

## LATE CALLS IN GENERAL PRACTICE

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*You must wake and call me early, call me early, Mother dear*

Tennyson: *The May Queen*.

ONE of the irritations of general practice is that requests for routine visits often come in after 10 a.m. It is well known that this disorganizes the day, may entail the doctor travelling over the same ground twice, encroaches on time which could be devoted to some other activity and generally adds to the frustrations of the day. It was decided therefore to investigate the frequency and nature of late calls in my practice, with particular reference to their urgency. This paper describes the results of this investigation, which took place between March 1963 and February 1964. Soon after the start of the survey, the results of a similar investigation were published by Jacob (1963). As his definition of a late call was identical to mine, I was able to follow his example and subdivide my urgent calls into 'emergencies' and 'urgencies', and thus compare my results directly with his.

The practice is single-handed and situated on the suburban fringe of Liverpool. The patients are predominantly lower middle-class. The population of the practice at the end of the survey year was 3,189; of these, 1,903 attended the main surgery and the remaining 1,286 are served by a branch surgery in a modern housing estate. The age/sex distribution in these two areas is shown in table I.

During the year, all late calls were specially denoted in the visiting book, the time of call, the degree of urgency and a few clinical notes being recorded on the spot. A late call is defined as a home visit following a request made after 12 noon for a visit on the same day. At the end of the year it was a simple matter to look through the visiting book and extract the details of the marked late calls. The degree of urgency was assessed on the same basis as that used by Jacob. Briefly this is:

(a) *Emergencies*

1. Any diseases in which the immediate prognosis is serious, e.g. myocardial

- infarction, peritonitis
2. Any disease in which the prognosis may be worsened without rapid treatment, e.g. pneumonia, acute appendicitis
  3. Severe symptoms: urgent dyspnoea, haematemesis
  4. Fractures
  5. Impending death
  6. Malignant disease
- (b) *Urgencies*
1. Severe pain, e.g. acute lumbago, otitis media
  2. Persistent vomiting
  3. Pyrexia of 103°F. or over
- (c) *No.-urgent*  
Any disease where the immediate prognosis is not altered for the worse without rapid treatment.

TABLE I  
AGE/SEX DISTRIBUTION OF PRACTICE, 1 MARCH 1964

		0-9	10-19	20-29	30-39	40-49	50-59	60-69	70-+
Males	Branch ..	191	84	56	188	86	34	11	7
	Main ..	129	114	145	146	96	110	112	67
	Total ..	320	198	201	334	182	144	123	74
Females	Branch ..	163	63	89	185	68	31	13	16
	Main ..	136	108	115	140	109	141	114	113
	Total ..	299	171	204	325	177	172	127	129
Grand total ..		619	369	405	659	359	316	250	203

### Results

Table II shows the distribution of late calls by day of the week and time of the day. It will be seen that there is a gradual decrease in the number of calls towards the evening. Table III analyses the degree of urgency by time of day and shows that this decrease is due primarily to a fall-off in non-urgent calls. The rise in calls between 6 and 7 p.m. is probably attributable to the fact that I have my main evening surgery at this time. This is supported by the absence of the 7 p.m. rise on Wednesday, when there is no evening surgery. Cynics might suggest that the rise is due to father returning from work and finding his infant ill. This is not borne out by the figures which show that for the period 6-7 p.m. the proportion of calls for children is 47 per cent compared with 42 per cent for the whole 12-hour period—not a significant difference.

Table IV shows degrees of urgency by day of the week. There is a high rate of non-urgent calls on Monday, but further analysis does not reveal any obvious cause for this. The total rates for

TABLE II  
NUMBER OF CALLS BY DAY OF WEEK AND TIME OF CALL

	-1	-2	-3	-4	-5	-6	-7	-8	-9	-10	-11	-12	1-6 a.m.
Mon. ..	6	5	6	10	2	1	9	-	2	1	-	1	1
Tues. ..	4	1	2	7	1	2	4	6	3	1	1	-	-
Wed. ..	2	4	1	2	3	1	1	-	1	2	1	1	2
Thurs. ..	4	3	3	8	1	5	5	3	3	1	1	2	4
Fri. ..	4	4	5	3	6	4	6	2	2	1	2	2	3
Sat. ..	2	2	3	-	2	1	3	-	-	1	-	1	-
Sun. ..	2	2	3	1	-	1	2	1	1	5	3	1	-
Total	24	21	23	31	15	15	30	12	12	12	8	8	10

