PRACTICE OBSERVED

Solving Problems

Access to physiotherapy services

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The mortality and morbidity from all sorts of conditions vary widely among the regions in Britain, which is a matter for both study and concern. Furthermore, the National Health Service contains within it big regional differences in the methods of organising and delivering health care. With the present Department of Health and Social Security policy of devolving power to regional and district health authorities, these differences may become more exaggerated. Studying and comparing the differences should help local health authorities—be they regional or district health authorities, family practitioner committees, or even individual practices—to arrive at better ways of organising and delivering health care, which is the idea behind this article and others that we hope will follow.

We have started with the problem of how best to provide general practitioners' patients with physiotherapy. In Bradford

How can physiotherapy best be provided for the patients of general practitioners?

the district medical liaison committee has decided that a consultant and a general practitioner representative will assess each case referred for physiotherapy. Not far away in Rotherham general practitioners have been able to refer their patients directly to physiotherapists for some time, while in Collingham, Nottinghamshire, the local health centre has a regular physiotherapy clinic. The authorities in north east Scotland have recently conducted a pilot study of open access and will probably read of the experiences of the other areas with interest because they are now considering introducing direct access to physiotherapy services for all the general practitioners. Each authority will, of course, make its own decisions and each has special local conditions with which it must contend, but a look at what other authorities are doing may allow valuable insights and may avoid the repetition of mistakes.

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At the first meeting of our district medical liaison committee the main item on the agenda was "direct access to physiotherapy by general practitioners." To many this may sound like an outdated issue, hardly worthy of consideration at the first meeting of this august committee. After all, it is common knowledge that 76% of districts provide community physiotherapy and 66% allow general practitioners direct access to physiotherapy. Even in our in some ways retarded region 76%

springs were bought. The main problem before the health centre clinic started for the 5300 patients of the Collingham practice was transport, 15 minutes' physiotherapy treatment sometimes taking four hours or more out of the patient's day.

At the beginning of 1982 there were two sessions a week totalling six hours, and in June this increased to three sessions, totalling seven hours. Thus a total of 322 hours of physiotherapy was given for the year and in December 1982 we added a physiotherapy helper to the staff. The table analyses all discharges of patients from the clinic in 1982. (There were 163

Analysis of discharges in 1982 from the Collingham physiotherapy clinic

Diagnostic group assigned by doctor	Total No referred (%)	No not from general practitioner	No of visits		
			Maximum No	Total No	Average
Chronic spinal problems	40 (24·2)	2	18	340	8·5
Arthropathies	33 (20·0)	5	25	339	10·3
Orthopaedic	29 (17·6)	7	21	191	6·6
Upper limb problems	17 (10·3)	0	18	150	8·8
Acute spinal problems	10 (6·1)	0	18	68	6·8
Neurological	8 (4·8)	1	16	55	6·9
Respiratory	5 (3·0)	1	6	16	3·2
Service: collar/splint, etc	4 (2·4)	0	1	4	1·0
Ill defined/others	14 (8·4)	0	21	103	7·4
Non-attenders	5 (3·0)				
Total No	165	16 (9·7%)		1286	7·7

new referrals, but discharges allow a better measurement of duration of treatment.) The number of new referrals varied from nine to 24 a month, the busiest month being June with 169 treatments. The new referrals from Collingham represented 7·3% of the total for the department of physiotherapy at Newark Hospital which employs 5·4 whole time equivalents of physiotherapy time. All referrals but one were from the Collingham general practitioners or local orthopaedic consultants and conformed to the advice in circular HC(77)33 (from the standing medical committee on the relationship between the medical profession and the remedial profession, 1977).

The physiotherapists assess all referrals, and the decision to stop, curtail, or prolong treatment is taken on their advice. They have access to the medical records of the practice, although they do not write in them. Consumables, such as collars, wrist braces, epicondylitis clasps, and walking sticks, are supplied from the physiotherapy department at Newark Hospital, and some patients need to have their treatment transferred there, or indeed to be seen in their own homes. Patients who have problems in getting to the health centre have used the voluntary transport scheme operated by the health centre user's group, and patient reaction to the clinic has been universally favourable.

The physiotherapists (Mrs Pat Shephard and Mrs Anne Burns) enjoy working outside their usual environment and are pleased with the easy access to the general practitioners. This has also helped the doctors to learn about physiotherapy, and the quality of their referrals has improved. Moreover, patients, physiotherapists, and doctors have benefited from the ability to get earlier treatment for acute injuries. The clinic maintains its popularity, and we all hope that it is a permanent feature of Collingham health care.

North east Scotland

DAVID W L RICHARDS

Open access to physiotherapy services has long been considered in north east Scotland, and a pilot study has been carried out among 20 doctors. The results of the pilot study suggest that there would be no inappropriate demand for physiotherapy time, although some doctors might refer difficult patients to buy some peace, which could create a "bottomless pit" of chronic complainers who, having already been for osteopathy and chiropraxis, would clog up physiotherapy facilities. They also suggest that general practitioners understand the changing role of physiotherapy and most allow for natural recovery. Those who refer patients early do so for immediate advice and instruction in self help.

