

# Patients' accounts of calling the doctor out of hours: qualitative study in one general practice

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## Abstract

**Objective**—To investigate patients' accounts of calling the doctor out of hours.

**Design**—Qualitative analysis of semi-structured interviews with two groups of patients who called their doctors out of hours from one general practice.

**Subjects**—23 people who had called the doctor on their behalf or on behalf of another adult and 23 people who had called on behalf of a child between 6 pm and 8 am on a week day (omitting the weekend from 6 pm on Friday to 8 am on Monday).

**Results**—Although respondents described symptoms as the main reason for the call, they also described a range of other factors that led to the call, including their feelings, concerns about specific illnesses, their responsibility for others, and their previous attempts to manage the problem themselves. They also described past experiences with health services that were important in explaining the current out of hours call or explaining their general approach to using services.

**Conclusions**—The pursuit of a model of out of hours care based on medical necessity that neglects the psychosocial context of illness may not be appropriate. The importance of previous experiences of health services and contacts with health professionals in explaining current service use requires wider acknowledgement by health professionals across sectors. Separate educational programmes to encourage patients to use out of hours services more appropriately that neglect these issues may be too simplistic.

## Introduction

The appropriate organisational and professional basis for providing out of hours care is being debated amid considerable controversy.<sup>1</sup> The overall increase and wide variations in demand between practices and regions for out of hours care need to be explained. Social deprivation, high expectations in affluent areas, and high proportions of young children are associated with higher rates of out of hours calls.<sup>2-8</sup> Studies looking at the relation between supply and demand have suggested that organisational factors such as use of a deputising service, list size, number of partners, aspects of the doctor-patient relationship, and the attitudes of doctors themselves may explain the variations.<sup>9-12</sup>

Alongside the debate about factors influencing demand for out of hours care is debate about the appropriateness of the demand. Substantial published work acknowledges that lay views of health problems and what should be done about them often differ from those of professionals, and the debate about appropriateness often hinges on this discrepancy.<sup>13</sup> Despite this evidence and calls for patient education as a means of tackling increasing demand and inappropriate use, patients' perspectives on out of hours calls have been neglected.

## Subjects and methods

The study practice has 5395 patients, three partners, and one associate and is in an inner city in an area of social deprivation with high rates of illness and use of health services.<sup>14</sup> The practice receives deprivation payments for 38.6% of its population, which has only 2% of people aged over 75, 39.9% of households with children under 16, and

8.1% of single adults in households with children. The practice offers open surgeries on every weekday morning. Out of hours work until midnight is shared with two other practices, calls after midnight being transferred to a deputising service. The rate of night visits is high, being 80 per 1000 patients per year compared with 45 per 1000 per year in Lothian as a whole.

**Sampling and recruitment procedure**—Over seven months we took about a 50% random sample of out of hours (after 6 pm and before 8 am) calls to adults and children on 30 nights. Weekend calls were excluded. Details of the sampling procedure are in the appendix. Within four days of the call we sent a letter to the caller asking him or her to take part in an informal interview for a study investigating how people make decisions about health care.

**Content of interviews**—The interviews focused on the sampled call but were semi-structured to allow respondents to talk about issues that were relevant to them. The interviews lasted between 20 minutes and an hour and were tape recorded with permission. Before we started an interview we asked about the respondent's general health and the health of his or her family. Then we asked respondents to tell us about the events leading up to calling the doctor. Most people gave long and detailed explanations about what had led up to the call. We followed up other issues mentioned by respondents to try to get as full a description and understanding as possible. Prompts were used if respondents did not spontaneously cover these topics in their accounts of what had happened. The main prompts were: What did you think the problem was? What did you know about the problem? Who, if anyone, did you talk to about the problem? Had you thought about seeing or had you seen a general practitioner about the problem beforehand? What did you think could happen if you didn't get the doctor out? What did you think the doctor would do? What did the doctor do? Would you call the doctor out again in similar circumstances?

**Analysis**—The interviews were transcribed in note form—that is, everything that the respondent said was noted in the transcripts but not given verbatim. The transcripts were analysed inductively to generate the main themes.<sup>15 16</sup> During the analysis previous experiences of health services emerged as important so the transcripts were re-examined to look specifically at the outcomes of the current calls and whether respondents would call the doctor out again in similar circumstances.

## Results

The practice received a total of 47 eligible calls for children and 57 calls for adults on the study nights. Of 52 households approached, 46 took part. Five people were not at home at the suggested time for interview on three occasions, and one person declined to take part. The maximum time between the out of hours call and the interview was 14 days. The interviews covered 25 calls for children and 24 calls for adults (table 1).

