Visiting through the night

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Abstract

Objective—To describe the time distribution of visits at night and to evaluate trends in night visits from 1982 to 1992.

Design—Analysis of a sample of one in 12 claim forms for night visits submitted over one year beginning 1 July 1991, and estimation of the number of night visits in previous years from data on payment. Further information was obtained from performance indicators from the Department of Health.

Setting—General practices responsible to Berkshire family health services authority.

Main outcome measures—Times of night visits, proportion performed by deputies, and trend in number of night visits after adjusting for the increased hours during which visits are claimed.

Results—The change in the hours for which payment may be claimed accounted for 33.8% (536/1584) of all night visits in the sample. After visits during these extra two hours were excluded, claims increased by 38.7% from 1989 to 1992 and more than doubled in the past 10 years. Use of deputies both in Berkshire and in England and Wales dropped by more than half since 1989. General practitioners in Berkshire claimed 31.5 night visits per 1000 population in 1992.

Conclusions—The increase in the number of night visits is only partly due to the change in hours during which visits may be claimed. It is also due to a long term and possibly accelerating rise in demand. This is despite a major reduction in the proportion of calls performed by deputising services, the use of which had been said to be the main factor increasing the numbers of night visits.

Introduction

There has been a considerable increase in the number of night visits claimed for by general practitioners since the introduction of their 1990 contract,¹ which brought two changes to the relevant payment structure. Firstly, visits could be claimed if they were requested and made between 2200 and 0800 (previously 2300 and 0700). Secondly, a differential payment was introduced with a lower rate for visits made by deputising services and a higher rate for visits made by doctors in a partnership or as members of a non-commercial rota. The higher rate of payment was set at more than twice the previous fee for night visits. Does the extension in claimable hours alone account for the increase in the number of night visits? The change in hours may compound an underlying increase in the number of claims, either because of increasing demand by patients or because the higher fee might encourage doctors to visit when previously they offered advice by telephone. An increasing number of claims for night visits was recorded during the 1970s,^{2,3} and anecdotal evidence suggests that this trend continued both before and after the new contract,⁴ although no

figures have been published. The differential fee for night visits is intended to discourage general practitioners from using deputising services, but it is not known whether it has had this effect. No studies have reported the proportion of night visits carried out by deputies before and after the 1990 contract.

During 1991 new forms were introduced which allowed details of up to 10 night visits to be claimed on a single form. Berkshire family health services authority amended the new form from July 1991 to ask for the time the visit was made. This makes it possible to calculate the number of visits performed within the previously claimable hours of 2300 to 0700 and comparisons can therefore be made with historical numbers of claims for night visits and with earlier published research.^{2,5-10}

My aims were to record the time distribution of night visits and to show the trend in claims in Berkshire over the past 10 years after adjusting for the change in claimable hours. I also considered the number of claims made for visits by deputies before and after the 1990 contract and the ages of patients visited at different times of night.

Methods

Claim forms for night visits, each containing details of up to 10 visits, are processed for payment and then filed by practice and by the quarter of the year. I estimated that a sample of one in 12 night visits performed by general practitioners in Berkshire in the year beginning 1 July 1991 would provide details of about 2000 visits. I used a stratified sample technique in two stages to ensure an adequate representation of singlehanded and group practices. Random numbers were used to identify one in six of each type of practice. This identified five out of 30 single handed practices and 14 out of 85 group practices. All item of service claim forms received from these practices by 1 September 1992 were retrieved and alternate forms were analysed, with details of night visits performed between 1 July 1991 and 30 June 1992 being recorded. If there were an odd number of claim forms from any practice half of the visits from the outstanding form were entered.

The following information was obtained for each visit: practice code number, the quarter of the year in which the form was received, the patient's year of birth, the date and time of the visit, and the relationship of the visiting doctor to the claiming doctor—that is, partner, locum, assistant, trainee, member of a rota, or a commercial deputy. Time was recorded in terms of the preceding whole hour—for example, 0750 was recorded as 07. These data were recorded on a computer and analysed with the Excel (Microsoft) package and a statistics package for personal computers (Timberlake Clark).

Historical data on claims for night visits were derived from the manual payment ledgers of the family health services authority for each quarter for the 10

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years beginning October 1982. Payment quarters mainly reflect visits done in the preceding quarter but also include visits made and claimed for in the first month of the payment quarter. The rates of payment for previous years were obtained from old amendments to the statements of fees and allowances.¹¹ The number of night visits made in each quarter was estimated by dividing the total sum paid by the fee payable for each visit in the preceding quarter. There will be slight inaccuracies in these estimates as a few claims will be received in April each year and be paid at a new rate after a rise in fees, and some very late claims may be paid at an old lower rate. These inaccuracies, however, are probably small and apply similarly in each year and therefore are unlikely to affect the overall results.

For quarters since April 1990 separate calculations were made for claims at high and low rates to calculate the total number of night visits. The annual number of night visits was obtained by adding up the four quarterly totals ending in September in each year.