In a recent paper by the Department of Health and Social Security it was suggested that community physiotherapists would be employed in health centres and group practices. They would be paid by the local authority but work on an attached or peripatetic basis. The superintendent physiotherapist in north east Scotland would welcome this addition to the main open access facilities that would be based at Woolmanhill and serve the city of Aberdeen. Preferably, patients should place as little burden as possible on the ambulance service and we should have to use our domiciliary physiotherapists more efficiently. But availability of trained staff does not permit the early start of a system of open access to physiotherapy, and we are not at the top of the priority list.

In 1979 there were 2552 new referrals to the physiotherapy department from all the hospital clinics; in 1980 there were 2576; and in 1981 there were 2647. Of these, 46% were orthopaedic referrals, 34·7% were from rheumatology clinics, and 19·3% from mainly medical, neurology, and dermatology clinics. In the pilot study we considered the patient, the appropriate consultants, the superintendent physiotherapist, the availability of qualified staff and staff in training for such a service, the general practitioner, and the primary care team.

Several schemes of open access operate successfully in Scotland, in particular at the Western and Eastern General hospitals in Edinburgh since July 1976 and at Leith Hospital since July 1981. The results of the pilot study suggest that open access would be used more for back, neck, and shoulder lesions, and also for some soft tissue lesions and cerebrovascular accidents. Our main worry is developing an administrative system for referral and, thereafter, satisfactory record keeping. It is striking that so few doctors have any knowledge of physiotherapy techniques, and it is important to remedy this.

The feeling in north east Scotland is that with the help and experience of others and the tremendous amount of local goodwill progress is being made towards open access to physiotherapy, and a more extensive study is being carried out.

ONE HUNDRED YEARS AGO Between the years AD 806 and 810, an Emperor of Japan commanded his court physicians, Abemanas and Idzumo Kirosada, to collect in one volume all extant records of native medicine and surgery. A manuscript copy of this work, for centuries forgotten, although the facts of its origin were recorded in Japanese history, was found in 1827 by a priest, in a provincial Buddhist temple. Dr Scheube, of Leipzig, has recently examined this work, and, in an article published in a recent number of *Archiv*, has shown its undoubted authenticity and its high value from a purely scientific point of view. It was written long before Chinese ideas had penetrated into Japan and influenced native practitioners. The most interesting passages are descriptions of local and general affections, which clearly prove that syphilis, and several allied disorders, were well known to the ancient Japanese. Chancroid and phagedenic chancre are clearly described, as well as a "swelling on the penis, of the size of a millet-seed," followed by eruptions, feverishness, pains in the bones and head, blindness, swelling of the testicles, and other very familiar symptoms. These were observed to continue for many years. The passages of this work, called the Daidorui Thiu-ho, which relate to the treatment of these symptoms, have not yet been translated into English. Herbs alone appear to have been used, and without much success; mercurial treatment was introduced at a comparatively recent date, from Europe. The ancient Japanese surgeons do not appear to have recognised the venereal origin of the disease which they describe, although the Daidorui distinctly traces all the secondary symptoms to "the poison from the affected organ." (*British Medical Journal* 1883;i:974.)

of districts have provided for direct access. Yet in Bradford, once known for its many progressive medical and social ideas, this has remained an insoluble problem. Indirect access means a patient with a simple complaint waiting up to 20 weeks to see a specialist to approve the need for physiotherapy. This often results in months of physical and psychological pain, with the inevitable threat to the patient's employment and finances.

There were grave predictions of a sudden explosion in the number of patients referred directly for physiotherapy, despite experience to the contrary in the districts with a policy of direct access. Our specialist colleagues believed that this would further delay the all important treatment of their "own" patients, although it was difficult to understand the distinction made between "their" patients and "our" patients. Futhermore, there was a totally unsubstantiated claim that direct access will lead to more medicolegal cases owing to inappropriate referral by less than competent general practitioners. Such a harsh and biased assumption is at least in need of some reliable evidence, if nothing else. Some of us, however, could recall that similar fears were expressed when general practitioners were for the first time allowed direct access to laboratory and radiology services, which has been proved to be cost effective and of immense value to both the patient and the doctor.

In the face of all the evidence in favour of direct access it was sad to encounter such resistance. The historical chasm separating the two main branches of the profession seemed to be as wide as ever, and the welfare of the patient, which should be the guiding light for all our decisions, was barely considered. After a month of negotiations, however, it was agreed to start an experimental scheme of direct access for a limited period. The cases referred for physiotherapy will now have to be vetted by a consultant and general practitioner representatives before acceptance. We have welcomed this new development and hope that the results of this experiment will justify implementing a policy of direct access in Bradford.

