Night calls in a group practice

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SUMMARY. Night calls attended in 1977 by four doctors in a group practice were analysed and divided into categories of urgency.

Slightly over half the night calls were genuine emergencies, and only four per cent were totally unnecessary.

Introduction

LOCKSTONE (1976) classified the night calls in a practice in North Yorkshire in 1974. The clear and concise method he laid down cannot be improved upon, and will be followed in this paper, so that easy comparison can be made.

Aims

The aims of the study were to find out the incidence of night calls and assess their urgency.

Method

Practice profile

The four-partner practice is situated in a small coastal town in East Lothian; it has a list of 6,020 patients and during the year 1,300 temporary residents registered.

About 80 per cent of the practice is urban. There are many retired patients (23 per cent of the patients are over 65 years of age). There are one or two light industries, an increasing number of commuters to Edinburgh, and a small fishing community. It is a popular and thriving holiday resort.

There is a small cottage hospital. The nearest general hospital is 12 miles away and poorly served by public transport. All the practice midwifery is carried out in Edinburgh, and maternity calls have been excluded from the study.

The calls recorded were all between 23.00 hours and 07.00 hours the next day and the details were noted in the practice diary. These included the partner's name, name of patient, time of call, age of patient, whether temporarily resident, diagnosis, and Lockstone's classification of urgency, which is as follows:

Group 1: Genuine emergencies.
This was defined as a serious condition clearly requiring urgent treatment to save life, 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 in 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 was therefore regarded by the doctor as a reasonable call.

Results

The total number of night calls in 1977 was 115. Of those, 96 were from permanent residents and 19 from temporary residents. This gives a rate of 15·9 calls per 1,000 patients permanently resident.

The total night calls for previous years were: 1973—80, 1974—97, 1975—125, and 1976—99.

Group 1: Emergencies—59 (52 per cent) (Table 1).

Group 2: Irresponsible calls—five (four per cent) (Table 2).

Group 3: Unnecessary but reasonable calls—51 (44 per cent) (Table 3).

Table 1. Group 1: Analysis of emergencies.

Medical causes		Surgical causes	
Myocardial infarction	7	Trauma	6
Asthma	5	Acute retention of urine	3
Angina	4	Acute cholecystitis/gall bladder colic	2
Acute gastro-enteritis	3	Fracture	2
Acute left ventricular failure	3	Appendicitis	2
Drug overdose	2	Acute obstruction	2
Haemoptysis	2	Perforated peptic ulcer	1
Paroxysmal tachycardia	2	Epistaxis	1
Congestive cardiac failure	1	Peritonitis	1
Acute vertigo	1	Urinary tract infection and ketosis	1
Diabetic hypoglycaemia	1	Burn	1
C.V.A.	1	Abortion	1
Haematemesis	1	Carcinomatosis	1
		Renal colic	1
Total (including one death) 59			

Table 2. Group 2: Analysis of unnecessary or irresponsible calls.

Black eye	1
Hysterics following family row	1
Mild diarrhoea	1
Drunk	1
Trivial epistaxis	1
Total	5

Table 3. Group 3: Analysis of calls considered unnecessary but reasonable.

Symptoms relating to abdomen	17
Symptoms relating to respiratory tract	8
Minor injury	7
Childhood fever	6
Psychoneurotic problems	5
Chest pains	2
Childhood croup	1
Haematuria	1
Epistaxis	1
Migraine	1
Back pain	1
Minor fit in epileptic of longstanding	1
Total	51

Table 4. Comparison of night calls made in North Berwick and Whitby (percentages are given in brackets).

	North Berwick 1977	Whitby 1974
Group 1: Emergencies	59 *(52)*	78 *(48)*
Group 2: Irresponsible	5 *(4)*	11 *(7)*
Group 3: Unnecessary but reasonable	51 *(44)*	74 *(45)*

Discussion

It is interesting that this survey, which shows that about half the night calls attended during 1977 were genuine emergencies, is very similar to Lockstone's study in Whitby (Table 4).

Though the Yorkshire practice is much larger, there are similarities in the two practices in that they are both on the east coast, have much the same proportion of rural patients, and an annual influx of holidaymakers. Both are some distance from a general hospital.

It may be that North Berwick has an unusually high proportion of patients over the age of 65, and hence a high morbidity.

Crowe *et al.* (1976) in a study of a semi-rural Leicestershire practice of 9,500 patients, seven miles from the nearest district hospital, handled a total of 151 calls between 23.00 hours and 08.00 hours in 1973/4. This is about 15·8 calls per 1,000 patients per year (that is, for a nine-hour rather than an eight-hour period each night).

Conclusion

The original Yorkshire survey was prompted by a letter in *BMA News* (Struthers, 1975) which suggested that night calls in general practice were largely unnecessary. However, not only do our figures agree with those of Lockstone, but our conclusions are identical with those made by him. These are, in summary: that there is a low incidence of patient abuse, and a higher incidence of real illness needing skilled attention than is usually thought; that patients in many instances cannot be expected to make a differential diagnosis when faced with an apparently alarming situation; that many of the emergencies required initial and possibly life-saving treatment before transfer to hospital; and that the burden on ambulance and casualty departments if patients made direct access to them could be too great.

It would be interesting to see a study of incidence of night calls in a compact urban practice where the patient had easy access to the accident department of a nearby general hospital.

References

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Priests or engineers?

It is perhaps better to talk of doctors not as priests *or* engineers but as priests *and* engineers, and then to ask: How much of each? The disparate states of health and non-health make any single answer impossible. If we accept that an appropriate goal of medicine and society is eliminating infection, parasitic disease, and malnutrition—the social illnesses that have largely passed out of Western life—then engineers in public health drawn from the ranks of medicine, civil and other engineering, and perhaps from sociology are going to be needed well into the twenty-first century to devise and administer immunization programmes, install water supplies and closed drainage systems, and, above all, persuade people that these things are important and culturally right. Probably in the last function they will have to use techniques derived more from the priesthood than from science.

If we limit ourselves to the developed world, the last 20 to 30 years have seen both doctor and patient cast the former more and more as an engineer. Particularly, but not exclusively, in surgery the changes are such that increasingly our task seems to be technical. This trend is bound to continue as we inevitably, though slowly, unravel the complexities of the material side of man. The doctor will increasingly act as if he were an engineer and the well-informed patient will increasingly perceive him as one.

Yet undoubtedly the patient loses much by our so doing if deep down he needs reassurance, support, and counsel. As it is largely cultural change that conditions medical practice rather than the other way round, it will be the social patterns of the twenty-first century that write the recipe for the mix of priest and engineer. Perhaps they will look back at us with pity for our failure to get it right now.

Reference

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