problems of a pool system for paying doctors. The new fee structure deters the use of deputies and means that increasing claims effectively lead to decreased payment for each visit.

I have shown that most night visits are made before 0100. Between 0100 and 0600 on an average night only about 12 visits are made across Berkshire. Hobday analysed night work in Maidstone in 1983 and showed that on an average night 26 general practitioners were on duty but did only 3·3 calls between them.[6] He argued that this was inefficient and that the workload at night in Maidstone could be dealt with by only two doctors.

Since about 35% of contacts at night are dealt with by telephone[10 13] the amount of disturbance for individual doctors is considerably higher than the number of claims, and the stress created by night work is out of proportion with the small number of contacts with patients. These issues have recently been discussed by Iliffe and Haug.[4] They predict a continuing rise in demand but argue that work out of hours is an essential part of a general practitioner's role. They suggest that the boundaries of this work need reorganising and that a 24 hour commitment for most doctors is neither necessary nor justifiable. A responsibility to the practice of 17 hours is proposed, with an emergency service being provided at other times by health authorities.

My proposal would be that general practitioners continue to provide 24 hour availability by telephone when their particular knowledge of an individual patient is needed. A service between midnight and 0700 should be the responsibility of family health services authorities, which could arrange for visits and perhaps a night time surgery. These authorities would contract with doctors who wished to work a night shift. There would be no financial incentive to visit or the perverse effect of more night visits leading to decreasing rates of payment. Few doctors would be needed at night by the family health services authority, and only a small proportion (less than 1%) of all patients' contacts with general practitioners would be affected. If the trends shown by my research continue and the numbers of night visits double again within another eight years then a reorganisation of this sort will become essential.

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MEMORABLE PATIENTS

Insight and honesty

None of the elderly patients with late onset paranoid psychoses, who are the subject of my brain imaging study, have complete insight into the delusional nature of their beliefs and experiences. When I visit them at home, the explanation that I am a doctor interested in the worries of elderly people, shouted through the letter box, usually gains me admission. Invariably I am then treated to an account of the persecutory activities of neighbours, relatives, and public figures, and presented with evidence of intrusion and interference. Scratches on a window sill indicate exactly how Cecil Parkinson got into the flat. Uneven wear of the soles of shoes demonstrates a neighbour's perverse desire to borrow only left sided footwear.

I'm still not really sure how I should respond to such an account and to the questions that follow: "Do you believe me doctor? What do you think I can do to stop it because the police were most unhelpful?" What I have learnt is that attempts at total honesty will lead me to join the general practitioner, other psychiatrists, and neighbours in the street as, at best, unbelieving bystanders or, at worst, active participants in the persecutory system. A man, tormented for over 20 years by obscene radio broadcasts made by the police, asked me to contact the Police Complaints Authority on his behalf to find out whether or not it intended to investigate his case. I agreed to write, but only on the condition that I could make it clear in the letter that I believed these experiences were hallucinatory in nature. To my surprise, the patient consented and approved a copy of my letter before I sent it. Four weeks later I received a letter from a firm of solicitors. The patient disagreed with my observation that he suffered auditory hallucinations and now wished to start libel proceedings against me.

There is, however, a narrow line to be drawn between indicating to such patients that you are willing to take their concerns seriously and downright dishonest collusion, in which you find yourself sucked into an insincere game, and from which unfair advantage could be taken. To gain trust and cooperation—I ask my subjects to spend almost an hour inside a noisy magnetic resonance scanner—without resorting to such dishonesty has meant adopting a definite strategy. This often means giving ambiguous answers to more direct questions. "Do you think I'm mad doctor?" and "You believe these things are happening don't you?" if met with a reply that suggests puzzlement on my part seems to satisfy. Furthermore, when I'm asked if the scan will detect the intracranial machine implanted by MI5 or the bubbles of gas introduced into a woman's brain by her neighbours as she sleeps I can say with complete honesty that if these things are there then the machine will see them. As we review the scan after the procedure, such patients never seem surprised to see nothing abnormal: "They knew I was coming here and had it taken out last night."

It troubles me that I am, in a literal sense, often economical with the truth in my dealings with such patients, although I try never to actively mislead them. In ethical terms complete honesty would be the best policy. Avoiding the resultant destructive confrontation means that patients will allow the community psychiatric nurse to visit and will even accept treatment. I received a message written in a Christmas card from a woman who endures nightly gang rape by Lord Hanson, Neil Kinnock, and Denis and Mark Thatcher: "Thank you for coming to see me, your visits have kept me sane."—ROBERT HOWARD *is a clinical lecturer in the psychiatry of old age in London*

We welcome contributions to fillers: *A patient who changed my practice*; *A paper that changed my practice*; *A memorable patient*; *The message that I would most like to leave behind*; or similar topics.