Author's response to reviews

Title: Home visits - central to primary care, tradition or an obligation? A qualitative study

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Author's response to reviews: see over
Dear Dr. McKinstry

Dear reviewers,

Thank you very much for giving us the opportunity to revise our manuscript according to your suggestions, which we found very helpful to improve the quality of our manuscript.

MS: 1403616164975141

**Home visits – central to primary care, tradition or an obligation? A qualitative study**

We addressed each of your remarks in the following point-by-point reply. All changes are highlighted with green. We hope that all of your remarks have been adequately considered. Please let us know if further changes are required.

Thank you for considering this revision.

With best regards

Dr. Gudrun Theile

(Responses: please see following pages)
Reviewer’s report, referee 1

This is an interesting question, adequately defined and studied by an appropriate method.
I first comment on the major features of the paper (and the editor’s questions) and end with some specific suggestions for minor textual issues.
The introduction is clear, giving adequate background, a clear research question, and justification for the study.
Method and analyses are clearly described.
Results read well with suitable and interesting quotations, supplemented by appropriate tables. Data appear to be sound.

The Discussion is the only section I find disappointing - the scope is too limited and poorly organised. While references to other work are adequate, meaning and interpretation are less well covered, limitations are skimmed over and there are neither clear implications for clinicians and policymakers nor highlighting of unanswered questions for further research.

I suggest the authors consider the structured discussion format as summarised in the BMJ many years ago (1). Note that the subheadings I quote below from this paper need not be written out – but they need to exist in the authors’ minds and evident to the reader!

→ Response to reviewer: Thank you for this helpful reference! Actually I did not know this article before, nor one of my colleagues. We had tried to structure the discussion along the order of topics presented in the result section. But indeed the format suggested in the BMJ is much more sensible and will be also helpful for future manuscripts from our institute.

1 Statement of principal findings.
The authors have already almost written this – but they have called it conclusions and put it at the end. Move it to the start of the discussion – maybe softening the wording a little.
→ Response to reviewer: Done.

2 Strengths and weaknesses of the study.
This study has strengths in its method. Readers need reminding of the strength of such qualitative research.
→ Response to reviewer: You are right. We are not used to emphasise the strength of qualitative research. Now we tried to do so.

Limitations are already there, but the under-representation of single handed practices is dismissed too easily. Achievement of saturation in data from larger practices by no means allows us to ignore smaller ones. This is a weakness and the authors might suggest from their own experience or from the literature why findings from smaller practices could be different. Typically smaller practices offer more personal care which is associated with higher patient satisfaction – if this is the case around Hannover then findings from singlehanded GPs could well be different.
→ Response to reviewer: We added some suggestions on this topic.

3 Strengths and weaknesses in relation to other studies discussing particularly any differences in results.
4 Meaning of the study: possible mechanisms and implications for clinicians and
policymakers. Most of the existing discussion comes under these two headings. I have several comments.

A You don’t suggest any local reasons why male GPs do so many more visits than females. (The slightly longer consultations of the females in no way compensate – see text suggestions below). One common reason is that females work shorter hours, another is that they avoid the perceived danger of home visits in some urban areas. Do you have any data here?

→ Response to reviewer: Indeed, the females from our sample did work shorter hours. Nevertheless we hesitate to overemphasise the quantitative results of our data, because numbers are so small and in no way representative. We just wanted to indicate the similarity/difference of our small sample results to those results from proper quantitative studies. Some additions picking up your suggestions are now made in the text.

B It is interesting how the younger doctors do more visits. Presumably your data cannot suggest a reason, so this is a question for further study.

→ Response to reviewer: German practice owners tend to delegate home visits to their vocational trainees. This is really customary in Germany and it is very likely the reason why the younger GPs in our sample do more visits than their older colleagues.

C Another reason for variation in visiting rates for so-called urgent requests is the willingness of doctors to risk the consequences of not visiting. You do mention ‘fear of complaint’ on page 20, but do not pursue the implications.

