Night calls in a group practice

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SUMMARY. All the night calls attended in 1974 by seven doctors in a group practice were analysed. Each call was classified by the doctor attending, into categories of urgency.

Half of all the night calls were found to be genuine emergencies, and only seven per cent were judged to be totally unnecessary.

Introduction

The real need for night calls in general practice has recently been challenged (*B.M.A. News* 1975), where it was considered that " most of the much publicised night work merely satisfies the doctor's delusions of grandeur and could be withdrawn permanently without serious loss ". No evidence was offered to support this opinion.

As there appears to be little recent published information on night calls, I analysed all the night calls in 1974 by a large practice in North Yorkshire.

Aims

The aims of the study were:

(1) To find out the incidence of night calls,

(2) To assess the urgency and severity of the conditions which led to night calls.

Method

Practice profile

The practice is situated in a small coastal town in North-east Yorkshire. It is made up of all seven doctors in the town with a combined list of 15,274 patients in December 1974. The community traditionally fishes and farms and has been a popular holiday resort for 100 years.

In the last ten years some light industry has come to the area, 75 per cent of the practice is urban, 25 per cent rural. In addition to ordinary general practice, the practice is jointly responsible for staffing a 50-bed general-practitioner hospital, the town's casualty department and a general-practitioner maternity unit.

The nearest district general hospital is 20 miles away. All the practice midwifery is carried out in the general-practitioner unit so there are no maternity calls included in this series and calls to the hospital or casualty department are also excluded.

All the calls were undertaken by the partners and a commercial deputising service was never used.

All calls attended between 2300 hours and 0700 hours the next morning are recorded on National Health Service form E.C. 81. The doctors in the practice recorded the required information on the back, which was then extracted by our practice secretary before forwarding these forms to the Family Practitioner Committee. In addition to recording diagnosis and management, the doctor classified each call into one of three groups according to his assessment of urgency:

Group 1—Genuine emergencies

This was defined as a serious condition clearly requiring urgent treatment either to save life, or to prevent further unacceptable and potentially serious deterioration, or to alleviate severe pain or distress. Patients found dead on arrival, or who died under treatment are included in this group.

Group 2—Irresponsible calls

No treatment was given in this group.

Group 3—Unnecessary but reasonable calls

Calls were placed into this group if the doctor felt that on examination the patient proved not to be a genuine emergency, in that he would not have died or deteriorated without immediate treatment, but did have a problem requiring a fairly urgent medical opinion and, having regard to the circumstances, was regarded by the doctor as a reasonable call.

Results

Total number of night calls in the practice attended in 1974 was 163 (10·7 calls per thousand patients per year).

Group 1 *Emergencies* 78 (48 per cent).

Group 2 *Irresponsible calls* 11 (7 per cent).

Group 3 *Unnecessary but reasonable calls* 74 (45 per cent).

Group 1 *Analysis of the emergencies*

(a)	Medical cause	35
(b)	Surgical cause	29
	Dead	14
	Total	78

A total of 29 patients were admitted to hospital.

(*a*) *Medical causes*

Myocardial infarction	6
Asthma	6
Convulsions	4
Haematemesis	4
Acute left ventricular failure	3
C.V.A.	2
Congestive cardiac failure	2
Haemoptysis	2
Paroxysmal tachycardia	2
Pneumonia	1
Hypoglycaemic coma	1
Ramsay-Hunt syndrome	1
Caissons' disease	1
Total	35
Dead on arrival or died under treatment	14
Total	49

(*b*) *Surgical causes*

Gall bladder colic/cholecystitis	9
Renal colic	3
Trauma	3
Perforated duodenal ulcer	2
Acute appendicitis	2
Ruptured ectopic pregnancy	2
Intestinal obstruction	2
Acute urinary retention	2
Abortion	2
Epistaxes (very severe, failed to stop after packing, both needed admission, one needed transfusion)	2
Total	29

Group 2 Analysis of the unnecessary or irresponsible calls

Mild influenza of 24-hours' duration
Manipulated " collapse " of wife after quarrel with husband.
Abdominal pain of two hours' duration, no other symptoms, no abnormal findings
Trivial epistaxes of 20 minutes' duration, which had stopped when doctor arrived.
Asked to examine a patient after a blow to the nose (probably for evidence for legal purposes)
Disturbed sleep due to pruritus ani
Diarrhoea of two hours' duration
Hysteria after family quarrel
Panic attack in a chronic hysteric
Drunk
Nothing. (Call made by drunk relative without consent of patient for a slightly twisted ankle.)

Total 11.

