closely allied to the primary health care team and not be seen as outreaches of the hospital empire.

Although the great majority of the elderly live on their own or with their family, a proportion needs some form of sheltered accommodation. Local councils are building more sheltered accommodation units with warden control; private housing associations are building similar complexes, while voluntary societies such as the Abbeyfield provide accommodation with a degree of communal living. Old people's homes run by the local Health Authority (Part III accommodation) have long provided a haven for the elderly, and continue to do so. In the present financial climate it is unlikely that sufficient new homes will be developed in time to cope with the projected explosion in the elderly population, and nor it is likely that more long-stay geriatric hospital beds will be available. The geriatric service, which was originally developed to care for the neglected long-stay patient, now sees itself as an acute rehabilitation service with the immediate aim of discharging patients back into the community. However, a domestic situation which was acceptable before admission may no longer be acceptable after discharge. As one solution to this problem, hospital doctors, geriatricians, general practitioners and social workers are arranging admission to private nursing homes and rest homes. In some areas there may be hundreds of beds available within a small district. Practices may have patients in a number of nursing homes; each home may have a large number of visiting doctors. The development of management policies is difficult: since the hospitals are discharging patients to these nursing homes and the Department of Health and Social Security is willing to pay the full fees incurred, it is appropriate that attention should be focussed on this sector.

Care of the elderly in the community is likely to be one of the major challenges for primary care in the future; in many areas it is becoming a fact without adequate consultation or transfer of resources. Even the Oxford Region, which recently published its 10-year plan for community care, appears to have been guilty of failure to consult local practitioners. Close cooperation between the College (covering the educational aspect) and the general Medical Services Committee (overseeing the organizational side) is urgently needed for these solutions.

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# Night calls—an emotional issue

PROGRESS in the debate about deputizing services and the organization of out-of-hours care generally will only be made if we give due consideration to the emotional aspects of night calls. The quantitative analysis of night calls is relatively easy, and is invaluable when comparing different practices and places. It is the qualitative aspects of night calls which attract the most interest and criticism. Lockstone's criteria of urgency,[1] which are biased towards biophysical medicine, reflect the perceptions of most doctors. Nevertheless, the anxiety of the mother about her child who is coughing may be real although inappropriate. Asking the doctor to call during the night is an exceptional event for the individual patient and not undertaken lightly. It is not true that night calls are generally a manifestation of emotional disturbance[2] but they do provide an opportunity for psychotherapeutic intervention.

Home confinements are now rare. Similarly, most deaths now take place in hospitals. The night call remains as one of the few opportunities for a general practitioner to intervene at a time of crisis in a patient's life. It is accepted that follow-up by a doctor the next day is seldom necessary; nevertheless, some night calls and particularly those with an overt psychological factor mark a significant change in the relationship between doctor and patient. Previous psychological and social barriers become irrelevant in the immediacy of a consultation at 02.00 hours.

It is generally agreed that the doctor on night duty should be a qualified general practitioner. What is implied in the recent discussions about deputizing services is that the public would prefer the duty doctor to be their own general practitioner or a colleague of his. One rational argument in support of this policy has been that it is only the patient's own general practitioner who will have access to medical records, and yet it is not known whether doctors with access to medical records do actually make use of them. The real point is surely that at a time of crisis the patient wants to see a familiar face. This desire for familiarity is not only understandable but it also has therapeutic effects. The possibility exists for both the patient and the doctor to benefit from a satisfactory night call, which can only happen if the duty doctor is in the same practice as the patient's own doctor.

It is necessary to look also at how general practitioners themselves respond to night calls. For experienced general practitioners the dominant emotions may

be irritation and frustration in the presence of weariness. While trainees and younger doctors may harbour these negative feelings it is likely that they will experience anxiety, at least on the way to the patient's home.

Night calls are an important component of general practice, and general practitioners will become 'nine to five' surgery doctors at their peril. Even the notion of out-of-hours calls is interesting. What are a doctor's hours? Perhaps general practitioners are opting out of night duty because of the emotional as well as the physical demands of night calls. General practitioners could increase their availability at night at the expense of daytime availability. Doctors have shown quite clearly that they no longer wish to be available to their patients at all times but perhaps both sides can agree on the priority of out-of-hours calls. At times when they are anxious about their own or their family's health, patients are entitled to have the attention of a doctor who is not only suitably qualified but is able to respond positively to the emotional needs of the moment.

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## Controlling myocardial infarcts with timolol

One hundred and forty-four patients admitted to the hospital within four hours after onset of symptoms of myocardial infarction were randomly assigned to either intravenous timolol treatment or to placebo. Timolol was given intravenously for the first 24 hours and orally thereafter for the duration of hospitalization. Infarct evolution was assessed by continuous vectorcardiography and creatine kinase release. The timolol group had reduced myocardial ischaemia and infarct size as measured by an accelerated reduction of ST-vector magnitude, a significant reduction of maximal cumulative creatine kinase release (29.5 per cent), and significantly smaller changes in QRS-vector variables (20 to 25 per cent). Furthermore, the predicted creatine kinase release and maximal QRS-vector change for a given initial ST-vector magnitude was significantly reduced in the timolol group. Timolol was also associated with significant reductions in pain and the need for analgesics and was well tolerated overall.

This study supports the use of intravenous timolol in the early phase of suspected myocardial infarction to limit infarct size.

Source: The International Collaborative Study Group. Reduction of infarct size with the early use of timolol in acute myocardial infarction. *N Engl J Med* 1984; **310**: 9-15.