TABLE III  
DEGREE OF URGENCY BY TIME OF CALL

	-1	-2	-3	-4	-5	-6	-7	-8	-9	-10	-11	-12	1-6 a.m.
E ..	3	1	1	6	1	1	5	2	4	2	3	1	5
U ..	1	1	4	7	2	5	9	5	2	5	-	-	3
N ..	20	19	18	18	12	9	16	5	6	5	5	7	2

(E = emergency; U = urgency; N = non-urgent)

TABLE IV  
DEGREE OF URGENCY BY DAY OF WEEK

	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun.	Total
E .. ..	5	5	4	7	9	2	5	34
U .. ..	4	9	2	11	9	2	5	45
Total .. ..	9	14	6	18	18	4	10	79
Total .. ..	14	32	21	43	44	15	22	221

Wednesday (my half day) and the weekend are lower than for the rest of the week, indicating that when the doctor is off duty, the patients tend not to bother him. Table V shows that there is no significant difference between the sexes in their late calls.

Table VI demonstrates the difference between the two areas of the practice. One might be tempted to ascribe the higher rate in the branch surgery area to social factors, but a glance at the age distribution (table I) shows that there is a preponderance of children in this area, and table VII confirms Jacob's observation that children are responsible for the largest proportion of late calls. This explains the discrepancy between the areas. This table also shows that the proportion of urgent to non-urgent calls tends to increase with the age of the patient, until the over seventies are reached. At that age the call is usually initiated by a neighbour or younger relative, who find themselves in much the same position as the over-anxious parent with an ill child. The rate of late calls to the over-seventies is consequently only slightly less than that to children, but the proportion of emergencies is naturally higher.

TABLE V  
URGENCY OF CALL BY SEX

	<i>Males</i>	<i>Females</i>	<i>Total</i>
E ..	18	16	34
U ..	24	21	45
N ..	60	82	142
Total	102	119	221

TABLE VI  
URGENCY OF CALL IN THE TWO  
PRACTICE AREAS  
(expressed as rate per 1,000 population)

	<i>Main surgery</i>	<i>Branch surgery</i>	<i>Total</i>
E ..	13	8	11
U ..	14	15	14
N ..	37	54	44
Total	64	77	69

TABLE VII  
(A) URGENCY OF CALL BY AGE GROUPS  
(B) CALLS (AS RATE/1000) BY AGE GROUPS

	0-9	10-19	20-29	30-39	40-49	50-59	60-69	70+
E .. ..	1	-	4	7	1	6	7	8
U .. ..	15	4	2	6	2	7	7	2
N .. ..	77	13	9	10	5	6	6	16
Total ..	93	17	15	23	8	19	20	26
Rate/1000 ..	150	46	37	35	22	60	80	128

Table VIII analyses the late calls by disease groups using the diagnostic classification of the College of General Practitioners (1959). The first column shows the figures obtained by Jacob (1963) for similar disease groups: his total of late calls was 558: by multiplying the individual figures by two-fifths, they become easily comparable with mine, and for convenience this has been done. The second column shows the results of the present investigation, and the third column gives the expected number of first consultations in each of the various diagnostic categories, extracted from a previous investigation (Hardman 1965). This shows a rough correlation between the proportion of diseases seen on late calls and those

TABLE VIII

COMPARISON BETWEEN NUMBER OF LATE CALLS AND (A) ROUTINE FIRST CONSULTATIONS; (B) LATE CALLS OF JACOB (1963) IN EACH DIAGNOSTIC GROUP

	<i>Late calls</i>		<i>First cons.</i>	<i>E</i>	<i>U</i>	<i>N</i>
	<i>Jacob (x 2/5)</i>	<i>Hardman</i>				
Infections ..	8	16	7	—	1	15
Neoplasms ..	8	2	—	2	—	—
General ..	6	7	6	1	3	3
Blood .. ..	1	—	1	—	—	—
Mental ..	10	12	16	1	1	10
C.N.S. .. ..	15	25	21	9	4	12
C.V.S. .. ..	13	12	6	5	1	6
Respiratory ..	77	53	72	4	17	32
Digestive ..	32	28	16	4	1	23
G.U. system ..	10	22	17	8	5	9
Skin .. ..	10	4	20	—	1	3
Locomotor ..	9	9	15	—	5	4
Ill defined ..	12	17	15	—	2	15
Accidents ..	12	14	9	—	4	10
Total ..	223	221	221	34	45	142

seen during the normal routine of the surgery—with the understandable exception of skin diseases. The subsequent columns give the breakdown into emergencies, urgencies and non-urgent calls by disease groups.