Group 3 Analysis of calls considered unnecessary, but reasonable

Symptoms relating to abdomen	28
Symptoms relating to respiratory tract	17
Childhood croup	5
Psychiatric problems	5
Childhood fever	4
Sciatica	4
Chest pains	4
Threatened abortion	2
Rectal bleeding	2
Epileptic fit	1
Haematuria	1
" Collapse " (vaso-vagal)	1
Total	74

None of these patients were admitted to hospital.

Discussion

This survey shows that half of all the calls attended at night (2300 hours to 0700 hours) in 1974 were genuine emergencies, and only seven per cent were totally unnecessary. This shows a much lower incidence of abuse and a much higher incidence of serious pathology than is the general impression.

Those critical of the value of night visiting may claim that the criteria of classification used here is too biased towards the patient, and that it might equally be argued that half of all the night calls were unnecessary.

This point of view fails to take account of the fact that patients cannot be expected to diagnose their own condition. We have a right to expect patients to use their common sense and to exercise some restraint, not to demand panic calls, and to provide their doctor on the telephone with as much information as possible to act on, but more than this we cannot reasonably ask.

We cannot criticise a patient for being unable to differentiate the chest pain of pleurisy from that of myocardial infarction, a life-threatening croup from the more usual, less serious, but still frighteningly noisy variety. Nearly all the patients in the reasonable group benefited from treatment or reassurance on the night visit, although such treatment was not necessary to avoid a threat to life.

Twelve of the patients in the emergency group (seven per cent of all the night calls) were in a critical condition and were given what the doctor regarded as life-saving resuscitation or treatment. If these patients had been transported directly by ambulance to hospital without initial treatment or resuscitation they would probably have died. Twenty-nine patients were immediately transferred to hospital.

In addition to the 163 calls attended, a number of calls received were given advice or reassurance over the telephone. These were not recorded but are estimated to be an additional 37. If therefore no general practitioner was " on call " I estimate that 200 " 999 " calls would have been requested, and 200 patients from our practice would then have been transported by

ambulance to the district general hospital, instead of 29. This would have meant moving patients quite unnecessarily and resulted in much additional suffering. It would also have meant moving critically ill patients before they have been given the benefit of initial treatment, analgesia and resuscitation which could have resulted in some loss of life that is totally unacceptable in a properly ordered civilised society.

Finally the additional burden placed on the ambulance service and hospital casualty department would be considerable. At a time when general practice is beginning to succeed in obtaining resources to care for patients within the community itself, I find it depressing that some general practitioners are apparently only too willing to pass on to the hospitals this very important part of general practice.

In my opinion it is of great value and comfort to the patients to be able to call an experienced general practitioner to the bedside when taken ill at night.

In our understandable desire to rationalise our work, to enable us to perform more efficiently and to enjoy a more reasonable family life, we must take care not to lose sight of the ethics and purpose of our profession, entrusted to us by many generations of responsible and dedicated men.

REFERENCE

B.M.A. News. (1975).

MANDATORY VOCATIONAL TRAINING

ONE of the improvements in primary health care to which the Government intend to give priority, is the continued raising of standards in general practice, through vocational training schemes for doctors. The profession have asked that, subject to Parliament passing the necessary amendments to the NHS Acts, by 1980 no doctor should be able to become for the first time a general-practitioner principal within the NHS unless he has satisfactorily completed an approved programme of vocational training including a period as a trainee in general practice.

I believe that this is a sensible target, and that we should go for it. Indeed, I hope that within a year or two all entrants will usually complete at least a trainee period.

The profession's representatives, and the Royal College of General Practitioners and Council for Postgraduate Medical Education and my officials are discussing details as regards the admission of doctors to training programmes, the approval of programmes, and the supervision and counselling of doctors during training. If the outcome of these talks shows that the target can be reached, and we can then secure Parliamentary approval, no one will be more delighted than I.

REFERENCE

Castle, Barbara (1975). Speaking as Secretary of State for Social Services, to the annual meeting of the Society of Family Practitioner Committees at Folkestone, 9 October.

MICROCOCCI CAUSING URINARY INFECTIONS

By selective culture and careful distinction from other cocci which contaminate normal urine, workers in Bristol and York have shown that micrococci are very commonly the cause of urinary tract infection. One hundred and fifty four young women with dysuria were studied: 103 had infected urine, 65 with *E.coli*, 29 with micrococci and nine with *Proteus*. Sulphadimidine cured 27 of the patients with micrococcal infection.

REFERENCE

Sellin, M. *et al.* (1975). *Lancet*, ii, 570–572.