LATE CALL—EMERGENCY OR ANXIETY?

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THE stimulus for this investigation came with my realization of the contradiction between my expectations on answering an urgent request for a visit, and the reality which I experienced.

The expectation was for some sort of medical emergency, defined in terms of my medical education and subsequent hospital experience. I found, however, many cases such as No. 1 in this series where I was asked to visit for what turned out to be a request to settle a quarrel between husband and wife as to whether he should continue to take sleeping tablets.

In hospital patients were brought in, in the middle of the night with acute myocardial infarcts, or cerebrovascular accidents, or with serious trauma, or appendicitis. All these conditions required immediate intervention of a nature which I had been trained to undertake. That this did not represent the whole story was demonstrated by my experiences in casualty on night call. Here all sorts of odd and seemingly trivial complaints were presented to my sleep-laden eyes. Someone was obviously filtering my true emergencies. I discovered who he was when I entered general practice. (In fact the casuals in casualty are an index of a breakdown in general practitioner services as clearly shown by the Nuffield survey[1]. However, in this setting no continuing relationship is involved, it is dealt with as an isolated event.)

I therefore collected all the late calls over a two-year period, 266 in all, and have attempted to analyse the situation in which the call is set. I do not think there is much point in subjecting this data to statistical investigation. Other workers[2] in this field have shown that the same range of diseases as encountered in his normal work is seen by the general practitioner on late calls. The age, sex, distribution is of little significance. Jacob[3] confirmed that in general those making the most late calls are those requiring most frequent medical attention at other times, that they are a susceptible sector

of the population. Klyne[4] uncovered some of the anxiety and emotional factors behind late calls.

The number of calls compares with those of other surveys (1½ per week per 1,000 patients at risk).

What I want to show is the extent to which this can only be viewed as a social or sociomedical problem. This becomes apparent when one tries to define the terms: late, urgent, emergency, or anxiety.

Thus late is defined in terms of the customs of medical practice in this country, now institutionalized in the National Health Service to request calls before 10 a.m. In other countries (or possibly in private practice) other standards prevail. Thus one call in this series was for the doctor to come on his evening round. The patient came from India where doctors are accustomed to visit in the cool of the evening, and she assumed the same pattern was followed here. In countries where the hospital casualty is the natural place to turn to, late calls to the general practitioner will not arise; in Sweden they do no calls after 5 p.m. In many areas of the U.S.A. it is now impossible to get a doctor to visit out of hours and advice is given over the telephone or the patient must be brought up to the doctor or the hospital, but only in real emergency.

I know of doctors whose dislike of traffic led them to arrange their rounds in the late evening—after 9 p.m. and the problem of ' late calls ' in such a practice would be quite different. Some doctors encourage the patient to feel free to call at any time, others discourage it strongly. That ' discouragement ' works would require an investigation into a number of practices but it can be shown to work in individual cases, as with the patient who made frequent late calls for minor illness such as conjunctivitis until I managed to get the leading member of the family to discuss the question and she admitted: " We all feel we're going to die when one of us is ill ". Bringing this out into the light has meant no further late calls in the next two years after. There are patients who believe that the National Health Service provides a 24-hour cover and the doctor must come at any time and are genuinely indignant if the doctor demurs.

The investigation is set therefore in a context of what is customary and the first reason for contradiction between expectation and reality lies in the variation of what is customary. This contradiction becomes one between doctor and patient; sometimes deliberately so on the part of the patient who uses the late call as an aggressive act.

This is again because of the organization of practice—the doctor organizing his day most efficiently wishes to avoid sporadic calls. And naturally he will try and protect his leisure time and sleep. If he feels the cause is not reasonable, or if he is made to switch from the mental set ' leisure ' to one of responsibility he will feel angry

or resentful. This is the opposite of the appropriate set of helpfulness towards a patient's need, and reinforces the contradiction first mentioned between expectation of emergency and the trivial complaint he actually finds. That this has a social setting is shown by the growth of rotas, partnerships, and emergency call services over the past 15 years in part to deal with this problem.

Finally, the complaints which turn out to be non-emergencies are the tips of icebergs whose mass represents an emotional situation with which the doctor trained in physical medicine may not be able to cope, and the anxiety in the situation may induce feelings in the doctor himself which are difficult for him to cope with. This is a third, fruitful source of contradiction and conflict.

Thus a call for a child late in the evening presented me with a 3-month-old baby with a minor coryza and a weeping mother. The father was away for a week at a school camp and the mother's resentment at his absence was unloaded on me. Here was a typical situation—child as presenting symptom, parental conflict, a nagging woman inducing dislike in me so that the unloading of her aggression did not relieve her tenseness. All very unsatisfactory.

It remains to define the difference between emergency calls and others. Following Jacobs, I took emergencies to be calls fulfilling any of the following criteria:

1. Any disease in which the immediate prognosis is usually serious—cerebral thrombosis or myocardial infarct.
2. Any disease in which the prognosis may be altered for the worse if the patient does not receive rapid treatment; pneumonia, acute retention.
3. Trauma—fractures and burns.
4. Dramatic symptoms which would be expected to alarm a lay person—febrile convulsions, haemoptysis and haematemesis.
5. Impending death.
6. Diseases accepted as causing severe pain—otitis media.