Rotherham

M HAMID HUSAIN, SUE CLIFTON

The attempts made by the Rotherham Health Authority to improve physiotherapy services for the community by giving general practitioners open access to the hospital physiotherapy department have not only greatly reduced the time that patients have to wait for treatment but has appreciably increased their chances of recovery, curtailed the duration of incapacity, and reduced the number of hours lost from work. The physiotherapy department at the district general hospital welcomes direct referral from general practitioners of all patients who live or work in the district. We hope that satellite departments will be set up at the periphery, which will be more accessible for patients.

The physiotherapy department provides rehabilitation, exercises, mobilisation of spinal and peripheral joints, cervical and lumbar traction, ultrasonics, hot and cold therapies, paraffin wax baths, and splintage. Advice and help are given on the treatment of patients with handicaps and disabilities, and on postural drainage, breathing exercises, and relaxation techniques. The staff have been trained in the use of acupuncture for pain relief and in the technique of transcutaneous nerve stimulation. A pool is used for hydrotherapy, for asthmatic children to improve breathing techniques, and for improving the mobility of disabled people.

There is a clearly defined protocol that everyone is advised to follow. The referring doctors are expected to complete a card requesting physiotherapy with relevant clinical details and the results of investigations undertaken. Precise diagnoses are not required, but it is assumed that the sinister pathologies have been excluded and that the patients who need specialist treatment are not referred. General practitioners are not required to indicate specific treatment, but it is always hoped that limitations and possible contraindications will be clearly noted.

New patients are interviewed and assessed by a senior therapist on Tuesday and Thursday mornings and appropriate treatment prescribed. Monday evenings are reserved for a sports clinic so that people who have been injured during the weekend may be treated with little delay. The referring doctor is always informed about treatment by a form letter and is sent a detailed report at the end of treatment, indicating the outcome and suggesting further action. The senior physiotherapist may decide if the treatment should be continued or terminated early and informs the doctor. Patients remain under the clinical care of their general practitioners and are not normally seen by a consultant unless referred. Physiotherapists may decline to treat a patient if in their opinion treatment is either contraindicated or unlikely to be helpful in the light of the information given. They may also delay treatment if insufficient information is given to assess the patient properly.

An open access service has reduced the pressure on consultant orthopaedic surgeons and enabled patients to receive treatment quickly. Those who suffer from back and neck pains and musculoskeletal disorders, including trauma, and those with chronic chest conditions have found the service especially valuable.

Community physiotherapy

Services are also provided in patients' homes and at special schools for those who find it impossible or difficult to travel to the hospital. Requests for domiciliary services are usually made by general practitioners, but community nurses are encouraged to initiate referrals for patients who are likely to benefit, with the general practitioner's approval. Treating patients at home prevents further deterioration, maintains mobility, and avoids admission to hospital. The physiotherapist can also see the conditions at home and advise relatives, nurses, or health visitors on appropriate exercises to be done in a familiar environment to retain as full a range of activities as possible.

Equipment such as nebulisers, heat pads, and nursing aids are sometimes loaned to patients who are trained to use them. But patients and their relatives are mainly taught exercises and about rehabilitation, thus avoiding the need for frequent visits to initiate passive treatment. Domiciliary treatment has been valuable, not only for chronically disabled people and those who have had a stroke and cannot go to hospital, but also for recently discharged patients who have had fractured hips or cerebrovascular accidents and need to exercise continuously to remain active.

We commend open access to physiotherapy services, believing that it has done much to reduce unnecessary suffering to patients.

Collingham, Nottinghamshire

MIKE PRINGLE, F E HILL

In May 1981 three partners and a trainee moved into a purpose built district health authority health centre. The district physiotherapist had helped in the planning, which led to reinforcement of a wall and ceiling in the treatment room. Because of the enthusiasm of both the superintendent of the local physiotherapy department in Newark Hospital (six miles away) and the district administrators a physiotherapy clinic for patient referrals was started in the health centre within one week of opening. With a special allocation of £2000 and some existing funds, a continental Akron couch, wall handrails, mirrors, and the equipment for ice, short wave diathermy, all forms of heat, ultrasound, electrical stimulation, cervical traction, and exercises requiring weights, pulleys, slings, and

Practice Research

Out of hours calls in general practice: does the doctor's attitude alter patient demands?

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We studied out of hours calls in two practices in the same health centre in London. At the time both practices had six partners and two trainees, and one partner in each took little part in out of hours calls. Both practices have roughly 12 000 patients on their lists and are similar demographically—that is, for age, sex, and social class. Both practices have few private patients. Out of hours calls are normally received by an answering service that passes on all calls to the doctor on duty. A deputising service is not used.

We were trainees in 1978 in the two practices, and it was apparent to us that demand for out of hours calls differed between the two practices. We therefore decided to carry out a prospective study of out of hours calls during four weeks in June and July 1978.

The study was set up to:

(1) Describe the pattern of demand in two north London practices.

(2) Document the number of calls received by both practices in a defined period.

(3) Compare the response of the two practices to out of hours calls.