All respondents described the problem in terms of symptoms. This was usually supplemented by a description of the context of the call, although the amount and kind of information given about the context of the call differed between respondents. Many respondents described previous experiences of health care. The main themes respondents used in explaining the call are described below.

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**Table 1—Details of calls sampled**

Calls for adults	No of patients	Calls for children	No of patients
Age of patient (years):		Age of patient (years):	
21-30	12	<1	2
31-40	8	1-2	3
51-60	1	2-3	7
71-80	2	3-5	3
		5-10	5
		10-15	3
Men	3	Boys	11
Women	20	Girls	12
Symptoms:		Symptoms:	
Abdominal pain	4	High temperature	6
Abdominal pain and burst lump	1	High temperature and vomiting	1
Earache	2	High temperature and convulsions	1
Migraine	2	Diarrhoea and vomiting	2
Migraine and flu symptoms	1	Vomiting	3
Vomiting	2	Abdominal pain	2
Diarrhoea and vomiting	1	Spots	2
Headache and vomiting	1	Sore throat	2
Breathing difficulties	1	Sore mouth	1
Sudden dizziness and blood in urine	1	Ear bleeding	1
Violent drunken behaviour	1	Back injury	1
Throat problems	1	Swollen testes	1
Itching	1		
Delirium	1	Caller:	
Breast abscess	1	Patient's mother	23
Back injury	1	Patient's father	2
Caller:			
Patient	17		
Patient's mother	2		
Patient's partner	4		

**SYMPTOMS**

Implicit in respondents' descriptions of symptoms were ideas about normal and abnormal illness.<sup>17</sup> Some symptoms such as severe, unrelieved, and unexplained pain, high temperature in young children, and serious breathing difficulties seemed to be a sufficient reason to call the doctor. Other common symptoms were a reason for calling the doctor only when accompanied by symptoms of abnormal illness—for example, vomiting blood, black sick, a green tongue, and foaming at the mouth.

The time for which the symptoms had persisted was important in differentiating normal and abnormal symptoms. Both sudden onset and prolonged distress were given as reasons for calling the doctor, although there was no set length of time which indicated that symptoms had persisted for too long.

Respondents often described the behavioural impact of symptoms. For example, the presence of abdominal pain was accompanied by a description of not being able to move or not being able to bear to be touched. Respondents calling on behalf of children often described a constellation of physical and behavioural symptoms such as crying, not eating, and not being herself or himself.<sup>18</sup>

**CONTEXT OF CALL**

*Concerns about specific illnesses*

Many respondents expressed concerns that symptoms might indicate specific illnesses such as meningitis and appendicitis. These concerns were not necessarily based on direct experience but on a general awareness that these illnesses were serious:

"I thought Sam was dehydrated because his lips were blue. I wondered if he might have Hib" (mother of 2 year old child).

*Caller's feelings*

Several respondents explicitly mentioned their feelings about the problem:

"I felt so ill, I felt someone had to come and help me" (34 year old woman with diarrhoea and vomiting).

For calls on behalf of children, in particular, people explained that they had "just panicked" or thought that the child had endured enough distress:

"I said, 'You're not going through all this, wee man. I'm going to get the doctor'" (mother of 6 month old baby).

*Responsibility for others*

Having a responsibility for other people was given as a reason for calling the doctor, particularly by mothers of children. In some cases, this was a concern when the responsible person was ill. One mother of three children aged 6,8, and 10 explained that she called the doctor out because of the way she felt: "I thought I was going to collapse and was a bit scared being alone with the children."

In other cases, callers were concerned for the health of others, particularly younger children, when an older child was ill.

*Previous attempts to manage the problem*

Most people had taken some action themselves or explained why this was not possible, implying that other reasonable courses of action had been considered.

Attempts to manage the problem included self treatment, consulting a family member or friend, and in some cases seeing a general practitioner (see below). Many respondents reported that they had waited to see what would happen, although by definition respondents who were worried about a sudden onset of symptoms had not considered this. After a time respondents thought that they had waited long enough, though the length of wait was not specified.

Some people had failed to get an appointment. Some mothers thought that they could not use the open surgery because of concerns about keeping an ill child or an accompanying child in the waiting room, both in terms of the distress and exacerbation of illness for the child and the discomfort for other people. A few people explained that they had not taken or given drugs because they did not have any in the house.

**PREVIOUS EXPERIENCES OF HEALTH SERVICES AND HEALTH PROFESSIONALS**

An overall impression from the interviews was that the respondents and their children experienced considerable ill health. Consequently, many respondents had substantial experience of health services for themselves, for partners, or for children.

