Should general practitioners resume 24 hour responsibility for their patients?

Roger Jones Wolfson professor of general practice, Department of General Practice and Primary Care, King's College London, London SE11 6SP **roger.jones@kcl.ac.uk**

YES New contractual arrangements to encourage practices to opt back into 24 hour responsibility and to support general practitioners who choose to discharge this responsibility personally would have many benefits. The change would begin to redress the increasing separation of daytime, surgery based care from out of hours care provided by deputising services. These arrangements would also improve general practice training; greatly increase the quality and appropriateness of out of hours care, particularly in terms of hospital admissions and appropriate use of services by patients; and enhance patient safety by improving the communication of important clinical information. They would be widely welcomed not only by patients but also by other sectors of the medical profession, and are also likely to be cost effective.

Sick system

The background to this debate is the new contract for general practitioners introduced in 2004, which allowed practitioners to opt out of 24 hour responsibility. In a recent article suggesting that out of hours primary care in the UK was becoming a shambles, Heath pointed out that the new contract provided little money for practices that wanted to continue to cover out of hours care, effectively forcing them to opt out.[1] This has led to a situation in which the best trained general practitioners concentrate their efforts on daytime care, while patients who become ill at night risk being seen by less experienced doctors without the depth of background knowledge needed to make the most appropriate decisions about management, including hospital admission. Not only does a parallel out of hours service lead to fragmentation of care and potentially dangerous communication errors, it is likely to be more expensive, in terms of both running costs and unnecessary inpatient costs.

Complaints about out of hours general practice care have risen sharply in the past two years. The Medical Protection Society opened 30 cases related to out of hours care in 2003 and 100 in 2006 (personal communication). Many of these complaints relate to poor doctor-patient communication (including rudeness) and to diagnostic delay and error.[2] The second Wanless report has linked a recent steep rise in accident and emergency attendances to changes in general practice out of hours arrangements.[3] Audit Scotland has recently declared the out of hours services in that country to be financially unsustainable.[4]

International experience

These difficulties are not restricted to the UK. Six years ago Dutch general practitioners gave up personal responsibility for out of hours services, many with mixed feelings, and now a subgroup of patients is emerging who use the service for semi-routine primary care consultations. Patients are often seen by recently trained doctors with little experience and no personal connection to their general practitioner. In Australia and New Zealand general practitioners are still responsible for 24 hour cover, which is usually contracted to out of hours services of varying quality. Some cover is provided by doctors who have made career decisions to work in out of hours services, avoiding the responsibilities of practice management and long term patient care. The Royal Australian College of General Practitioners has set out detailed requirements for the arrangements that practices are required to make when delegating their 24 hour responsibility, including stringent guidelines for the communication of essential clinical information. There is evidence that in the UK quality assurance arrangements of this kind do not always work well, and that patient satisfaction is often not assessed.[5]

Complaints about out of hours general practice care have risen sharply in the past two years

I am not suggesting that all general practitioners resume out of hours responsibility for their entire professional life. And I am certainly not supporting the view that surgeries should be open at all hours for routine care—this entirely misses the point. However, during vocational training and in the early years of practice, seeing patients in their homes, assessing acute medical problems—particularly in areas where paramedical services are not readily available—and making appropriate decisions about treatment and hospital referral should be regarded as core aspects of training and professional development, just as they are in hospital medicine. Younger doctors, more able to tolerate broken sleep, may also be more interested in earning additional income by taking part in out of hours rotas for their practices, and more senior doctors may also wish to maintain patient contact.

In parts of Canada, regional health authorities help general practitioners to form networks in which out of hours care is shared between practices, and in which trainees in family medicine, supervised by experienced primary care doctors, are first on call. Heath suggested that the NHS should be able to devise and fund a system of out of hours care based on smaller rotas of general practitioners covering smaller populations,[1] so that the possibility of some sort of continuity—of hearing a familiar voice or seeing a familiar face—is enhanced.

I have covered my practice at night in the rural south of England and in inner city areas of Southampton, Newcastle, and London. I have sometimes been concerned for my safety. I do not underestimate the difficulties of re-engaging with personal out of hours care but am convinced that for many doctors and patients a return to a more personal approach to 24 hour responsibility would reap enormous benefits.