→ Response to reviewer: To our feeling the “fear of complaint” quoted by Court et al. is more a psychological one than a concrete fear of being accused. And the implications are named in the citation: doctors conduct home visits to avoid “nagging” patients. (And in reverse: patients call for home visits, because they are “spoiled”). Nevertheless we picked up your suggestion and added some sentences about the liability aspects of non-visiting.

D You specify economic reasons for disliking home visits without explaining what these are for non-German readers. Some of your reported advantages of home visiting such as prevention of hospital admission and avoiding psychiatric crises have considerable economic implications. If GPs had to commission hospital care, as is currently suggested in England, there might be a clear economic justification for some home visits! The more direct incentive of home visits ‘selling the practice’ is interesting and seems characteristics of countries such as Germany and Belgium where there is local sufficiency of GPs and overt competition.

→ Response to reviewer: According to our understanding we did explain the economic reasons for disliking home visits. It is as simple as it is stated in the text: GPs get very little money for doing home visits – considering the time investment home visits are a loss-making operation. The German health care payment system is extremely complicated and intricate (and a very important reason why German GPs are so dissatisfied.) At the time of the study there was a mere fee-for service system in the ambulant German health care system, without any capitation fee. (Nowadays there is a capitation fee, but some measures are still cleared within a fee-for service system, e.g. home visits – but only if certain conditions are complied…) Therefore services with a high remuneration were/are much more interesting for GPs than those of a lower financial compensation. As there are two completely different payment systems for the inpatient and outpatient sector, GPs neither have an incentive to act with regard to the inpatient sector nor do they have to commission hospital care. The
suggested economic advantages of home visits as prevention of hospital admission or avoiding psychiatric crisis do not have any direct financial impact on the service provided by GPs. We decided rather not to make an attempt to explain the German payment system to international readers, because it would go too far beyond the issue of the article. But we added another explanatory sentence.

E The emotional burden is important and you discuss this well. But did any respondents mention the uncertainty of time planning inherent in home visits? The combination of traffic problems and the patient having more control of the agenda (which you do mention) can make the length of a visiting round hard to predict, giving it a high perceived opportunity cost.

→ Response to reviewer: We do see the point of your suggestion but actually none of our respondents mentioned this uncertainty of time planning. Obviously this wasn’t an aspect as relevant as other constraints.

F When it comes to your respondents’ failure to suggest ideas about the future of home visits this could mean either that they have no ideas or that your question failed to elicit their ideas!

→ Response to reviewer: We do agree and integrated some remarks on this aspect into the “limitation section of the discussion”

G Finally, your findings on attitudes to nursing homes are striking and have strong face validity. Surely these raise a number of questions for future research?

→ Response to reviewer: We added a note on a new project of our institute, which will be about interprofessional collaboration and communication in nursing homes.

5 Unanswered questions and future research.

It is the nature of qualitative research to give important insights into a topic, but also to raise new questions. Also new findings such as the negative attitudes to nursing homes may suggest a need for replicating your study on a wider scale and in contrasting settings.

→ Response to reviewer: We added some suggestions in the last section of the discussion.

In my opinion this paper will be suitable for publication once the discussion is revised, along the lines of the suggestions above.

Reference

1 Docherty M, Smith R. The case for structuring the discussion of scientific papers: Much the same as that for structuring abstracts BMJ 1999;318:1224

Notes on the text

The language is clear and easy to follow. The standard of English would do credit to many native speakers. There are just a few minor errors, some of which may hamper the reader’s understanding (these indicated by *).

p3 line 6 - ‘envisage’ instead of ‘envision’ → Response to reviewer: Done

p5 line 9 - insert ‘the’ between ‘if’ and ‘above’ → Response to reviewer: Done

p7 line 7 - ‘more than 200 patients per quarter’ *. This is unclear. I assume it
concerns the practice workload, or perhaps is a consulting rate. Perhaps this is a familiar expression in Hannover, but I find it unhelpful. Practice workload should allow for practice size and could be expressed as an annual rate per (whole time equivalent) doctor. A patient’s consulting rate should be the number of consultations per patient per year. Maybe I’ve missed something?