Most respondents spontaneously described previous experiences of health services and contacts with health professionals either in the context of the current out of hours call or to explain their general approach to using services. In many examples the outcome of care was presented as justification or necessity for having sought help.

*Past frights*

Respondents described past frights in which illnesses had turned out to be more serious than they had expected. Implicit in these stories is the disruption of self confidence in determining and managing serious and non-serious illness. People often referred to previous out of hours calls (box, case 1). Frights with one family member seemed to have implications for decisions about other family members, particularly children. In the case of children a past fright with another child could be used in describing the background of the current call.

*Current concerns about illness*

Some respondents described how current concerns about other illnesses were influential in making the call (box, cases 2 and 3). Previous contacts with health professionals could trigger later concerns about illness (box, case 4).

**Table 2—Summary of outcomes of calls**

	No of calls for adults	No of calls for children
Patient given a prescription or an injection	17	10
Patient referred to hospital by doctor	1	4
Parent referred to hospital	-	2
Patient visited and advice and reassurance given	5	5
Caller given advice on the telephone	-	2

*Lack of confidence in health professionals*

For some respondents lack of confidence in health professionals was important. This was in terms of the contacts with health professionals in relation to the episode of illness that was the focus of the call (box, cases 5 and 6) and as a result of past experiences. Some of the respondents described previous negative experiences of health care, in which they had not been taken seriously but in the end had managed to get what was confirmed as necessary treatment. As a result they had learnt to be more proactive in seeking care (box, case 7).

*Medical successes*

Other respondents described previous experiences in which medicine or health professionals had been especially helpful. One woman told a heroic story of the doctor who immediately referred her to hospital, where, after tests, she was told she had had a heart attack. As she explained: "When I get a pain now I'm always worried it's another one [heart attack] because when I had the last one the symptoms were very vague."

Similarly, a respondent who had had major heart surgery explained that she would not be alive if it were "not for the doctors." She added that they liked to "keep an eye on her."

**Case histories***Past frights*

*Case 1*—A call was made for a child who had stuck something in his ear, which was now bleeding. The father, who had made the call, described another incident from a year before when the doctor had been called out and the child had had to go to the local children's hospital for nebulised oxygen for a few hours. The father explained that on that occasion they had thought that the child would "just" need some medication and had not realised it was so serious as to require admission.

*Current concerns about illness*

*Case 2*—A call was made for a 14 year old girl who was "really ill" with a high temperature and was not eating. Her mother explained that she had had a tonsillectomy and adenoidectomy a week before. She had been discharged from hospital at 10 am after having the operation at 3 pm the previous afternoon. Her mother thought that this was too soon to discharge her, and since being discharged her condition had declined. As the woman explained, she might not have been so worried if she had not just had an operation.

*Case 3*—A woman who had visited a baby clinic in the afternoon discussed the baby's continuing weight loss with a health visitor and a general practitioner. The baby was referred to hospital by letter. The mother explained to us that she thought that if there was a problem it should have been dealt with straight away, and she also indicated that she thought that the health visitor had expected the general practitioner to refer immediately. That night she called the doctor because the baby was being sick and not feeding and had been crying for a long time. The baby was referred to accident and emergency.

*Case 4*—A woman who had been consulting for headaches or migraines she had been having for a month was asked by a general practitioner at one consultation whether she was ever sick with headaches. When she started being sick later she called the doctor.

*Lack of confidence in health professionals*

*Case 5*—A woman who had taken her 3 year old child to see the doctor that morning thought that the doctor was rushed ("He kept looking at his watch"), implying a lack of confidence in the doctor's assessment of the problem. When the problem persisted in the evening she called the doctor.

*Case 6*—Two respondents who made two calls in the same evening expressed a lack of confidence in the first visit. A woman who was visited by a doctor from the deputising service whom she had seen previously, when "he was more interested in the hamsters," remarked that the doctor had not done a proper examination. Another respondent commented that the doctor from the deputising service "looked like he should be retired."

*Case 7*—A woman said that she had learnt to be more proactive in seeking care as a result of her experiences, saying "you have to keep a check" on health professionals. She had been sterilised while in the early stages of what turned out to be an ectopic pregnancy. After several calls and visits to hospital over a period of time she was admitted as an emergency and was told by the surgeon that she had got there "just in time."

