Why Home Visits? Analysis of 142 Planned Home Visits

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The functions of the traditional home visit in practice and teaching are controversial. A different kind of planned home visit was developed and implemented as part of orientation of first-year family practice residents. The objectives were to get acquainted and establish communication; to facilitate observational skills and awareness of the community; and to improve research parameters of the family record. This kind of home visit is feasible: all residents participated; 92.2 percent of families participated of whom 90.8 percent responded to a follow-up questionnaire. Communication patterns between doctor and patient/family were analyzed for skills at listening and speaking clearly. Poor communication was infrequent, occurring in only 8 to 12 percent of the encounters. Ethnic differences between family and resident were important in such visits.

Background

The controversy over the proper use of the home visit in family practice and in resident education is real. A recent authoritative book of guidelines for family practice education omits mention of the home visit in its 265 pages.[1] In contrast, the 1973 Mackenzie Lecturer describes one weekend's worth of home visits as an indispensable part of his role as a skilled and caring general practitioner (20 visits to 12 patients).[2] Opinions on the utility of the home visit sharply differed during in depth discussions at a recent International Workshop in Spain. [Curry HB: (Personal Communication) International Workshop on Family Medicine (The Challenge: Man – The Family – The Community), Fuengirola, Spain, November 1-9, 1975.] Some of the pro and con views on home visits can be listed as follows:

Pro

- indispensable
- enriching to doctor/family relations
- efficient for selected conditions
- optimal for geriatrics
- essential for epidemiologic research

Con

- inefficient
- outdated
- impractical
- a routine for paramedical personnel only
- a useful chore/exercise for undergraduate students

In contrast to argument among family practitioners, many social work professionals agree that the home visit is one of their essential tools for maximizing patient/professional encounters.[3] An appropriate sense of purpose, timing, and judgment by the professional can increase the probabilities of a useful home visit and a successful patient-professional outcome.[4-6] Thus, the question arises, how can the good and useful features of the traditional home visit be preserved in the contemporary setting of family practice? A related question (which is beyond the scope of this report) is, should the home visit, as judged by quantitative and qualitative standards of excellent family practice, be preserved? We suspect that answers to the cost-benefit aspects of home visits will depend upon many geographic, economic, medical, and social variables.[7-9]

Objectives and Methods

A two-month period of orientation for incoming first-year residents is carefully planned in Charleston, South Carolina, to help residents (and their spouses) make the transition from medical school senior to first-year family practice resident (and often to a different community). Before entering their hospital rotations, the new residents become familiar with inpatient-outpatient facilities and routines, computerized problem-oriented medical records, and family workups. They are also introduced to community resources, behavioral science skills and attitudes, and teacher observation and evaluation tools. Assuming that new residents are eager to become acquainted with their practice families as soon as possible, we reasoned that planned home visits could facilitate the getting-acquainted process in a way that episodic illness and scheduled health maintenance examinations over an extended period of time could not. The central features

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Table 1. Participation of Patients/Families in Planned Home Visit and in Follow-Up Questionnaire, By Race

	Nonwhite	White	Total
Home visits scheduled	77[a]	77	154
Home visits cancelled:			
(1) By family	7	4	11
(2) By resident	—	1	1
	7	5	12
Home visits made	72[a]	70	142
H.V. participation rate %	93.5	90.9	92.2
Replies to follow-up questionnaire received:			
(1) Replies by mail	38[b]	54	92
(2) Replies by telephone	26[b]	11	37
	64[a]	65	129
Questionnaire participation rate %	88.8	92.8	90.8

[a]Includes 2 oriental families [b]Includes 1 oriental family

Table 2. Analysis of Replies to Follow-Up Questionnaire (N=129)

Question	Code	Nonwhite N=64	White N=65	Total N=129
#1. The home visit by the doctor was:	(3) Too short	2	1	3
	(2) About right	62	63	125
	(1) Too long	0	1	1
#2. The doctor understood what we had to say:	(3) Yes	54	60	114
	(2) Most of time	8	5	13
	(1) No	2	0	2
#3. We understood what the doctor had to say:	(3) Yes	56	63	119
	(2) Most of time	8	2	10
	(1) No	0	0	0

of the planned home visit for each participating family would be: (1) voluntary on part of resident and family; (2) brief (30 to 60 minutes); (3) by appointment; telephone arrangements in advance; (4) a simple checklist form to facilitate observations by the resident and provide epidemiologic data; (5) optional participation by faculty and auxiliary personnel; (6) a follow-up questionnaire by the participating families to evaluate the encounter; and (7) no expense to family or to resident.

Participation of Families

In the summer of 1975 the orientation period coincided with a health survey project, undertaken for the first time by the Family Practice Center, Medical University of South Carolina, in which families being assigned to the first-year residents were invited to participate more actively in a broad range of services being offered. Multiphasic screening services were offered by appointment at a minimal charge and the planned home visits were offered also on a voluntary basis at no charge. Of the 154 home visits scheduled, only 12 were cancelled for reasons of illness, summer vacation, or breakdowns in communication. All of the 14 residents participated in the home visits: all were white; one was female.