→ **Response to reviewer:** “More than 2000 patients per quarter” means, that more than 2000 patients had a consultation within this practice. This is a familiar expression not only in Hannover but in whole Germany. “More than 2000 patients” means it is a busy practice. “Less than 2000 patients” is standing as a surrogate for smaller practices. Maybe this differentiation is a German specific, but we collected our data on this basis and we are ambiguous to change this dimension afterwards.

p7 last line* - While certainly female GPs carried out many fewer home visits than their male colleagues, in fact 60% fewer according to table 2, the difference in consultation times was trivial, less than 8% - hardly worth reporting in a sample of 25! What we need to know is whether the females worked fewer hours each week but perhaps these data were not collected?

→ **Response to reviewer:** See response above. We added some suggestions on this topic.

p8 penultimate line* - I don’t understand ‘the boundaries of self-abandonment’ - this needs to be explained! Perhaps the authors mean that provincial GPs are abusing themselves or working too hard?

→ **Response to reviewer:** We discussed this phrase with an English native speaker and you will find the result in the manuscript. Your realisation/interpretation of the term was correct. May be we should adopt your phrase “abuse”?

p11 3rd line from bottom of page* – ‘confident’ should surely be ‘confidential’?

→ **Response to reviewer:** Of course! Thank you.

p14 line 11 – ‘aforementioned’ should be written as one word.

→ **Response to reviewer:** Done

p 17 line 11 – your reviewer is English and writes the verb ‘practise’ with an s, not a c. But in the USA they use c for both noun and verb. This is a matter for the editor’s house style.

→ **Response to reviewer:** We leave this decision to the editors.

p19 line5* – the word ‘dispensable’ appears several times. While technically correct, it is seldom used in English (the opposite sense – indispensible – is quite common). Classification of visits as necessary or else of low importance is emotive and is known to be viewed differently by patients and doctors. I suggest the authors consider a neutral phrase such as ‘low medical priority’.

→ **Response to reviewer:** Done

p 20 lines 14 & 16. Reference 15 is a multi-author paper. Therefore the authors should be named as ‘Court et al’ or ‘Court and colleagues’ and line 16 should read ‘They concluded…’

→ **Response to reviewer:** Done

p28 table 2 line 1* should read ‘Number of home visits per GP and length in
minutes’. Columns 2 & 3 should then be reversed to follow the same order as the title.
→ **Response to reviewer:** Thank you, we had overlooked that.

Table 2 row 1 cell 2* should read ‘Median length of home visits (interquartile range)’ cell 3 should read ‘Median number of visits per week (interquartile range).
→ **Response to reviewer:** Done

p 28 table 3 column 2* I don’t recognise ‘caserns’ for the elderly. These might be caissons? cisterns? (prisons?) – probably a typo!
→ **Response to reviewer:** The German term is “Kaserne”, military barracks. We asked an English native speaker and he told us the translation into “casern” would be fine?!

p 29 table 4. There is grammatical inconsistency here. The list should be either be a list of nouns or else a list of sentences, each with a verb. Both are present. As a more consistent example I suggest the following:
A diversion from the daily routine
Satisfying professional curiosity
Preventing hospitalisation
Immediate help for psychiatric crises
Enhancing the practice’s market value
Pleasing the patients!
→ **Response to reviewer:** Thank you very much! We followed your suggestions.

### Reviewer’s report, referee 2

**Background/Importance**
The subject is of continuing interest as home visiting is a component of general/family practice in many countries of the world. It is however seriously under-researched.
The results fit well with what is known about the subject, especially the mixed feelings of general practitioners about home visits and the opinion that they are not adequately remunerated for them (In the UK general practitioners are not remunerated specifically at all for them).

1. Is the question posed by the authors well defined?
   Yes
2. Are the methods appropriate and well described?
   Yes. The submission reports a series of interviews with generalist doctors using a reasonable number of doctors, 24, standard techniques are used and also standard transcript analysis techniques eg Atlas.ti
3. Are the data sound?
   The data appear reasonable. I have not seen the original transcripts.
4. Does the manuscript adhere to the relevant standards for reporting and data deposition?
   The standard of presentation is satisfactory.
5. Are the discussion and conclusions well balanced and adequately supported by the data?
   Generally Yes. Given the study was qualitative and the authors are reporting the opinions of the doctors studied.
The authors do report in addition to the serious negative views some important positive opinions like gathering knowledge of the patient’s social circumstances and that patients like home visits.

