24-hour cover: time for reappraisal

THE provision of services to patients out of hours is one of the most emotive issues in general practice at the moment. The Royal College of General Practitioners has made support for its members a high priority and the issue is central to the welfare of many general practitioners (RCGP development plan, 1991). The council of the RCGP has recently accepted a discussion document which highlights many of the issues and provides a framework against which any proposed new arrangements can be tested (RCGP, 24-hour cover, 1993). It is accepted that a large proportion of general practitioners want to be able to opt out of 24-hour cover[1] and there is a perception of a rising demand from patients which general practitioners have difficulty meeting.[2] The introduction of the new contract for general practitioners in 1990 has also resulted in both an increase in the workload of general practitioners and a sense of frustration.[3] However, in addition to concern about the welfare and morale of its members, the RCGP is anxious to maintain and improve the quality of care for patients, and recruitment to general practice.[4]

In looking at the needs of doctors, it is apparent that out of hours cover is an important source of stress — there is a real possibility of a deterioration in the mental health of general practitioners.[5,6] The number of calls a doctor receives in any period of cover can vary greatly, but even if the number of calls is small, the emotional significance of providing such cover is great (Hastings A, personal communication). Doctors also vary in their physical capacity to cope with this work. To the disruption of lifestyle must be added the effect of the exposure of doctors to violence, or the fear of it.

Against this list of concerns, there are advantages to be gained from the provision of 24-hour cover. These include the satisfaction of providing a personal service, the increased self confidence which may derive from close involvement in care, the educational benefits of observing the outcomes of patient management and the financial reward for providing a service.

The needs of patients result in conflicting demands. On the one hand patients would seem to want continuity of care from a personal physician, consistency of advice and care of a particular type or quality. These may be more easily achieved when services are provided by one individual. On the other hand, patients increasingly appear to want services at a time which is convenient for them and with an urgency that may be determined by social rather than medical considerations. Patients generally report high satisfaction with deputizing arrangments,[7] suggesting that access to services has a high priority. Patients also appreciate clear information and would like some input into the evaluation of services. In responding to these conflicting demands, there are a number of issues which require elucidation. These include the use of delegation, the use of technological aids including the telephone, and the reasons for various patient behaviours.

Society as a whole needs to be assured that the quality of any out of hours care is as high as possible. Such care must be provided economically in a way that is acceptable to the public. A balance may therefore need to be struck between the requirements of patients and those of the profession.

It is clear that the present arrangements do not have the support of the majority of general practitioners.[1] They are a potential or actual threat to the health and welfare of doctors and their families. They also threaten the quality of care provided because doctors may not function well under severe stress. There is unlikely to be a single solution to the needs of doctors and their patients in different geographical and social settings. In addition, the needs of individual doctors may vary with age, health and family commitments. At present the options available are limited, and out of hours cover is generally only available through home visits. Perhaps the requirement should be that the service be provided at a place appropriate for the condition of the patient and the proper functioning of the service. Experimentation in the provision of care at night assessment centres should be encouraged. The present regulations and system of remuneration do not, however, favour such experimentation and these should be adjusted. The involvement of general practitioners in accident and emergency departments is currently being evaluated. However, the current workload of accident and emergency departments should not simply be shifted to primary care without additional resources. It is also not in the interests of patients or the development of the service that primary care be considered as a subdivision of accident and emergency departments.

Debate about responsibility for out of hours cover has been clouded by confusion between responsibility for and actual delivery of the service. The RCGP believes that surrendering responsibility would diminish the role of general practice and open the way for a variety of other forms of provision of primary care which might encroach on the role of general practice more generally (RCGP, 24-hour cover, 1993) However, general practitioners should be able to opt out of the actual provision of out of hours cover when their own circumstances and those of their practice demand this, and there should be much greater flexibility for arranging such provision. In particular, the financial disincentives to large rotas and deputizing services employing trained general practitioners should be removed.

The evaluation of alternative approaches to the provision of care will be important — it should include the views of patients and be supported by official funding. At the same time education of the public in the appropriate use of out of hours cover is important and patients should have easy access to services, including advice by telephone.

