'Do I don't I call the doctor': a qualitative study of parental perceptions of calling the GP out-of-hours

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Abstract

The purpose of this study was to investigate how parents use the GP out-of-hours service. There was a lack of information about how parents managed childhood illness and what strategies they put in place to help them to cope before calling the GP. The investigation of parental perceptions was based on a qualitative design using in-depth interviews of 29 families from a semi-rural location in the south-east of England. All parents said they found dealing with a sick child out-of-hours stressful and were concerned to make the right decision for their child. Furthermore, parents usually employed a reasonable strategy in attempting to manage the child's illness. This study demonstrated that the decision to call the doctor was not taken lightly. Many parents had implemented useful strategies prior to calling the doctor. However, most parents were also aware of their limitations and feared doing the wrong thing. It would seem that on occasion this fear combined with factors such as a lack of social support and loss of parental confidence resulted in calling the doctor out of hours to seek 'peace of mind'. A rethink is needed among health professionals about the 'problem' of out-of-hours calls. GPs could actively seek to empower parents by educating them about minor illness during visits and consultations. It is not enough to offer reassurance to parents that their children are fine. Health visitors and other health professionals who come into contact with young families may help to educate and empower.

Introduction

The apparent increase in out-of-hours GP consultations is a source of considerable concern and debate.[1–11] The underlying premise of much of this concern is that many of these calls are unnecessary[2] and the result of a combination of over expectation and inadequacy on the part of those making the request for consultation. Such ideas have informed research aimed at offering educational strategies, information in the form of checklists and booklets to help patients to manage the problem themselves and call at an appropriate time for help.[12–16] These studies aimed at identifying and implementing supportive interventions targeted at those most likely to frequently use the service have not been successful.[14,16] Much remains to be done in identifying characteristics

specific to 'frequent users' in order to reduce the frequency of out-of-hours consulting.

This study was designed to contribute to understanding by exploring the service users' perceptions of the circumstances in which out of hours GP services are used. The study sample consisted of families with young children. Previous research has shown a positive correlation between increased consulting and the under five age group in the practice population.[7,17,18] Further important correlations have been shown with both social deprivation and, conversely, high expectations in affluent areas.[8,17–19] The idea that parents focus on behavioural change whilst the GP concentrates on signs and symptoms, has been helpful in addressing this issue.[20,21] Also useful is the idea of parents attempting to control the illness while feeling disempowered by the threat of the supposed seriousness of the illness.[22,23]

Methods

The study employed in-depth interviews within a qualitative research framework. The study was conducted in a large, semi-rural community in Haywards Heath, West Sussex. The practice population has above average affluence with pockets of need in relation to above national average teenage pregnancy and post-natal depression and a problem with substance misuse particularly Heroin. The main characteristics of the practice are given in box 1.

Sampling and recruitment

A purposeful sample of 30 families was recruited. One family declined the invitation to take part leaving a sample of 29. Optimum sample size is a complex issue, Holloway and Wheeler[24] suggest that richness of detail can be lost if the sample number is more than 40. They also remind us that there is no justification for a large sample size that will not enhance qualitative research. Mays and Pope[25] highlight the importance of identifying the specific groups of people who possess the characteristics to be studied. Participating families had at least one resident child under the age of 10 years. The following categories of out-of-hours service user provided the sampling framework:

- Frequent users of the out-of-hours service – these were defined as families who had used the service twice or more in the previous 6 months or four times or more in the previous year. 10 families were recruited
- One-off-callers – families who had made one call in the past 6 months and none in the prior 3 years. 11 families were recruited.
- Non-callers – families who had not used the service in the previous 3 years. Eight families were recruited

Out-of-hours visits were defined as any visit made by the GP between the hours of 7 PM and 8 AM Monday to Friday and at any time during the weekend. Frequent users were identified from a practice computer print out of all out-of-hours visits in the previous year. Others were randomly selected, for the sample, from health-visitor records. Families known to be experiencing particular distress such as bereavement or serious illness were excluded from the study. Families were invited to participate by letter, which was followed by a telephone call to arrange an interview.

The breakdown of families by category and family type are given in Table 1.