Personally, I think the discussion should make the point that the whole of this work is doctor orientated, by definition, and that to achieve a full understanding of home visits the perspective of patients needs to be researched as well.

Response to reviewer: We added accordant explanations at the beginning and end of the discussion:

“In this particular study we deliberatively focused on GPs’ attitudes while ignoring the perspective of patients or health care policy stakeholders, because we wanted to ascertain the views of those who actually performed the home visits.”

“Moreover patients’ perspectives on home visits and those of other stakeholders from the health care system will have to be explored.”

There is no mention of the training offered on the professional assessment of the home in Germany for future general practitioners or whether or not these doctors had had any such training.

Response to reviewer: Young doctors are not specially trained on the home assessment. The vocational training itself is barely standardised. This is a flaw several interested parties in Germany are working on. Trainees often have to “jump into the deep water”, not only with regard to home visits. We assume none of our interview partners ever had a special “home visit or assessment training” during his vocational training. We even didn’t ask for it, as it would have been completely out of the ordinary.

The striking findings about the quality of life for residents in the rest homes, merits rather more discussion.

Response to reviewer: We agree. We considered writing a separate article – but due to pragmatic consideration we did not.

6. Are limitations of the work clearly stated?
This study was based in Hanover and entirely within one European country, Germany. The authors do make passing reference to other countries but I suggest should spell out more clearly that their findings are country specific and cannot be interpreted widely even within Europe. For example, general practitioners in Belgium undertake relatively more home visits and British general practitioners do many fewer than 24 home visits a week.

Response to reviewer: As we understood it we already spoke out clearly that our finding are country specific. We now tried to stress it linguistically:

“It should be emphasised that although many of our results are similar to those from other countries, it would be inappropriate to generalise. The aim of this study was to uncover the perceptions and issues faced by German GPs regarding home visits.”

The authors correctly note that their findings are the subjective opinions of doctors and there is no objective evidence on the assessment such as recordings by audio or video of these consultations.

7. Do the authors clearly acknowledge any work upon which they are building, both published and unpublished?
They cite some relevant publications. One other of note is:
This includes a table showing that [British] patients who had received five or more home visits regarded their general practitioner “as something of a personal friend”.

→ **Response to reviewer:** Unfortunately, we were not able to obtain this book!

8. Do the title and abstract accurately convey what has been found?
The authors have chosen a challenging title which catches the attention and which is appropriate.

9. Is the writing acceptable?
Not quite. Of course I understand these authors are not writing in their native tongue and I admire their ability to use English. However, international journals must require clarity and whilst the writing is generally clear apart there is a phrase on page 8 “boundaries of self abandonment “ which I did not understand.

→ **Response to reviewer:** We discussed this phrase with an English native speaker and you will find the result in the manuscript. We meant that sometimes provincial GPs are abusing themselves or working too hard.

The term “rest homes” is not in line with current use in English where there is a distinction between ‘nursing homes’, where the staff include qualified nurses and ‘residential care homes’ which do not.

It would be helpful if the authors could clarify both the term and the category of establishment or both.

→ **Response to reviewer:** We definitely meant nursing homes and changed the term, where it was necessary. Thank you for your advice!

**Category**
I place this article in the category of: An article of importance in its field.

**Statistician**
I do not think this manuscript need to be seen by a statistician.

**Opinion**
I recommend that the article be published.

There is a serious shortage of research on home visits and this work may usefully stimulate more. The need for training for future general practitioners in home visiting may need review.

It raises some important new questions such as the apparently poor quality of life for residents in the “rest-homes”. This may be the nature of these establishments, but it may be an attitude in the doctors or both. In itself this merits research.

**Redrafting**
I suggest the article be redrafted (compulsory) to deal with the points listed under heading 9.

Secondly, I suggest that the authors be given the opportunity to review the comments made here to see if they wish to widen their discussion (discretionary).