Further information about claims for night visits in Berkshire and in England and Wales was obtained by using the health service indicators supplied to family health services authorities by the Department of Health.¹²

Results

The 14 group practices and five singlehanded practices identified by the sampling technique represented 66 or 16% of the 403 general practitioners responsible to Berkshire family health services authority, and the sample consisted of half of the claims for night visits from these doctors, a total of 1988 visits. This was 8.0% (1988/24 803) of all claims received from general practitioners in Berkshire in the four quarters. Of these claims, 1535 (77.2%) were paid at the higher rate and 453 (22.8%) at the lower rate paid for visits done by deputising services. The percentage of visits done by deputies varied widely between different practices, ranging from 0% to 66%. The figure of 22.8% of claims at the low rate in the sample is higher than the rate for Berkshire as a whole (14.8%) in the same period because the largest practice in the sample used a deputy for 53% of its night visits. The table shows the times at which visits were made. Doctors did not always provide this information on claim forms so times were available for only 1591 (80.0%) of the visits analysed.

A disproportionate number of visits in the late evening were to young children. After 2200 and before 0100, 217 (26.8%) of the visits were to children aged under 5 years whereas only 110 (14.2%) of the visits later in the night were to this age group ($\chi^2=37.47$, $df=1$, $p<0.001$).

Of the calls for which times were available (and excluding the seven visits which occurred outside the claimable hours), 536 (33.8%) were done between 2200 and 2300 or between 0700 and 0800 (SE proportion 0.0119, 95% confidence interval 31.5% to 36.1%).

The trend in numbers of night visits claimed is shown in the figure. Assuming that the proportion of visits done in the sample between 2300 and 0700 can be applied to the whole of Berkshire, it becomes possible to estimate the number of night visits which would have been claimable by using the definition of a night visit which applied before April 1990.

The figure shows this estimated number of visits with 95% confidence intervals. The change in hours accounts for 64.7% (8393/12 975) of the increase in the number of claims since 1989.

Analysis of the health service performance indicators¹² shows a large drop in the proportion of night visits performed by deputising services. In the quarter ending June 1989, 37.5% of night visits in Berkshire

and 45.6% nationally were done by deputies; these proportions dropped to 14.8% in Berkshire in the year ending September 1992 and 28.1% nationally in the year ending March 1991 (calculated from payment data as the health service indicators no longer record the percentage of visits done by deputies). Of all practices in Berkshire, 28.5% use deputies, which compares with the national average of 38.1%.

General practitioners in Berkshire claimed 31.5 night visits (20.8 visits between 2300 and 0700) per 1000 population in the payment year to September 1992. In total the 403 general practitioners in Berkshire claimed 24 803 night visits in the year to 30 September 1992, an average of 61.5 visits per doctor per year.

Discussion

Adding two hours to the period within which night visits may be claimed has caused a clear rise in claims, and this accounts for most, but not all, of the increase observed since the 1990 contract. The change in hours compounds a long term upward trend in the number of night visits. Even after visits made in the extra two hours are excluded there has still been an increase of nearly 39% in night visits from 1989 to 1992, and the number of night visits has more than doubled in the 10 years since 1982. The data suggest that the underlying increase has accelerated since 1990. This may reflect doctors' increasing willingness to visit or increasing consumer demand.

Fry noted that night visits had trebled in the seven years from 1967 to 1974.³ Buxton *et al* showed an increase between 1967 and 1975 from 4.3 to 10.1 night visits per 1000 patient population per year.² The equivalent estimated figure from my research is 20.8 visits, which represents an almost fivefold increase in 25 years. In terms of individual doctors this means an average practitioner will do a visit between 2300 and 0700 every nine days instead of less than once a month.

Several authors have described wide variations in the number of night visits, which have proved difficult to explain.^{2,5,8} The most important factor was said to be a high use of deputising services associated with higher rates of visiting and less use of giving advice by telephone.^{2,5} Two studies have shown that general practitioners can deal with a high proportion of night calls on the telephone,^{10,13} but Sheldon and Harris found that fewer than 3% of night calls received by two deputising services were dealt with by giving advice by telephone without a visit.⁵

It has been argued that factors in medical organisation, such as the use of deputies, may be more important than variations in patient demand in shaping the number of night visits.^{2,8} Since the introduction of a differential fee, however, the number of visits in Berkshire undertaken by deputies has dropped by more than half, yet overall numbers have risen steeply. A national study is needed to see whether these trends are representative but little information about night visits is collected centrally. The performance indicators which are produced¹² consist mainly of data on payment, which makes useful analysis difficult.

Why a differential fee was introduced to encourage general practitioners to do their own night calls is unclear. It seems ironic at a time of mounting concern about the excessive hours of junior hospital doctors. It may have been from a belief that deputies provide a less good service, although published research has shown high patient satisfaction with deputies.¹⁴ Alternatively it may have been because a rising number of night visits, increasingly performed before 1990 by deputies, increases health service expenditure as the cost of deputies is eventually reimbursed in the expense element of general practitioner remuneration. Escalating numbers of night visits highlight the

Numbers (percentages) of night visits according to time in sample of general practitioners in Berkshire

Time	No (%) of visits (n=1591)
2200-2300	263 (16.5)
2300-2400	379 (23.8)
2400-0100	169 (10.6)
0100-0200	86 (5.4)
0200-0300	93 (5.8)
0300-0400	66 (4.1)
0400-0500	64 (4.0)
0500-0600	69 (4.3)
0600-0700	122 (7.7)
0700-0800	273 (17.2)
Other*	7 (0.4)

*Visits performed before 2200 or after 0800 and yet accepted by the family health services authority. Calls not included in later analysis of times at which visits were done.

Increase in total number of night visits by general practitioners in Berkshire from 1982 to 1992. The estimated number of visits between 2300 and 0700 in 1992 (○) is given with its 95% confidence interval

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.*