### Discussion

Comparing these figures with those of Jacob (1963), one or two interesting facts emerge. Both investigations confirm the findings of Backett *et al.* (1953) and the South-east Scotland Faculty of the College of General Practitioners (1957), that two-thirds of late calls are for non-urgent conditions. However, the most striking feature is the difference in the total number of late calls (table IX).

TABLE IX  
COMPARISON OF NUMBER AND URGENCY OF LATE CALLS

	<i>Emergencies</i>		<i>Urgencies</i>		<i>Non-urgent</i>		<i>Total</i>
		<i>Percent</i>		<i>Percent</i>		<i>Percent</i>	
Jacob .. ..	129	(23)	48	(9)	381	(68)	558
Hardman ..	34	(15)	45	(20)	142	(64)	221

For a practice population of 3,656, Jacob had 558 late calls, a rate of 153 per 1,000 population, compared with my rate of 69 per 1,000. This discrepancy is probably due to a number of factors. Jacob has shown that the group of people who send in late calls have certain personal characteristics. They are “young people of average intelligence with relatively large families of young children (many of their calls being on behalf of their children). As a group they have neurotic tendencies”. That there is less morbidity generally in my practice is shown by my rate of 4.7 items of service per patient per annum, as opposed to Jacob’s 5.9 items of service. Furthermore, the ratio of home visits to total consultations in my practice (15 per cent) is at the lower end of the range 13.1 to 43.6 per cent, found by Logan (1953) in his survey of eight practices. Nevertheless, these facts are insufficient to account for the gross variation between the practices in the number of late calls.

Equally curious is the differing number of emergencies. It is hard to imagine that there is any real difference in the incidence of emergencies in the two practices, and yet the rate per 1,000 is 35 in Dundee and 11 in Liverpool. This points to some difference in age distributions between the practices, as emergencies are far commoner in patients over 45 (see table VII). Only 30 per cent of my practice is over 45, compared with the figure of 36 given for the population as a whole by the census of 1955—a figure which in 1964

probably errs on the low side. One would hazard a guess that Jacob has a higher proportion of elderly patients than I have.

However, these factors of increased morbidity and a more elderly population are not sufficient to explain the disparity in the results, and the cause must, for the moment, remain a mystery, although the answer may be found, as Jacob suggests, in a study of the separate populations. His results showed

that the medical needs of two groups differ in relation to the personal characteristics of the groups, and not solely in their relation to their diseases. . . . The variation observed in work-load studies may be indicative of similar differences in the personal characteristics of the types of people who predominate in the practices studied.

It has been shown that the level of morbidity can vary, even between two areas of the same practice, for reasons that are apparently non-medical (Hardman 1965), and there is thus no reason for supposing that the same variation for the same reasons cannot be found between different practices.

This point needs stressing in any future plans for general practice based on work-load and morbidity studies. I am fortunate in having few, if any, inconsiderate patients on my list—ten night calls in a year is perhaps indicative of this. Indeed, without this consideration I would think it impossible for a family doctor to run a practice of this size single-handed. But it is dangerous to draw conclusions from a practice such as this, and apply them to general practice as a whole. A good deal of publicity has been given recently to general practice work-studies, without stressing the environment in which these practices are situated. Surely enough variation between practices has been demonstrated in the literature to make it apparent that, if we are to draw any statistically valid conclusions, possibly affecting the future of general practice in this country, then the sample from which these conclusions are drawn must be large, if it is to be representative.

### Summary

1. All late calls from an urban general practice for one year have been recorded and the degree of urgency of each call has been assessed. The calls have also been analysed by age, sex, time of call, area of practice and disease groups.

2. The results are compared with a similar investigation by Jacob (1963).

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