The open ended responses to item (8)—Doctor's initial impression on the questionnaire (figure) were collected and entered into a general classification as shown in table 11. 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

TABLE 11—Doctor's initial impression of reason for call

	Practice A No. (%)	Practice B No. (%)
(1) Minor named illness	26 (26.3)	23 (25.3)
(2) Major named illness	11 (11.6)	10 (10.8)
(3) Minor unspecified illness	24 (24.5)	18 (19.6)
(4) Major unspecified illness	14 (14.6)	9 (9.8)
(5) Exhaustion of chronic condition	6 (6.1)	9 (9.8)
(6) Acutely symptomatic response, intervention	12 (12.5)	20 (21.8)
(7) Request for advice	2 (2.1)	5 (5.5)

sixth category includes anxiety shown by the patient or relative; family conflict; behaviour considered typically difficult—for example, the patient about whom the doctor remarks "A mercurial old woman: I have asked that he be removed from our list" (this structure occasionally misfired, as when a doctor referred to a particular patient's "typically demanding behaviour," but checking the records

Form completed by doctor for each out of hours call.

CONFIDENTIAL

OUT OF HOURS CALL

1. Date: _____ 2. Time: _____

3. Patient: _____ 4. Age: _____ 5. Address: _____

6. Do you know patient? ☐ Yes ☐ No ☐ By request ☐

7. Patient's initial impression: _____

8. Doctor's initial impression: _____

9. Reason for your decision to visit or give phone advice: _____

10. Reason for decision to visit or give phone advice: _____

11. Revised diagnosis after visit or phone advice: _____

12. Nature of further advice or treatment: _____

13. Did you feel that this call was necessary? ☐ Absolutely necessary ☐ Completely unnecessary

14. Any other comments: _____

Form completed by doctor for each out of hours call.

TABLE 12—Doctor's rating of necessity of 188 out of hours calls

	Absolutely necessary (n=...)	Completely unnecessary (n=...)
Practice A	15 (15.5)	2 (2.1)
Practice B	19 (20.7)	11 (12.0)

Note: A remarkable unanimity about the necessity of individual out of hours calls emerged. There was no precise rating between practitioners and trainees.

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 sodium and a call at 0400 for hair loss due to a badly applied perm (table 11).

It seems that practice A doctors more often classified reported symptoms as illness while practice B doctors seemed to classify symptoms as part of patient behaviour.

It is apparent that doctors in practice A visit more frequently in response to out of hours calls than do doctors in practice B (table 12), and the difference is accentuated when trainees are excluded. Sixty seven (76%) out of hours calls to principals in practice A resulted in a doctor's visit, compared with 46 (50%) in practice B. All the trainees were nearing the end of their training year.

TABLE 13—Doctor's response to out of hours calls

	Phone advice only No. (%)	Visit No. (%)	Both No. (%)
Practice A	31 (33)	59 (59)	10 (10)
Practice B	11 (12)	12 (13)	10 (11)

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 (30%) of practice A's visits and 27 (37.4%) 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 (4.4%) 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 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 telephone advice 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 59 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 (9%) 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. Many doctors dispute that such work is necessary, 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 Valentine¹ suggested health education and financial penalties. Some authors have considered factors governing demand, such as patients' characteristics, including social class,^{2,3} and the use of a deputising service.⁴ Others have examined the pattern of demand searching for abuse.^{5,6} Richman⁷ and Clyne⁸ have considered the emotional factors that may trigger the patient's decision to make an out of hours call. Stevenson⁹ 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,¹⁰ Morton,¹¹ and Cunningham¹² 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,¹⁰ Morton,¹¹ and Crowe¹³; about the same as in Riddell's¹⁴ but fewer than in Cunningham's.¹²) 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 by the staff 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 made by one doctor allocated the task.

During the study both practices had a similar number of out of hours calls, although practice A had many more (1159) than practice B (786) 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 due 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 overactivity on

the part of the patients or relatives, or that specific out of hours calls were unreasonable requests.

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 "disciplined, 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 expectations 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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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—more area in which I am most interested, 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 in 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 concepts were 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 his or her case, 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 4 and 6 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

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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 in the full disclosure of a 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 must operate. Bates came to the anaesthetic room and 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 depricate 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 some ways stark contrast to that of the high court, 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. Mother is going into the bank 10 times a day to withdraw £5. The only way the family can prevent such a nuisance is by bringing her affairs to 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 most part 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.

Without any argument or a single word, I put down the apparatus and McFerridge superimposed me. Again I watched Gooling operate. But Bates kept interfering, telling Gooling 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 unable 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 flattered him since no one had ever dared to snub him back. He ignored me for the rest of the afternoon, but I was in noisier up.

I started to give chloroform for the third case in which Mr Pollard was interested. He came and asked me what I was giving him. 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 anyone was so afraid of Bates. He did not answer.

After this first operation, I used to go into the operating theatre on every occasion. If I thought that a case seemed to require ether, so, but the surgeons would not have it. And so I only administered a few cases of ether.