

Sir,  
The paper by Marsh and colleagues (July *Journal*, p.301) alarmed me on several counts. It seems evident that the authors are in favour of telephone management but by its very nature the basic medical precepts of history, examination, investigation, diagnosis, prognosis and treatment are violated since management must be decided from history alone. To reassure patients, prescribe and even admit to hospital on this basis seems to be inviting disaster.

The authors state that only 30% of callers were known to the doctor receiving the call. Calls are often made at times of physical, social or psychological crisis and non-physical factors affect the decision to visit. In the absence of such knowledge, to offer advice alone may be totally inappropriate.

The authors also state that 'the doctor knows from the address whether the patient lives in a deprived area, when the history may be inaccurate and when social circumstances may worsen the illness'. To use such a patronizing assumption to help to decide whether to visit or not is outrageous.

It is also stated that there was no evident detriment to the patients' health but this was measured retrospectively and in physical terms only. Fifty five per cent of patients given advice only and 65% of patients asked to attend the surgery, consulted again within a week. These patients, therefore, did not feel healthy.

The failure of the doctor to visit at a time of crisis could easily damage the doctor-patient relationship and prescribing without examination of the patient may also lead to unnecessary or inappropriate medication.

I would agree that some calls can be easily dealt with by telephone advice alone, usually when specifically asked for by the patient. However, with no benefit to the patient, possible damage to the doctor-patient relationship and inappropriate and unnecessary prescribing, one must question one's motivation in reducing a commitment to patients in this way and ask if this is responsible medicine.

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Sir,  
May I take this opportunity to congratulate Dr Marsh and colleagues on their excellent study of telephone advice in managing out-of-hours calls (July *Jour-*

*nal*, p.301). Dr Marsh states that his out-of-hours visit rate of 47.5 per 1000 patients per year is with one exception<sup>1</sup> the lowest reported so far. However, this is only the number of visits made by the doctor to the patient's home. He must add to this the face-to-face consultations that occurred at his surgery during the out of hours periods. This would then give a total visit rate of 53.8 per 1000 patients per year which is not dissimilar from Riddell's 58.6 reported in his inner urban area of Glasgow.<sup>2</sup>

The study which Dr Marsh refers to as showing the lowest out-of-hours visit rate is that by Crowe and colleagues.<sup>1</sup> In their practice of 9500 patients in semi-rural Leicestershire they performed 416 home visits in out-of-hours periods — 43.8 visits per 1000 patients per year. But when all face-to-face consultations are included this gives an overall visit rate of 62.1 per 1000 patients per year, making Dr Marsh's 53.8 the lowest. I am surprised that Dr Marsh did not refer to Webster and colleague's study of night calls, in a practice of 7997 patients in 1960-63.<sup>3</sup> They found a night call rate of 10.7 per 1000 patients per year for the period 23.00 to 08.00 hours. Lockstone<sup>4</sup> defined a night call as one between 23.00 and 07.00 hours. Therefore if the calls between 07.00 and 07.59 hours in Webster's study and the calls given telephone advice only are subtracted this gives the night visit rate as 9.5 per 1000 patients per year, which is similar to Dr Marsh's 9.8.

Webster's practice gave telephone advice to 4.5% of night calls compared to Dr Marsh's 58.2%. Perhaps the unusual arrangement in Dr Marsh's practice where each doctor is on call every weekday night for his own patients is responsible for the higher call rate. It may be an incentive for patients to telephone for advice. Some studies<sup>5-9</sup> refer to out-of-hours calls as actual visits by the doctor to see the patient, while others<sup>1,10,11</sup> refer to them as telephone calls coming from the patient. May I suggest that all out-of-hours telephone calls to the doctor be used to calculate the 'telephone call rate' whether or not a visit is made and that the number of face-to-face consultations be used to calculate the 'visit rate'. Calls and visits between 23.00 and 07.00 hours would be used to calculate the respective night rates. Such standardization would help to clear up much confusion, especially when attempting to compare studies.

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#### References

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Sir,

Dr Marsh and colleagues have written an interesting paper (July *Journal*, p.301), but I cannot agree completely with their ideas.

I have been out of practice for some years now, and must admit to being a whit old-fashioned; but I do think there is something to be said for seeing the patient. An obvious jaundice, the caller might mention, but a trace of icterus in the eyes might go unnoticed; a parent or relative might easily miss a very slight tremor. Nor is it possible, over the telephone, to make a judgement about possible non-accidental injury, or simply to tell if a child seems frightened.

'Clinical medicine' means practising medicine by the bedside. And it always will.

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#### A team approach to terminal care

Sir,

Dr Aldridge has published a challenging article (August *Journal*, p.364) on the implications for general practitioners of a team approach to terminal care. Challenging is perhaps a kinder adjective than patronizing.

In his article he refers to the developing skills of counsellors. He seems, however, to discount the skills which general practice has developed over many years of experience in dealing with chronically ill or terminally ill patients,