were thought unnecessary by the doctor, even after he had allowed for difficult social circumstances. A further 25% of

patients could have come to the surgery had a transport system been available.

Reference to Table VII shows that it was the younger patients who the doctors thought could most easily have come to the surgery—over half of the new visits to patients aged under 1 year were made when the patient did not need a home visit; similarly, one-third of all the children did not need a home visit. Of the adults aged over 65 about one-quarter could reasonably have come to the surgery. Of the patients who the doctor thought could have come to the surgery but who asked for a new visit 80% were not in bed compared with only 43% for all new calls. This suggests that the attitude of the doctor in assessing the number of unnecessary calls was not unreasonable.

Of patients making calls between 8 and 10 a.m. only 29% were revisited. Nevertheless, the later the new call the more serious the illness. Hence of patients making calls between 10 a.m. and 8 p.m. 37% were revisited and in the case of patients making calls between 8 p.m. and 8 a.m. as many as 44% were revisited. A parallel increase in hospital admissions became evident the later the time of the call (1.6% of routine morning calls made between 8 and 10 a.m., 6.4% of those between 10 a.m. and 8 p.m., and 16.7% for those between 8 p.m. and 8 a.m.) There is therefore a 1 in 6 chance that a visit carried out between 8 p.m. and 8 a.m. will require the patient's admission to hospital.

The late call rate of 17% found in this survey is almost identical with the 18% found in South Wales by Williams⁵ using similar criteria. Though late calls in general practice are frequently considered to be frustrating and irritating, this survey showed that the conditions were more serious, as an increasing proportion of patients had to be revisited and admitted to hospital the later the calls were received. This would appear to be at variance with the findings of Jacob,⁸ who suggested that the personal characteristics of the adult making the calls was the deciding factor in many late calls rather than the severity of the condition.

Chronic revisits represented a considerable proportion of the visiting load. Their value has often been doubted. There is a danger in labelling chronic patients with a diagnosis, since if new conditions supervene these can be more easily missed. Only 3 out of 10 chronic patients were in bed and 4 out of 10 were not examined. Hence probably many chronic visits do not require much in the way of clinical skill, and these patients need social help as much as medical assistance. Co-operation with the new local authority departments of social service—particularly close liaison of social workers with general practitioners—would undoubtedly improve the overall general standard of care to the

aged and people with chronic disabilities as well as providing more time for the doctor to deal with purely clinical problems.

For patients with chronic disabilities who require clinical supervision the use of transport should be considered, for this can help both patient and doctor. Doctors thought that only 9% of chronic patients could have come to the surgery unaided, but on postulating a minibus service for this purpose the figure increased by a further 36%. The use of a minibus would be particularly valuable in reducing chronic visiting in rural areas. Organizing such a service for patients with acute illnesses would be full of problems—not the least being assessing need—and thus its value for them would be less. Young doctors thought almost twice as many patients revisited could have come to the surgery by minibus than did older doctors.

The number of revisits carried out by nurses was surprisingly low—only 14%. Even more surprising was that they did only 17% of revisits to chronic patients, especially when one remembers that doctors did not examine 40% of their chronic patients on a revisit. Hence probably the full potential of nurses for this work has not yet been achieved and the prophecies of earlier workers^{3, 9} have not yet been fulfilled. Perhaps as well as asking himself why he is revisiting any particular patient the general practitioner should also consider whether he is the most appropriate person to do so.

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Clinical Endocrinology

Pituitary Tumours and Hypopituitarism

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The anterior pituitary gland secretes corticotrophin (ACTH), thyrotrophin (TSH), gonadotrophin, growth hormone, prolactin, and melanocyte stimulating hormone (MSH). It is under the control of the hypothalamus, in which stimulating or

inhibitory factors are synthesized and pass to the gland down the pituitary stalk. One of these, thyrotrophin releasing factor (TRF), has recently been synthesized and its properties are being studied. ACTH regulates cortisol secretion by the adrenal cortex, and also has a direct action on the skin leading to increased pigmentation. TSH stimulates the secretion of thyroxine and tri-iodothyronine by the thyroid gland. The gonadotrophins, follicle stimulating hormone (FSH) and luteinizing hormone (LH), act on the gonads, regulating germ-cell maturation and sex-hormone secretion in both men and

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