(4) Investigate factors influencing the response of the doctors.

(5) Document the rating that doctors gave for the necessity of individual out of hours calls.

Method

Out of hours calls were monitored for four consecutive weeks in June and July 1978. An out of hours call was defined as one occurring between 1900 and 0830 on weekdays and between 1200 on Saturday and 0830 on Monday.

We requested that for each out of hours call the doctor fill in an encounter form (figure). The results of the questionnaire were recorded, using a modification of the Royal College of General Practitioners diagnostic classification for items (7) and (11) and a group of broad categories for other items. The data were then put on computer at Bedford College, London, using the Defend program of the Statistics for Social Sciences Package (Vogelberg Computing Center, Northwestern University).

We also obtained data for the number of out of hours calls in the six months up to and including the study period, and we asked local hospitals to tell us how many patients of the two practices referred themselves to the accident and emergency departments without a general practitioner's letter.

Results

In the four weeks studied in June and July 1978 practice A received 100 out of hours calls and practice B 91. In the period January to July 1978 practice A received 1156 calls and practice B 788. Table I gives the time that the calls were made in the four weeks in June and July.

TABLE I—*Time of call*

Time (h)	Practice A	Practice B	Total No
1901-2300	42	39	81
2301-0900	20	16	36
0901-1900 (that is, weekend "day" calls	38	36	74

AGE AND SEX OF PATIENTS

There were 64 calls about children aged under 10 years: 10 children were under one year, 26 were aged 1 to 5, and 28 were aged 5 to 10. There were 12 patients aged 10 to 20, and 35 were aged 20 to 35, of whom 23 were men. This is in line with the population profile of the district. Twenty six patients were aged 35 to 50 years, 15 were 50 to 65, and 31 were 65 and over, of whom 22 were men. In other age groups there was no difference in sex distribution. There were 14 unrecorded observations. In all, there were 103 (57·6%) male patients and 74 (41·8%) female patients.

KNOWLEDGE OF PATIENT

There was no important difference between the practices with regard to prior knowledge of patients, and prior knowledge did not noticeably affect the decision to visit.

STATED REASON FOR THE CALL

In 56 out of hours calls the stated reason for the call was fever, with or without a rash, or respiratory or ear symptoms. Twenty patients had chest pain, 14 patients abdominal pain, and 11 diarrhoea and vomiting and a similar number neurological symptoms. Ten "reasons" could only be described as malaise or collapse. Ten calls were for accidents; eight were related to psychological symptoms; eight were for skin ailments; 10 were classed as social problems or miscellaneous queries—about drug dosage or side effects; six were for musculoskeletal symptoms; five were about asthma; three were about urinary tract symptoms; two were about symptoms of pregnancy; and one concerned a gastrointestinal bleed.

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The open ended responses to item (8)—Doctor's initial impression—on the questionnaire (figure) were collated and entered into a general classification as shown in table II. The first two categories—minor named illness and major named illness—are self explanatory. "Minor unspecified illness" includes fever, myalgia, malaise, falling about, etc. "Major unspecified illness" includes chest pain, dyspnoea, etc. The sixth category includes anxiety shown by the patient or relative; family conflict; behaviour considered typically difficult—for example, the patient about whom the doctor remarked: "A meticulous old woman: I have asked that she be removed from our list" (this stricture occasionally misfired, as when a doctor referred to a particular patient's "typically demanding behaviour," but checking the records showed that the doctor was unknowingly castigating a different patient of the same name); and unreasonable requests—for example, one doctor reported during one night a call at 0200 for sunburn and a call at 0400 for hair loss due to a badly applied perm (table III).

TABLE II—*Doctor's initial impression of reason for call*

	Practice A No (%)	Practice B No (%)
(1) Minor named illness	26 (26·5)	23 (25·3)
(2) Major named illness	11 (11·2)	11 (12·1)
(3) Minor unspecified illness	24 (24·5)	8 (8·8)
(4) Major unspecified illness	14 (14·3)	9 (9·9)
(5) Exacerbation of chronic condition	6 (6·1)	9 (9·9)
(6) Anxiety, unreasonable request, overreaction	15 (15·3)	26 (28·6)
(7) Request for advice	2 (2)	5 (5·5)

Dr | Please use a new sheet for each call

CONFIDENTIAL — OUT OF HOURS CALLS

1 Date | 2 Time

3 Patient | 4 Age | 5 Address

6 Do you know patient Yes ☐ No ☐ By repute ☐

7 Patient's stated reason for call

8 Doctor's initial impression

9 Did you: Phone advice ☐ or visit ☐

10 Reason for your decision to visit or give phone advice

11 Revised diagnosis or impression after visit if any

12 Nature of further advice or treatment

13 Did you feel that the call was necessary ?
Please rate on scale
Absolutely necessary 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Completely unnecessary

14 Any other comments

Form completed by doctor for each out of hours call.