## OUTCOME OF CALLS

Most callers were given a prescription or were referred to hospital (table 2). As with descriptions of previous experiences of health services, the outcome of the call seemed to be integral to the retrospective account of the decision to call the doctor and, by implication, to whether the respondent would call the doctor in similar circumstances. Calls in which the outcome was admission or referral to hospital were assumed to have been necessary by us and by the respondents. Getting an injection or prescription could also indicate that the call had been necessary. One woman who could not stop vomiting explained that the doctor had made her feel stupid but that the fact that he had given her an injection "must have meant that it was something."

Only four people said that they would not call the doctor again in similar circumstances.

**Discussion**

The analysis draws attention to two issues.

Firstly, from the patient's point of view a wide range of contextual factors as well as the particular medical problem or symptoms influence the use of out of hours services.

Secondly, previous experiences of health services and contacts with health professionals are important in users' explanations of current use of the health service.

## METHODOLOGICAL ISSUES

The study was carried out in one general practice. The demographic profile of the practice meant that there were comparatively few calls from older people in the sample. The sample of calls for adults by chance also includes a high proportion of women.

## Key messages

- Research on patients' explanations of out of hours calls has been neglected
- In this study, respondents described the context of the out of hours call, as well as the patient's symptoms
- Descriptions of previous experiences of health services and contacts with health professionals were also important in explaining the current call and respondents' general approach to using services
- The role of health professionals in developing and maintaining patterns of service use is important
- Separate educational campaigns that focus on symptoms and neglect the context of the call may be too simplistic

Although we were careful not to imply criticism, respondents may have interpreted the interview as a request to justify making the call. The accounts were retrospective and may be different from those gathered prospectively.<sup>17</sup> Retrospective accounts may be reorganised or restructured to be more coherent or to suit a particular audience, although they may be valuable in showing how people make sense of their experiences in a social context.<sup>17 19</sup>

### SYMPTOMS AND CIRCUMSTANCES

Many of the themes identified form part of the extensive published work on why people seek medical help.<sup>20 21</sup> Previous studies have also shown that decisions to seek medical help are based on ideas about normal and abnormal illness<sup>17</sup> and that substantial management of illness, in terms of seeking advice or treatment, self treatment, and waiting and seeing, is often done before seeking professional help.<sup>20 22</sup> The importance of feelings and the impact or potential impact of illness on daily life are also known.<sup>23</sup>

Although these findings are not new, our research places them in the context of out of hours care and suggests that patients' explanations for seeking medical help are similar both during the day and out of hours.

### PREVIOUS EXPERIENCES OF HEALTH SERVICES AND CONTACTS WITH HEALTH PROFESSIONALS

Respondents' descriptions of previous contacts with health services highlight the importance of understanding patients' perceptions of the process and outcome of care. Paradoxically, both positive and negative experiences were used to explain the importance of seeking formal help. Some experiences of health care and contacts with health professionals disrupt confidence in self management and fail to allay concerns, even increasing them.<sup>24</sup>

### CONCLUSIONS

Professional models for daytime primary care acknowledge the importance of circumstances and the psychosocial context of the experience of illness,<sup>25</sup> as well as the positive potential of current contacts to modify patients' future use of health services.<sup>26</sup> Although there has been some acknowledgement that in responding to out of hours calls doctors may be responding to a diversity of factors other than purely medical factors,<sup>11</sup> much of the debate about out of hours care focuses on medical necessity and the extent to which patients understand what constitutes a medical emergency. Similarly, the extent to which management of illness by professionals and lay people is determined by rational decision making based on information about symptoms and treatments rather than on responding to circumstances has been questioned in other contexts.<sup>21</sup> Our findings highlight the limitations of rational decision making models for out of hours care. Despite these limitations, the idea of separate educational initiatives informing patients about appropriate management of illness and symptoms remains popular.

Our study suggests that health professionals, across a range of sectors, should reflect on their role in developing patterns of service use in their day to day contacts with patients.

They should also consider whether it is reasonable or appropriate for different professional models of daytime and out of hours primary care to underpin debate about the future of services.

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Conflict of interest: None.

## Appendix

### Sampling procedure

**Randomisation**—A pragmatic random sample was drawn. The nights chosen for sampling depended on the feasibility of following up calls quickly, given the other commitments of JH and RH.

**Exclusion criteria**—We decided to exclude calls for the following reasons before we started the study: (a) when the request to participate in the study was likely to cause distress, specifically when the patient was terminally ill or the call was requested by recently bereaved relatives; (b) when the call was for problems for which the patients would almost always have been advised in advance to seek medical help (in the event this applied to bleeding during pregnancy and a blocked urinary catheter); and (c) when the patient was known to be in hospital at the time the interview was to be carried out.

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