Table 1 shows a participation rate of 93.5 percent for nonwhite families (72/77) and 90.9 percent for white families (70/77). Approximately two to three weeks later, a follow-up questionnaire was mailed which yielded an overall response of 90.8 percent. Black families were less likely to respond by mail than white families, but a little extra effort with the telephone brought their responses up to the average.

Questionnaire

Space does not permit printing of the Resident's Observation Sheet (2½ pages) which itemizes observations on neighborhood; exterior and interior of

home (pets, hobbies, crowding, "atmosphere"); dietary features; medications; pertinent housing characteristics for known household handicaps or diseases; a special section on interpersonal relationships observed during the visit; socioeconomic information of medical importance; a succinct profile of the home visit experience; and, finally, plans for follow-up. Copies of the form are available upon written request.

The follow-up questionnaire, completed by each family visited, provides essential information on: the length of visit ("Would you say that the home visit by your doctor was: too short, about right, too long?"); doctor listening ("When *you* were talking did the doctor understand what you had to say; yes; most of time; no"); and doctor talking ("When the *doctor* was talking did you understand what he/she had to say? yes; most of time; no"). In addition, two general questions probed for *any* "good (positive) things that happened during the visit" and for *any* "bad (not so good) things that happened during the visit."

In Table 2, responses to the three essential follow-up questions by the families are tabulated. The open-ended questions yielded some of the following representative comments:

"Good" things: (1) "He (the doctor) can reach us quick in an emergency." (2) "Knowing he didn't have another appointment in 10 minutes." (3) "He seemed concerned about our well-being." (4) "Had a good way with children." (5) "I was more at ease in my own house!"

"Bad" things: (1) "My husband talked a lot of the past." (2) "The dog broke loose; I had to chase the dog: he saw a 'typical' day at our house!" (3) "No one called to say he was coming. We were surprised; he was embarrassed."

Respondents' Rating of Doctors on Listening and Speaking Clearly

For each home visit, the family had been asked to rate the doctor on listening and speaking clearly. These functions of a good family doctor should be related. The data in Figure 1 graphically show that, in general, good listening and clear speaking are related characteristics, as perceived by families, regardless of ethnicity. On

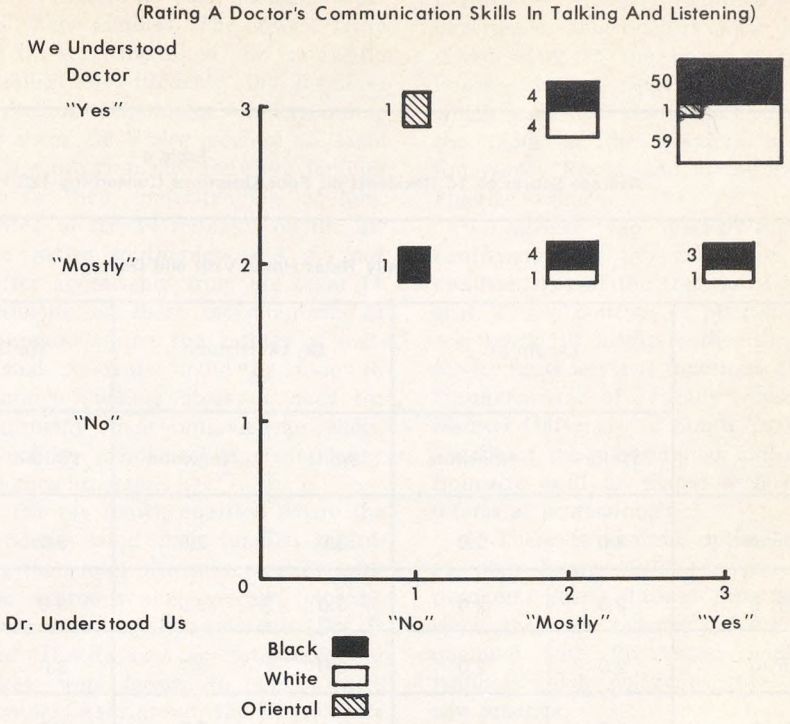

Figure 1. How 129 family respondents rated 14 residents after the home visit, by race

Table 3. Summary of Average Scores for 14 Residents on Four Major Questions Rated on 1-3 Scale

Question	White	Nonwhite	Scale	Rating by (F)amily/ (R)esident
1. Length of Visit	1.9	2.0	1. Too long 2. About right 3. Too short	F
2. Dr. Understood Us	2.9	2.8	1. No 2. Most of time 3. Yes	F
3. We Understood Dr.	2.9	2.8		F
4. Family's Communication with Dr.	2.5	2.2	1. Closed 2. Average 3. Open	R

Table 4
Average Scores of 14 Residents on Four Questions Concerning 129 Home Visits Rated on 1-3 Scale

