Out-of-hours Calls and Self-referrals to Casualty Departments

Sir,
There have been numerous analyses of night calls and out-of-hours visits since Lockstone's (1976) original study; and Inwald (1980) has compared patients who referred themselves to accident and emergency departments in urban district (high rate) and a rural district (low rate). I decided to try to discover how our patients used the out-of-hours services offered by the practice and the local casualty department when I was the partner on call on our rota between January and June 1980. The pattern of use is shown in the Table below.

Our three-partner practice is in a residential village three miles from the county town of Stirling. The list size was 5,300 during the study. The age-sex distribution is quite typical for the U.K., but the community has a relatively large middle-class section by local Scottish standards.

It was not feasible to estimate how much advice (if any) was given by the local casualty department by telephone. But I usually dealt with 1.5 cases by telephone alone during each out-of-hours session; none of these patients then became a self-referral to the accident and emergency department later that evening. My rate of home visiting and my classification of each case in terms of urgency were broadly similar to Lockstone's; but almost half of the (relatively low) number of cases who referred themselves to the casualty department would have required only telephone advice from me as the family doctor or instructions to attend our surgery the following morning.

Riddell (1980) has reported a much higher rate of out-of-hours visiting in a deprived inner city area of Glasgow, with irresponsible calls accounting for at least 15 per cent of the cases seen; the out-of-hours use of a commercial deputizing service (Murray and Barber, 1977) is also associated with increased patient demand and a lower proportion of significant morbidity. So what are the implications of a deputizing service for self-referral rates to casualty departments?

The characteristic feature of the NHS is the registration of each patient with a general medical practitioner. In group terms, the relationship of a practice list to its doctor(s) may be the most important determinant of the way each list within a similar catchment area uses NHS resources.

It would be interesting to uncover the pattern of use of out-of-hours services elsewhere, including large urban areas and where this information is based on practice lists, rather than on either the GP workload or casualty department attendances.

R. FAIRLEY

Health Centre
Bridge of Allan
Stirlingshire
Scotland.

Out-of-hours GP home visits and casualty department attendances

	Times of day		
	0700–0900 1800–2300	2300–0700	Saturday 1300–1800 Sunday 0900–1800
Days on call	45	45	12
GP home visits*	20	6	9
Casualty attendances*	11	4	8

*The GP home visits included seven emergency admissions to hospital and the casualty department attendances included three telephone referrals by the GP.

References

Inwald, A. C. (1980). A comparison of self-referred patients to accident and emergency departments between an urban district and a rural district. *Journal of the Royal College of General Practitioners,* **30,** 220–223.

Lockstone, D. R. (1976). Night calls in a group practice. *Journal of the Royal College of General Practitioners,* **26,** 68-71.

Murray, T. S. & Barber, J. H. (1977). The workload of a commercial deputizing service. *Journal of the Royal College of General Practitioners,* **27,** 209-211.

Riddell, J. S. (1980). Out-of-hours visits in a group practice. *British Medical Journal,* **282,** 1518-1519.

Child Diabetes

Sir,
Alpha-adrenergic blocking agents are not generally recommended as supplementary therapy in juvenile diabetes, but the following case history suggests that they may sometimes be helpful.

Malcolm was 13 and had been diabetic for 10 years. Despite regular and careful attention from the local diabetic clinic, he had reached a point when he was able to attend only 25 out of 131 schooldays in two terms. During that time he also had many home visits and four hospital admissions for ketoacidosis. Efforts to tutor him at home failed, and his education came to a virtual standstill.

The problem was primarily one of morning ketosis, almost exclusively on school days; this would not disappear despite manipulation of his insulin regime and diet. It was thought that he was eating sweets to avoid school; but as it also occurred when a favourite aunt came to stay and he is an excitable lad, it seemed possible that he might be suffering from intermittent catecholamine-induced hyperglycaemia in addition to his diabetes.

In the hope of blocking this hypothetical response, I asked for advice and searched the literature, and could find little guidance except that glycogenolysis is probably an alpha-adrenergic effect. The alpha-blocker phenoxybenzamine was said to be safe, so I started him on 10 mg at night.

In six days his urinary ketones had disappeared; but as he became bad tempered his mother stopped the drug on the 17th day. Six days later the ketones reappeared; the drug was restarted and in a further two days the ketones had gone again. His temper improved. He was able to return to school, and attended 46 out of the next 69 schooldays, a considerable improvement that would have been better still if morning tummyaches and school phobia had not begun to appear instead. However, these in turn resolved. Nearly a year later he is enjoying school and keen to go to agricultural college.

Whilst it is arguable that other factors may have been involved and the biochemistry not adequately studied, the disappearance of urinary ketones and the marked improvement in school performance that followed the administration of phenoxybenzamine suggests a reasonable probability of cause and effect.

Further trials in such situations could be worth while.

COLIN SMITH

Alexander House
School Lane
Higham
Near Rochester
Kent.