TABLE III—*Doctor's rating of necessity of 188 out of hours calls*

	Absolutely necessary (n = %)			Completely unnecessary (n = %)	
	1	2	3	4	5
Practice A	15 (15·5)	23 (23·7)	28 (28·9)	26 (26·8)	5 (5·2)
	38 (39·2)			31 (32)	
Practice B	19 (20·9)	17 (18·7)	26 (28·6)	20 (22)	9 (9·9)
	36 (39·6)			29 (31·9)	

Note: A remarkable unanimity about the necessity of individual out of hours calls emerged. There was no difference in ratings between principals and trainees

TABLE IV—*Doctor's response to out of hours calls*

	Phone advice only No (%)	Visit No (%)	Both No (%)
Practice A			
All	31 (33)	59 (59)	10 (10)
Principals	18 (24)	47 (62·7)	10 (13·3)
Trainees	13 (52)	12 (48)	0
Practice B			
All	45 (49)	43 (47·3)	3 (3·3)
Principals	39 (52)	33 (44)	3 (4)
Trainees	6 (37·5)	10 (62·5)	0

P = 0·0032, χ^2 test.

DOCTOR'S REASONS FOR GIVING PHONE ADVICE OR FOR VISITING

In both practice A and practice B the reason given most frequently for visiting was a potentially serious diagnosis: 27 (39%) of practice A's visits and 27 (57·4%) of practice B's visits. Of practice A's visits, however, 27 were recorded as being required because of patients' or relatives' insistence or anxiety, as opposed to three (6·4%) of practice B's visits. Other reasons given for visiting were: eight patients could not be contacted by phone, and in five cases there was difficulty with language or comprehension. In five cases the call was from a colleague (nurse or midwife). In two cases only was the reason given as the age of the patient, and in two cases the out of hours call was to confirm death. In four cases there was a second out of hours call.

Of 46 persons given telephone advice by practice B, nine were considered to have requested only advice or information as compared to nine out of 30 for practice A. In both practices phone advice was given for "trivial complaints" in about 30% of cases. Practice B doctors gave advice in seven instances when the patient was apparently well or getting better compared with no such cases for practice A. In seven cases practice B doctors did not visit because the caller seemed to respond well to reassurance compared with only one for practice A.

REVISED DIAGNOSIS AFTER VISIT

After visiting the revised diagnosis seemed to accord with the doctor's initial impression on taking the call in 80% of cases. The commonest out of hours calls resulting in a visit were fevers with or without rashes, respiratory and ear, nose, and throat symptoms, and viral illnesses in 41 cases; chest pain, left ventricular failure, dyspnoea, palpitations, and myocardial infarction in nine cases; diarrhoea and vomiting in seven cases; and skin symptoms in seven cases. There were six psychological problems, five cases of asthma, and 18 other diagnoses. There was no evidence that practice A patients had a higher rate of morbidity. In 99 cases (80·6%) the diagnosis was not changed by visiting. In 10 cases (8·5%) there was no apparent agreement between the doctor's initial impression and revised diagnosis after visiting. In seven cases (6%) there was no clear relation between the two.

Discussion

Out of hours calls are perhaps the most vexatious part of the general practitioner's work in the United Kingdom. Some authors dispute that such work is necessary,[1] while others think that there is a low level of "abuse" of the service. It seems that it is generally assumed that part of the purpose of "training" patients is to limit out of hours calls that the doctor thinks are unnecessary. How this is to be achieved is not clear, but Valentine[2] suggested health education or financial penalties. Some authors have considered factors governing demand, such as patients' characteristics, including social class,[3-7] and the use of a deputising service.[8] Others have examined the pattern of demand searching for abuse.[9-14] Richman[11] and Clyne[12] have considered the emotional factors that may trigger the patient's decision to make an out of hours call. Stevenson[13] showed that in one practice there was a marked variation among doctors as to whether they responded to an out of hours call with telephone advice or a visit.

Our results are not directly comparable with those of Lockstone,[5] Morton,[9] and Cunningham[10] because they were concerned with calls late at night (generally 2300 to 0830 hours), whereas our study covered calls in the evening and during the day at weekends. (Extrapolation from our lists suggests that there are 18 late calls per 1000 patients a year: more than in the series of Lockstone,[5] Morton,[9] and Crowe[14]: about the same as in Riddell's[7]: but fewer than that in Cunningham's.)[10] The type of illness reported, however, seems less serious than in the rural series and the rate of hospital admission was low.

How the attitude and behaviour of a doctor may affect the demand for out of hours calls has apparently not been studied. The two practices in our study are similar in many respects. They have demographically similar patient lists, participate in undergraduate and postgraduate education in primary care, occupy the same premises, employ in common certain practice staff (notably treatment room nurses), and use the same answering service. Both practices have primary care teams, but the decisions in practice A tend to be doctor initiated and in practice B to be made democratically. There are other important differences between the two practices that are related to their histories. Practice A rose from a long established and traditional practice of father and son in a mainly middle class residential area. Its style of practice remains traditional, academically orientated, personal, and somewhat paternalistic in its internal relationships. Personal lists are encouraged, and team decisions tend to be doctor dominated. Home visits during the day are made by the patient's own doctor.