Box 1 Practice characteristics

Practice size: 16 500
Number of partners: 9
Number of practice nurses: 8
Number of out of hours calls: 30 per month
Demography: 12% of registered patients <10-year-old
Deprivation payments: nil
Ethnic minority: small in number including Kurdish refugee population

Data collection and analysis

In-depth interviews lasting about 1 hour took place in the respondent's home. The interviews followed a semi-structured approach which began with a discussion about the family's health and social needs and moved on to explore beliefs about health and illness, managing the

Table 1 Description of the sample

			Frequent callers		One-off callers	Non-callers
			Four or more out-of-hours calls by the family in the last year	Two calls in last 6 months	(i.e. one call made in last 6 months, no calls made in the 3 years prior to that)	(i.e. no calls made in the last 3 years)
Two parent families (i.e. families with two adults living together as a couple)	One of adults is in professional employment	Oldest child under 5		F13, F23	F8, F18	F6, F17, F19, F14
		At least one child under 10	F5	F24	F10	
	Other (i.e. non-professional or unemployed)	Oldest child under 5	F11, F28	F29	F7, F25, F16, F26	F2, F3
		At least one child under 10	F9		F15	F12
Single parent families (i.e. families with one adult living on own)	Any employment status	Oldest child under 5		F22	F1, F27	F21
		At least one child under 10	F4		F20	
TOTAL			10 families		11 families	8 families

F = Family. Number depicts code number assigned to give the family anonymity and protect confidentiality

family's health, use of health services and use of out-of-hours services. For those families who had called the out-of-hours service, the researcher asked about the calls made and the factors influencing the decision. In the non-user group the researcher probed more specifically on the issue of when to call the doctor.

In the majority of cases the mother was interviewed alone as most of the interviews were conducted during the daytime.

The 'Framework' methodology[26] was used to analyse the data and to identify key themes. This method is an analytical approach developed in the context of conducting applied qualitative research. In common with other qualitative methods 'Framework' uses in-depth interviewing or group discussion as a starting point, and from that point themes and categories are developed. Unique to this method is the systematic method of mapping and charting, used to display the process as analytical typologies are developed. This method also offers between and within case analysis and an opportunity to experience an overview of the analyst's method due to the clear and transparent view of the research process. Ritchie and Spencer[26] suggested that qualitative research, 'has a key role to play in providing insights, explanations and theories of social behaviour'.

Results

The sample consisted of roughly equal numbers of two parent families with one or more adults in professional employment, two parent families in non-professional employment or unemployed and one parent families. Within each of these three groups, there were families with young children (the oldest of which was under five) to reflect less experienced parents and families where there was at least one child aged between 5 and 10 years of age. The latter group, reflecting more experienced parents, often had children aged under five. Information gathered on their experiences of using out of hours services was not restricted to those for the older children.

Analysis of the data revealed that all the parents in the study had similar perceptions about their own responsibility for managing their children's illness and had developed

appropriate management strategies but yet still worried about whether they were doing the right thing. The decision about calling the GP was universally regarded as a 'real dilemma'.

Belief in self management

The strategies that parents put in place for managing their children's illness were underpinned by a strong belief in self-management and a desire to cope and to take responsibility for their sick child.

> Everybody has a responsibility to look after themselves. (F18)

> I don't think he [the GP] is responsible for my health, I think it's up to me at the end of the day to be responsible, the doctor is only there really to advise. (F22)

> [I] never call out the GP service…monitoring was the key and wait until the morning. It's about tolerance and your own internal coping mechanisms and the out of hours service should be used absolutely as a last resort. (F6)

The idea of internal coping echoes the work of Antonovsky[27,28] on coping mechanisms. At the heart of Antonovsky's approach is a belief that families' coping abilities are dependent on how well they are able to use life resources (e.g. wealth, ego strength, social support, cultural stability) to help them to cope. His salutogenic approach and his Sense of Coherence model offer some understanding of how families make health decisions. This can assist health professionals to understand why some families manage major life events with ease and others struggle with seemingly minor difficulties.

Strategies for managing childhood illness

All parents had strategies for dealing with a sick child that they described during the interview. These strategies usually involved taking the child's temperature, tepid sponging and giving medication. None of the strategies described were unreasonable in that they could cause harm and most were in line with the advice that a health-visitor or other health professional might have given.

> [I] check for a rash, put her in a bath to cool down, dose up with Disprin. (F4)

> I try to manage it with Calpol first. (F22)

> If they are throwing up or whatever then I tend to see if I can give them a little bit of Calpol or just basically put them in bed with me and look after them. If they want a drink they have a drink, if they throw up then I am there to clear up, you know. (F21)

Responsibility and fear of making the wrong decisions

All the parents felt a strong sense of being responsible for the health and well being of their children. This was recognized to be an integral part of the parenting experience and, as such, was welcomed. However, when faced with a sick child the sense of responsibility was often eclipsed by fear of the potential consequences of the child's illness or of 'making the wrong decision'. All parents wanted to do the right thing.