In his list Jacob includes pyrexia of 103° F. or over, malignant disease (i.e. sudden change in condition), frequent vomiting, in fact conditions like my No. 4 which might be expected to alarm the patient. In fact he is trying to draw a broad distinction between reasonable and other calls and this is bound to be essentially subjective. Every doctor would draw up his own list. The same difficulty arises in estimating anxiety which is ever present in our society (some analysts claim it as the main motive force for activity) and in any case always presents when someone is ill. I do not need to define anxiety. The emotion as such is known to us all subjectively, as are the autonomic changes associated. But we never observe isolated anxiety—it is always part of a total pattern of behaviour. The question again is whether anxiety is reasonable (the tiger in the jungle) or out of proportion as in the call I made in the middle of surgery to a man who turned out to have acute winter vomiting.

The wife explained: " I thought he was dying as he took out his false teeth for the first time in 40 years". In the absence of more fundamental knowledge and despite questionnaires and the work done on defining neurosis, the estimation of anxiety remains subjective, relates to a particular doctor/patient relationship, and is conceptualized in relation to disposal. Is reassurance enough? Or do we use a sedative, psychotherapy, referral elsewhere, or what? On this distinction between reasonable and other, I find one third of the calls come into the urgent category: 72 out of the 266, a similar proportion to Jacob.

By comparison (though the situations are not strictly analogous) over a two-week period, out of 60 routine visits 12 were thought to be due to disproportionate anxiety. Out of 188 surgery attendances 61 were for anxiety. In these two weeks there were six late calls of which three were reasonable. The proportion of calls the reason for which is not obvious, is then much higher than the incidence of anxiety-provoked interviews in routine work. On the whole, routine visits are for more serious conditions than routine attendances (four-fifths against two-thirds), whereas with late calls the proportion of serious conditions falls to one-third.

On the other hand, as patients have limited medical knowledge they have their own definitions of emergency. Failure to communicate between doctor and patient is a complex question but obviously if a patient thinks the condition urgent and does not or is unable to explain why, or assumes it is obvious, conflict may result. Thus many patients fear rashes in children—perhaps from the days of scarlet fever or even smallpox. But some of these visits were insisted on despite reassurance by the person taking the call (doctor, wife or secretary) that it was non-urgent.

Here other factors must be at work. An analysis of the 172 non-urgent calls reveals in dramatic form features of the life situation of patients or family groups, often providing material which a score of routine attendances would fail to show. Thus, many showed abnormal aggression, were in a state of panic, unrelated to the real illness, or calls were the result of anxiety in the person calling, not the patient.

The patient, consciously or unconsciously, had avoided asking for the visit directly in order to use the illness in their relationship with the caller. The fact that the anxiety was excessive was shown by the frequent failure of diagnosis and disposal (treatment and reassurance) to allay it. The anxiety seemed excessive, to have elements of fantasy, to irradiate over wide elements of behaviour outside the precipitating cause (the physical illness) and to interfere with social relationships (e.g. doctor/patient, or husband and wife). These are features of anxiety neurosis, and again, one is viewing the situation

for the effect it has on oneself as much as one attempts to understand the behaviour of the patient.

It would be useful to be able to follow patients outside the isolated doctor/patient contact in order to amplify this understanding. Thus a man had gone to work with acute gout and this in face of urgent pleas from the wife who liked to mother him and was resentful of his refusal to be fussed. (She was childless and herself had emotionally induced abdominal pain. My persistent attempts to relate her complaint to her situation made her feel very aggressive to me, although eventually this was sorted out.) The wife had therefore sent for me late in the evening to prove to her husband (who didn't want the visit) that she was justified. She could also display aggression safely. In this case, follow-up, by getting the patients to become aware of their feelings, has saved me further late calls.

Conclusion

In this paper an analysis of 266 late calls over a period of two years has been made in an attempt to determine the underlying cause of the call. Anxiety by the patient or more usually a near relative was a common reason for the call.

An analysis of the work of the practice might lead to a better understanding of what actually happens. It is also essential in planning general medical services—e.g. the present discussion of National Health Service terms of service and practice organization.

Factor not analysed—calls to patients not *on our list*, i.e. emergency as expressioning breakdown of doctor/patient relation—as with casualty.

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Treatment of Weber-Christian Disease. BENSON, R., and FOWLER, P. D. *Brit. med. J.* 1964. **2**, 615–616.

Weber-Christian disease is a rare complaint of unknown aetiology, characterized by periodic attacks of crops of painful tender subcutaneous fatty nodules associated with fever. A wide variety of treatments, few of them satisfactory, have been tried. In the case reported, a woman of 46 who failed to improve on steroid therapy was treated with tanderil (oxyphenbutazone) with rapid and maintained improvement.