Practice B originated from a practice of two doctors deliberately set up in a run down working class area at the inception of the National Health Service. The practice has always been committed to team work, and a great deal of its work has been delegated to the treatment room nurse, health visitor, social worker, and geriatric visitor. Personal lists are not particularly encouraged. Team meetings tend to be democratic and chaired by any team member, by no means always a doctor. Home visits during the day are done by one doctor allotted the task in rota.

During the study both practices had a similar number of out of hours calls, although practice A had many more (1159) than practice B (788) in the six months up to and including the study period, which confirmed our impression. During the study there were variations in the response to out of hours calls, although both practices were more likely to make visits in response to out of hours calls to patients calling between 2300 and 0900 than at other times and both practices responded similarly to patients having symptoms of major illness. There were no major differences in out of hours calls in terms of sex, symptoms of major illness, and doctors' attitudes towards the calls. Doctors in practice A, however, were much more likely than those in practice B to respond to an out of hours call with a visit, and when trainees were excluded this statistical difference is further accentuated.

The difference in response might be attributable to apparent differences between the two practices in assessing symptoms. Doctors in practice A seemed to consider that non-specific symptoms were related to minor illness, the diagnosis of which was unspecified: doctors in practice B were more likely to think that the symptoms were related to overreaction or overanxiety on the part of the patients or relatives, or that specific out of hours calls were unreasonable.

It seems that the difference in visiting rates is related to a difference in the doctor's attitude and response towards minor symptoms. In terms of response to out of hours calls such attitudes might be described for practice A as "caring, paternal, anxious" and for practice B as "disciplining, educative, unanxious." It may be that such attitudes are communicated to patients either directly in a discussion with the doctor or indirectly as a result of the long term relationship between the doctors and their patients, and that those attitudes colour the patients' expectations and ultimately their needs. It is impossible to say whether patients in these two practices have chosen a particular style of doctoring to suit them: there is almost no interchange of patients between the two practices, but it cannot be presumed that this implies satisfaction. The results of our study do not show whether patients are better served by, or satisfied with, the different approaches of the practices.

To visit or not to visit? In those cases where not to visit would be widely agreed to be negligent or, at the very least, to be legally hazardous the decision making process is clear. In less clear cut cases, however, our results show that the doctor's decision is not necessarily based on medical factors or experience but rather on the doctor's assessment of non-medical needs that might be met by his visiting and on the expectation of the patient. Perhaps such responses by the doctor influence demand and ultimately the degree of dependency of the patient, and it is on this that the importance of the study lies.

Conclusion

The requests for a doctor out of hours that were made to two group practices of similar size in the same health centre in north London were compared, and the way in which these requests were dealt with by the two practices was contrasted. One practice received more requests for out of hours attention and was more likely to respond with a home visit. We examined possible reasons for this difference and ways in which the attitudes of doctors influence the demands made on them.

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References

1. Rogers A. Golden slumbers. *World Medicine* 1980 Aug 23: 8.
2. Valentine J. Out-of-hours calls. *World Medicine* 1980 3 May, 15: 38-9.
3. Jacob A. A diagnostic consideration of the late calls in a general practice. *J R Coll Gen Pract* 1963; **6**: 272-8.
4. Jacob A. The personal characteristics of people who require late calls. *J R Coll Gen Pract* 1965; **8**: 436-47.
5. Buxton MJ, Klein RE, Sayers J. Variations in GP night visiting rates. Medical organisation and consumer demand. *Br Med J* 1977; i: 827-30.
6. Riddell JA. Out of hours calls in a group practice. *Br Med J* 1980; **280**: 1518-9.
7. Morton DJ. Night calls in a group practice. *J R Coll Gen Pract* 1979; **29**: 305-8.
8. Lockstone D. Night calls in a group practice. *J R Coll Gen Pract* 1976; **26**: 68-71.
9. Cunningham RJ. Night calls in a single-handed rural practice. *J R Coll Gen Pract* 1980; **30**: 745-7.
10. Richman G. Late calls—emergency or anxiety. *J R Coll Gen Pract* 1965; **9**: 241-5.
11. Clyne MB. *Night calls—a study in general practice*. London: Tavistock Publications, 1961.
12. Stevenson JSK. Advantages of deputising services: a personal view. *Br Med J* 1982; **284**: 947-8.
13. Crowe MGF, Hurnwood DS, Taylor RW. Out of hours calls in a Leicestershire practice. *Br Med J* 1976; i: 1582-4.