Competing interests: None declared.

Complaints about the care provided by out of hours services in the UK are growing. **Roger Jones** thinks that general practitioners should take back the role, but **Helen Herbert** believes their efforts would be better focused on improving current systems

Helen Herbert chair Royal College of General Practitioners Wales, Cardiff CF10 4RU
nedmunds@rcgp.org.uk

NO

The question should not be whether general practitioners should take 24 hour contractual responsibility for their patients; rather we should be calling on primary care organisations to take creative and innovative action to engage providers, including general practices, to provide good local solutions. Several organisations have done this already so why not the rest? Access to good quality care should be the preserve of all, not just the lucky few.

Danger of long hours

The relinquishing of out of hours responsibility has led to accusations that general practitioners do not care about their patients. But it is precisely because we want the best care for patients that the change was made. Surely it cannot be in the interests of patients for doctors to work all day, be up most of the night on call, and then work through another full day in surgery. Sleep deprived people should not be making life threatening decisions. Lorry drivers and airline pilots would not be allowed to put others in such danger, so why should general practitioners?

The profession largely welcomed the new contract on the grounds of patient safety and improvements in their work-life balance. The newer generations of doctors have a more objective attitude to working hours, and recruitment to general practice was becoming a problem. The contract has been successful in its aim to improve quality of life for family doctors and thus help ensure the future of the profession.[1]

GARO/PHANIE/REX

Those who criticise doctors for accepting the new contract fail to appreciate the stresses of the isolated and unsupported practitioner and the consequences of sleep deprivation on performance the next day.[2] When I began in my practice 25 years ago, I worked a one in three rota, caring for 6000 patients covering an area of over 200 square miles. During the long periods on call, I worked alone without any team support. Often in a state of exhaustion, I would be called time and time again from my barely warm bed. Understandably, patients preferred the immediate contact with a known and trusted general practitioner, but many needed direction in the appropriate use of services and the system was open to abuse.

Sleep deprived people should not be making life threatening decisions

General practitioners are blamed unfairly for the state of out of hours services when the responsibility for commissioning and providing these services resides with primary care organisations. Although many do provide an excellent out of hours service, some services are confusing and fragmented and patients are often unable to determine the most appropriate service to access. The lack of clear signposting is a big problem, and we must urge primary care organisations to take action. As experts in providing out of hours care, general practitioners are the solution to improving urgent care services, not the problem.

Delegation not abdication

Recognising this, the Royal College of General Practitioners has published a position statement on urgent care, recommending that services are designed around the clinical needs of patients.[3] It states that patients should expect to receive a consistent and rigorous assessment of their needs and an appropriate and prompt response to that need—regardless of who is administering their care. Crucially, the action plan calls for better signposting for access.

Where out of hours care is properly organised and resourced, it works well, and many studies have shown high satisfaction with the care provided.[4 5] However, we must not be complacent when this care does not come up to the standards that our patients deserve. It is necessary to continually monitor not only the process but the outcome of the care, including patient satisfaction and effect on other services such as the ambulance service, accident and emergency departments, and social and secondary care.[6 7]

Nowhere is the need for good out of hours care better exemplified than for patients requiring end of life care. Being ill in the middle of the night can be a frightening and lonely experience for patients and carers alike. There are many excellent models facilitating systematic, anticipatory care in primary care and nursing homes[8] with evidence of positive measurable outcomes such as the doubling of home death rates and reduction in hospital deaths. General practitioners continue to use their professionalism by identifying those patients likely to require out of hours care and anticipating their needs: providing drugs in the patients' homes, communicating with the out of hours providers, possibly sharing personal telephone numbers, and following up relevant consultations the following morning.[9]

Continuity and accessibility remain important professional values of general practitioners. The profession made the difficult decision to withdraw provision of out of hours care to ensure the safety of our patients and recruitment of future generations of doctors, but we must maintain responsibility for these values by providing excellence in anticipatory care and by influencing the providers, commissioners, and policy makers to ensure provision of the high standards of care that we expect for our patients. Our advocacy role remains as important as ever, and we must champion optimal standards of out of hours care for our patients.

Competing interests: None declared.

All references are on bmj.com

WHERE DO YOU STAND ON THE ISSUE?
Tell us on bmj.com