> it's a scary responsibility (F13)

> I want to make sure I am doing the right thing for him [her child] because he is number one to me. (F11)

> sometimes it just overwhelms me….I just feel what if I missed something, if anything happened I would feel the weight on my shoulders. (F16)

Despite this sense of responsibility many parents expressed feelings of being ill equipped to manage the health-care problems of their children, as one new parent said:

> when you are a new parent you have been given this bundle with no instruction leaflet and you think what on earth am I supposed to do. (F23)

Another parent realised that she lacked confidence;

> I do phone up the doctor quite a lot….anything that happens to him like a cold or whatever I seem to panic too much. (F11)

A real dilemma

For parents the decision about whether or not to call the doctor presented 'a real dilemma'. Many recognised the burden that calls could place on

the out-of-hours services and were highly reluctant to call.

> Using the out-of-hours service should be literally a life or death situation. (F8)

> People say that [making out-of-hours visits] is what doctors are there for but I feel bad using their time. (F11)

However, not wishing to impose upon the doctors had to be weighed against wanting to do the right thing for the child. One mother aptly described this:

> I do find it very hard, if they become ill, there is that point where I think "do I call the doctor, don't I call the doctor" and I personally find that very difficult. I know you have all your checklists of when they have a temperature of 102 for a couple of days and then you take them off to the doctor…if they have been sick for so many times-…then call the doctor, but I do find it very difficult….it is always this borderline thing. (F14)

Calling the doctor

For some of the parents, on some occasions, the dilemma was resolved by calling the GP out of hours. The analysis revealed no single pattern of events that led to the decision being made to call the doctor. Rather it suggested that calls were triggered by the emotional response referred to above, combined with specific characteristics related to the particular situation of the caller, e.g. a new mother with good extended family support explained why she had called the out-of-hours service:

> it was the projectile vomiting, not just once but twice in a row…he was so little, I got worried and felt I had to just get some professional advice, I just rung the number I didn't even think it was an out of hours service. I just thought we need help, help. They were brilliant. (F23)

The emotional response can also be linked to the existence of a pre-sensitivity to call the out-of-hours service: e.g. One mother who frequently used the out-of-hours service for all her children, had called the out-of-hours service on more than three occasions in a short period of time for her 9-year-old son. The child was eventually admitted to hospital with a chronic infection, and she said that she had been right all along to be concerned for his health and to persist in calling for help. (F5) In this instance the frequent calling behaviour was vindicated and the idea that the doctor must be called for everything was strengthened.

In many instances parents demonstrated a loss of confidence in the measures that they had put in place to manage their child's illness. This resulted in a call to the out-of-hours service. One single mother, who had made no out-of-hours calls within the previous 3 years, reflected on how it had taken her time to learn when it was appropriate to call the doctor and when she could manage by herself;

> many a time I would call the doctor out and he was not needed at all. I think I have learned from that, I have learned a valuable lesson from that. (F21)

Social support

Being able to call on external sources of support was often pivotal to the decision whether or not to call the GP. Many families in the study explained that they had good support from immediate family, extended family, friends and neighbours and had called on this support for help and advice when their child was ill, rather than calling the doctor.

> I nearly called the doctor the other week but my mother-in-law she came down and helped with her. (F2)

> I leave calling the doctor until the morning, if necessary I ring the family first. (F6)

Where there was little or no immediate support, the GP was more likely to be called. One mother with no family near and whose husband worked shifts said that she had rung the doctor at night. She was offered advice but not a house call she said;

> I ended in going to see the doctor the next day anyway and I was quite cross. I thought to myself, hang on a minute, you should be coming out. It is a young child we were talking about. I felt quite niggled that he did not come out because I thought he should. (F10)

Another mother who was a single parent, used the out-of-hours service frequently for her

children and was a carer for an elderly and infirm relative who lived nearby. She said she called the doctor for her daughter who was eight years old;

> She woke me up in the middle of the night screaming that her head was hurting. (F4)

The mother looked for a rash, gave medication to reduce the temperature and tepid sponged the child. The mother then called the doctor, because the child:

> was getting worse she started being sick. By the time the doctor turned up she felt better again…she had perked up, I felt such a fool. (F4)

The social isolation of looking after a sick child during the night creates sufficient anxiety to encourage mothers to call the out-of-hours service. Indeed one mother who used the service frequently said that it was:

> better to phone than not to phone. (F5)

Previous health-care experiences

Some parents appeared to feel less equivocal about calling the doctor out-of-hours. Typically, these parents had experienced an unusually high degree of contact with the health services, either for their own or their children's health. They included a single parent who had lost a child and another whose youngest child had had suspected meningitis. They were more willing to hand over responsibility for decision-making, in relation to their child's health, to a health professional and expected the health professional to intervene early. Their previous experience had somehow disempowered them in the management of minor illness.