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Overlapping General Practice

Lawyer

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As the son of a consultant physician brought up on *Dr Finlay's Casebook* I had a romantic idea of the role of the general practitioner. My subsequent professional and social contact with the medical profession has never quite dispelled that image. When I turn to a general practitioner for help in resolving my client's problems I have fairly high expectations that he will provide the key, and these expectations are rarely unfulfilled. The occasions on which I am disappointed are, more often than not, the result of my client having failed to discuss his other problems with the family practitioner. Of the problems that clients discuss least often with the practitioner are those associated with marriage breakdown—the area in which I am most concerned and where there is probably more scope for the pooling of our skills than in any other field of law.

Divorce

It is perhaps difficult to appreciate the rate of increase in divorce over the past few years. In 1980 there were 12 divorces per 1000 married couples in England and Wales. The total was 148 000 divorces—six times the 1961 rate and double the 1971 rate. Using 35 years of marriage as a base line, one in three marriages may be expected to end in divorce. The figures belie the human misery but the problem has created a considerable workload for the solicitor who is interested in people and their problems and is prepared to work in this specialty. A great proportion of my practice is concerned with marriage breakdown and the consequent associated problems.

I often feel a great sense of frustration when confronted by clients who seek advice on problems that have led them to conclude that divorce is their only solution when I feel confidently that if they had had some advice at an earlier stage their problems could have been solved and their marriage perhaps saved. Often I inquire whether they have sought such advice, and one of the first people on my list of possible advisers is the general practitioner.

Perhaps it is wrong of me to expect a doctor to be concerned with such a problem. Perhaps it is more an area for counselling. But my conception of a general practitioner's role probably dates back to my youthful expectations when the general practitioner knew his patient and his circumstances. His professional concern was not limited to treatment of ailments. It is a concern that I think is expected of the solicitor, although certainly more so in the suburban and country practices.

I commonly turn to the general practitioner when my client is seeking a divorce in the first three years of marriage. When Alan Herbert's 1937 Matrimonial Causes Act became law it liberalised the divorce laws. One of the sops to the opponents of this liberalisation was a bar on divorce in the first three years of marriage. But then came the lawyer's ubiquitous exception or the Englishman's famous compromise. A spouse could obtain the court's permission to seek a decree if he or she could establish that the case was within one of two exceptions—either that there had been exceptional depravity on the part of the respondent or the petitioner suffered exceptional hardship.

There have been several judicial attempts to define these exceptions. The first, seemingly indefinable, was explained by Lord Denning in a 1948 ruling. He held that to find "exceptional depravity" it was necessary to inquire into the degree of depravity alleged. He went on to say that certain matters were ordinary depravity about which there was nothing exceptional. It was a ruling difficult to understand and harder to follow in subsequent cases. Doctors were called upon to give evidence in the parties' attempts to bring themselves within these exceptions. This ruling has to some extent been modernised and the only effective exception is that of exceptional hardship. It is a matter on which I turn to a general practitioner for expert evidence only to find far too often that my client has never mentioned his or her matrimonial difficulties and the general practitioner cannot help.

Interests of the child

Another of the frightening statistics of marital disharmony is the projection that in the next 10 years 1 600 000 children under 16 will have divorced parents. In 1971 there were only 82 000. There are often disputes between parents about the welfare, custody, care, and control of their children and in this area too I often look to my client's general practitioner for expert guidance. Cases concerning children are difficult because as a solicitor one owes a duty to the courts, the child, and the client, and it is often difficult to balance the conflicting claims. The law is that the child's interests and welfare are paramount and the court is required to regard them as such, but the client is none the less entitled to have his case put, even if it is a hopeless one.

I remember acting for parents, both of whom had been not infrequent guests of Her Majesty, who wished to prevent their local authority from taking into care their two daughters, who at 14 and 16 had been earning their living on the streets. Their case was hopeless, but the solicitor's duty is to put it and argue it, even though no medical help could there be obtained.

I cannot doubt that the adversarial nature of court proceedings is not best suited to resolving children's problems, which are sensitive and emotive issues. The obligation and duty of the lawyer to give forceful presentation to his client's case may sometimes extend to the colouring of medical evidence. I well recall acting for a husband in a case where his entitlement to access to his 6 month and 2 year old sons was being opposed. The wife called her general practitioner who gave evidence that she thought it a bad thing for a father to have rights of access to such young children. On cross examination it transpired that her views were expressed in a friendly discussion between the doctor and wife at a party but the problem had not been raised in a formal consultation. Fortunately, cases like that are few and far between and the general practitioner's views are generally fairly and objectively expressed and their advice is directed towards what they consider to be in the child's best interest.

Medical reports

Approaching an expert, such as a doctor, for evidence gives the solicitor the problem of seeking the desired response without putting words into his mouth. It is to some extent akin to the doctor's difficulty of obtaining a full description of his patient's problems or symptoms. How often the onset of those symptoms is recalled by relating them to established dates and occurrences, such as Uncle Fred's funeral or Aunt Flora's holiday, and how often one has to listen to the patient's social diary. The solicitor must tread warily. He must guide the doctor but not write his own report for him. The Court of Appeal has held in the widely reported case of Whitehouse and Jordan that they deprecate the practice of a doctor's report being drafted by leading counsel.