	Family Rates Home Visit and Doctor						Doctor Rates Family	
	Length of Visit[a]		Dr. Understood Us[b]		We Understood Dr.[b]		Communication with Visitor[c]	
	White	Nonwhite	White	Nonwhite	White	Nonwhite	White	Nonwhite
Dr. A	2.0	2.0	3.0	2.8	3.0	3.0	2.5	2.6
Dr. B	2.0	2.0	3.0	2.5	3.0	2.7	2.4	2.5
Dr. C	2.0	2.0	3.0	2.7	3.0	3.0	2.2	2.0
Dr. D	2.0	2.0	3.0	2.6	3.0	2.6	3.0	2.3
Dr. E	2.0	2.1	3.0	2.7	3.0	2.8	2.3	2.3
Dr. F	2.0	2.0	2.7	2.8	2.7	3.0	2.7	1.8
Dr. G	2.0	2.2	2.7	3.0	3.0	3.0	2.5	2.0
Dr. H	2.0	2.0	3.0	3.0	3.0	3.0	3.0	2.6
Dr. I	2.0	2.0	3.0	3.0	3.0	3.0	2.7	2.0
Dr. J	2.0	2.0	2.8	3.0	3.0	3.0	2.8	2.0
Dr. K	2.0	2.0	3.0	3.0	3.0	2.6	2.7	2.1
Dr. L	2.0	2.0	2.7	2.8	3.0	2.8	2.7	2.6
Dr. M	2.1	2.0	2.8	3.0	3.0	3.0	2.1	2.5
Dr. N	1.8	2.0	3.0	2.5	2.8	2.5	2.2	2.5
Totals (Average)	1.9	2.0	2.9	2.8	2.9	2.8	2.5	2.2

[a]1—too long 2—about right 3—too short [b]1—no 2—mostly 3—yes [c]1—closed 2—average 3—open

the vertical axis, most families (54 black; 2 oriental; 63 white) reported they understood the doctor. Among those who indicated they understood him "most of the time," there were more black families (8) than white (2). On the horizontal axis, again the majority felt the doctor understood them but there were 13 families (8 black; 5 white) who rated him as understanding them "most of the time" and 2 families (1 black; 1 oriental) who felt their doctors did *not* understand them.

Analysis of Families' Ratings and Residents' Ratings

In Table 3, the average scores of 14 residents are summarized in regard to the four questions rating the home visit, three questions rated by the family and one question rated by the resident physician. (In retrospect, and for future studies, we should ask the same three questions of each resident that we asked of the family.) For purposes of evaluating communication, however, we feel these data (which were collected systematically in a standard way over a defined period of time) are useful within their limits.

When it came to the length of the visit, the average response among whites and nonwhites was similar: 1.9 and 2.0 respectively. The overall average rating given the two-way communication (Dr. Understood Us; We Understood Dr.) was 2.9 for both questions by white families, and 2.8 for both questions by nonwhite families.

Individual Residents' Scores

In Table 4, the scores for *each* resident are listed. Considering individual averages, three residents received perfect scores (3.0 out of a possible 3.0) on "Dr. Understood Us" in ratings by both their white and nonwhite families, while seven residents received perfect scores from both white and nonwhite when being rated on "We Understood Dr." Two residents (Drs. H and I) received perfect scores on both questions from all their families. The lowest score (2.5) was registered by nonwhite families for 2 residents (Drs. B and N) regarding their doctor's understanding of them. Dr. N also received the same low score from his nonwhite families as to their understanding of him. Three of the 14 residents on the list are native southerners and did not differ appreciably from the other 11 residents on these measurements of communication. The ratings of individual residents could be used to identify possible areas of need for improving their interviewing skills, which is a major goal of our residency training program.

On the fourth question where the residents rated their families regarding their level of communication with the visitor (open, average, closed), there were only two residents (Drs. D and H) who gave perfect scores and these were given to their white families. As a group, the 14 residents rated their families, white (2.5) and nonwhite (2.2), less communicative than their families had rated them.

Summary

1. Planned home visits were feasible and satisfying from the points of view of both the residents and the families. The visits served to warm up each resident to his new practice and to warm up each family to their new doctor. Some residents reported greater efficiency in their physical examinations and histories in the clinic among those persons whose households they visited.

2. Clues to the two-way flow of communication between resident and family were provided by the analysis of responses recorded on the questionnaires. Individual residents may be evaluated at an early stage of their residency in relation to their communication skills.

3. The orientation process from fourth-year medical student to first-year resident in assuming responsibility for total, continuing family care can be enhanced by scheduled, planned home visits. Fourteen residents were introduced to 142 households distributed throughout Charleston County. Through this experience, the doctors were introduced early to the broad range of households and neighborhoods from which their patients/families come to see them in the hospital, in the Emergency Room, and in the Family Practice Center.

4. Against the background of controversy on the advantages and disadvantages of the traditional home visit, a new concept of planned visit was found to facilitate the teaching, service, and research functions of the Department of Family Practice, Medical University of South Carolina. Details of the methodology and questionnaires will be shared with other interested professionals.

5. There is no more optimal time to plan home visits for incoming residents than during orientation, when they are eager to become acquainted with the broad range of families which will constitute their new practice.

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