A typical, if perhaps slightly extreme, example of this was one participant, a mother of three children whose first child had been hospitalised as a baby, who explained that she felt that she had become 'very dependent' on her GP. She said that if she had 'any cause for concern' she 'would readily call the doctor'. She appeared to have little expectation of managing her children's illnesses herself and regarded calling the doctor as caring and appropriate.

Differences between callers and non-callers

As indicated above, the perceptions of all the parents in the study were remarkably similar.

There were some subtle differences between callers and non-callers in their beliefs about using health-care services. Non-callers regarded it as *very* important to manage and to be seen to manage.

> I would never bother to phone in unless I was really worried about my children, they have to have been drastically ill, or been ill for a few days before I would even think about ringing up…literally a life or death situation. (F8)

A single mother with three children and very good extended family support said:

> [I] don't go to the doctor for every little thing. I do not have time, you know to be a day tripper…I can usually cope with most things. (F20)

Those who did not use the out-of-hours service wanted to be viewed as 'coping well' with their role as parents. They worried about the stigma of not coping, or their parenting being seen as a failure.

> you feel a failure if you find it difficult. (F6)

> I think some people do call the doctor out unnecessarily. (F21)

Callers, on the other hand, believed that they were entitled to use the service, they regarded the best thing for their child was to see the doctor immediately.

> people say that is what doctors are there for…the first thing I would do is ring the doctor. (F11)

Another mother checked her child's temperature and if it was raised she called the doctor, she said that:

> Talking can help. (F5)

and that she had often rung up just for advice rather than a call out.

Discussion

This was a relatively small study in which the participants and context cannot be assumed to be typical of General Practice settings or service

users in other areas. However, it was not the intention of the study to develop generalisable explanations of service user behaviour but rather to describe a service user perspective on the use of out-of-hours services. The themes here require further study in order to develop generalisable understandings of out-of-hours calling.

The results suggest that, rather than as is sometimes supposed, parents of sick children do have a strong sense of responsibility for managing their child's illness. Furthermore, they suggest that parents usually employ a reasonable strategy in attempting to manage the child's illness and do not take the decision to call the GP lightly. However, most parents are also aware of their limitations and fear doing the wrong thing. It would seem that on occasion this fear combines with factors such as a lack of social support and loss of parental confidence resulting in the doctor being called out for 'peace of mind'.

Further study is required to address the particular needs of the subgroups identified in this study: i.e. (i) parents lacking in confidence (ii) parents disempowered by a previous experience (iii) parents lacking social support networks. This would enable targeted strategies to be developed to support the parent in caring for the sick child.

The results point to a number of ways in which health professionals may be able to enhance the ability of the parents to manage childhood illness without expert help. A worry about lack of knowledge and fear of the consequences of getting it wrong suggest a willingness to learn and a need for reassurance. The findings also support the argument put forward by Kai.[22,23] He suggests, that professionals have considerable potential to empower parents by sharing more information and helping parents to become more skilled in managing the care of their sick child. This echoed the work of Stott[29] when he talked of the exceptional potential of the primary consultation.

Using each episode as a teaching session to increase the parent's level of control and improve their skills would be one way of achieving this for all health professionals who come into contact with the 0–5 age group in primary care. For example, one mother who used the out-of-hours service said:

> the doctor examined him…and explained to me that if you press the spots and they go away it is nothing serious…the doctor checked him over to make sure that he was still weeing, make sure he was not dehydrated which is something I do now, if I cannot get fluid down him, the doctor explained to me about that. (F16)

The ability to gain knowledge and add it to the armoury of resources is important as shown by Antonovsky cited by Cowley and Houston[30] who suggest that:

> people may be able to manage quite serious problems themselves because they have high levels of coping resources; those whose problems are less severe sometimes need more help because their coping resources are limited.

Timing of educational support would also appear to be important. If parental control and skills are established early subsequent service over use may be prevented. This points to the importance of the involvement of the whole primary care team and in particular health-visitors and midwives. All the parents talked of the support offered by the health-visiting service, one mother talked of how her confidence grew and how she felt the support offered by her health-visitor was:

> invaluable…that is a pretty scary time actually bringing a new baby home. (F23)

The educational input offered enabled the couple to develop strategies of managing minor illness. The child was aged 8 months and the mother said:

> We just learned to trust our own feelings with him. You are parents you are learning, they are only little but they are pretty hardy as well. (F23)

Conclusion

The results suggest that a change of thinking is required among health professionals and researchers in their response to parents who call the GP out of hours. The use of the

out-of-hours service is a complex phenomenon. The parents participating in this study could not be characterized as having unrealistic expectations, of lacking responsibility, or of being inadequate in their management of their children's illness. Interventions that start with this or a similar premise thereby risk being unsuccessful. The findings of the study suggest that an educational approach aimed at empowering parents in their decision-making might be appropriate.

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