The importance of the report can be more effectively appreciated in personal injury cases. I was surprised some few years ago when I read my first personal injury report. The doctor's first line was "This man says he fell from a bike." It seemed to my semitrained mind that the doctor was as much challenging the patient's account as simply and faithfully recording his clinical observations. I have since learnt through experience the importance of this wording, although I cannot recall a client who has been shown to have suffered injury at the hands of a person other than his opponent in litigation.

I am often surprised at the variance between reports prepared by opposing sides in the same case. The report supporting the plaintiff records substantial disability and discomfort and long term deterioration. The observations are well known. The report prepared on behalf of the defendant records a complete recovery with a good long term prognosis. The judge must assess the medical condition from the two conflicting reports of experts. He, as a lawyer not as a doctor, is required to reach a conclusion on medical matters. It cannot be much of a surprise that litigation is such a lottery.

Perhaps the best known case about such a problem, although not in the field of personal injury litigation, was that of the so called Yorkshire Ripper. There was clear medical evidence that Peter Sutcliffe was insane within the meaning of the MacNaughten Rules. Several doctors gave such evidence. The judge notwithstanding the evidence found as a matter of law that the defendant was fit to stand trial.

Perhaps the only other area where my work overlaps with that of the general practitioner is that relating to the Court of Protection. The problems that require a patient's affairs to be supervised by the Court of Protection are of course quite different from those experienced in other areas of law. The court's discretion is exercised towards helping and resolving difficulties. Accordingly, its procedure is in somewhat stark contrast to that in the high and county courts where there is often the feeling that both the other side and the administration are opponents.

Perhaps this is an area where the general practitioner looks to the solicitor for assistance rather than the other way round. The practitioner is faced with the real social problem of a patient in a geriatric ward who has no family and nowhere to go but has funds that need to be administered and property that needs to be sold. Prejudice tells me that it is not a problem with which a solicitor will readily be concerned. There are occasions when the family takes the problem directly to a solicitor. Another is going into the bank 10 times a day to withdraw £5. The only way the family can prevent such a seeming nuisance is by bringing her affairs into the court. It has to look to the general practitioner to certify that the patient is suffering from such physical or mental illness as to be incapable of managing her own affairs.

One of the best examples I have been concerned with that show the court's approach to such problems was one in which the patient was a tenant of a flat but she was not then in occupation and the landlord desired to sell the flat at a substantial undervalue. The court approved purchase by the patient and subsequent resale at a profit of some £10 000.

I have sought to discuss overlap between my practice and that of the general practitioner. For the main that requires working in tandem with a common aim. There is of course another side to the coin when the solicitor is acting for a client who wishes to sue his doctor. The client considers it was his right to be cured and if he has not been then blame must be apportioned to the doctor and damages recovered. It is hard for the client to accept that sometimes medicine is not infallible. For some reason he more easily accepts the fallibility of the law.

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Diary of Urban Marks: 1880-1949

Things at Worcester promised to be interesting and in the nature of an adventure. And so they were. On the first operation afternoon I had commenced to give chloroform to the first case on which Bates was about to operate. Bates came into the anaesthetic room and in his querulous voice asked what I was giving. I informed him and very rudely he told me to give ether. There was no request but simply a command. Now the anaesthetist always has the choice of giving what anaesthetic he himself deems wise and I reminded Bates of this. He fairly shouted back at me not to argue. I told him I should not continue and McFetridge had to carry on. I watched Bates operate while the other two assisted. After my experience at Swansea the exhibition was disgusting. He knew no anatomy and was not at all clean during the operation. He certainly scrubbed his hands before it but never once during it did he dip his hands into an antiseptic. No rubber gloves were worn. But by the end of the operation nothing could surprise me.

I commenced to give chloroform in the second case which was to be operated on by Mr Gosling as he always followed Bates. Gosling came out and in the manner of his senior, ordered me to give ether.

Without any argument or a single word, I put down the apparatus and McFetridge superseded me. Again I watched Gosling operate. But Bates kept on interfering, telling Gosling what to do and whether he was right or wrong. It was just as if Bates was instructing a medical student in the steps of an operation. By this time I was shaking with laughter and was tickled to death with Bates. Once he caught a smile on my face and asked me what there was to laugh at. I told him that he was too dense to understand. This rather flattened him since no one had ever dared to answer him back. He then ignored me for the rest of the afternoon, but I was in nowise upset.

I started to give chloroform for the third case in which Mr Pollard was interested. He came and asked me if I would mind giving ether. He whispered this request in my ear, and when I asked him why he preferred ether he gave me the answer I already knew from Mac. I deferred to his request but asked him why everyone was so afraid of Bates. He did not answer.

After this first afternoon, I used to go up into the operating theatre on every occasion. If I thought the case demanded chloroform I said so, but the surgeons would not have it. And so I only administered a few cases of ether.