Finally, whatever arrangements are made, it is important that primary medical care be provided by trained general practitioners at all times. Training practices should ensure that trainees have the opportunity to learn about out of hours cover, whatever arrangements are in operation locally, and doctors working for deputizing services should have proper support arrangements and fair and satisfactory working conditions.

Our patients need appropriate access to a service of high quality at all times, but this should not be provided at the expense of doctors' health and welfare. Early resolution of these issues is a matter of urgency, and support for the development of flexible arrangements should have the highest priority.

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A blueprint for shared psychiatric care in the community

PRIMARY care is traditionally the point of first contact for patients with psychological disorders. Between one fifth and one quarter of the workload of the average general practitioner is concerned with patients with mental health problems.[1] Dunn and Skuse, in an analysis of John Fry's patients,[2] found that over a 20 year period three quarters of all women and half of all men had seen their general practitioner about a mental health problem, usually depression. General practitioners also provide continuing care for patients with such problems. The increasingly rapid emptying of the large mental hospitals has further increased general practitioners' involvement, raising new challenges in caring for the larger number of patients with chronic psychoses or with learning difficulties now living in the community and seeking generalist care from their family doctor. These changes have had profound effects on the traditional working relationships between general practitioners and specialists, leading to a re-evaluation of professional roles and of services for patients. For the last two decades psychiatrists have been moving from their hospital base to establish liaison consultation clinics in the community[3] often in health centre premises.

It was in response to these changes that a joint working group was set up by the Royal College of General Practitioners and the Royal College of Psychiatrists to examine shared care with special reference to the management of patients with depression, patients with chronic psychoses, elderly patients with mental illness and individuals with learning disabilities. The working group report, just published, seeks to provide a consensus on general principles from which locally-based protocols may be developed by those providing care directly to patients.[4]

Among the recommendations in the report is the call for catchment areas to be determined by populations registered with individual practices and for community psychiatric teams to be aligned with primary care services. This is to be preferred to catchment areas based on local authority or other geographic boundaries and would avoid practices having to liaise with several different specialist teams, which is particularly awkward when seeking urgent care for acutely distressed patients. Closer integration of training for general practitioners and psychiatrists is recommended. A period of training in general practice is already acceptable as part of the requisite postgraduate experience for membership of the Royal College of Psychiatrists and a joint college statement has recently been published on general practice vocational training in psychiatry.[5] General practice disease registers are advocated for patients at risk from chronic mental illness. This becomes increasingly important as more and more patients are discharged from long-stay psychiatric beds, and such a facility would complement registers already in place for common chronic physical illnesses. Joint continuing education for general practitioners and psychiatrists is advocated, as is the joint audit of the care of mentally ill patients.

The working party has recommended only general principles for shared care, recognizing that local practice should be based on local resources and circumstances. The value of the consensus and the benefit derived by patients from the recommendations will depend on the local application of these principles and their acceptance by general practitioners and psychiatrists alike. For the present, many problems remain in caring for people with mental illness. Supervision and community care for patients with psychiatric illness is often inadequate. General practitioners are well aware of the problems faced by these patients and are equally aware of the enormous emotional strain on carers. It will be important to ensure that new community based services do not care for the less ill at the expense of patients with severe chronic mental disorder.

In 1973 a World Health Organization working party on psychiatry in primary care predicted that '... the general practitioner is likely to play an increasing role in the mental health services'.[6] The prediction has certainly come true 20 years later in the British National Health Service. It is now clear that general practitioners deal with a wide range of mentally ill people who never reach psychiatric services, and have direct and often continuing contact with the families of those affected. Recent legislation and government policies have shifted the balance of health care from hospital to the community. These reforms have given general practitioners the opportunity to influence the pattern of services both in hospitals and the community, as general practitioners in effect 'purchase' the greater part of health care.[7] The new organization and structure of primary care can be used to establish priorities for the types of services provided by secondary care and to develop new ways in which general practitioners and psychiatrists can work together. Liaison should also be improved between the primary are team and other professionals such as community psychiatric nurses and clinical psychologists.

In the transfer of resources from hospital-based to community-based care there must be no overall loss of resources nor should primary care become a dumping ground for patients for whom services are required but which general practitioners are not resourced to manage. This is particularly true for patients discharged from long-stay hospital beds. Studies of schizophrenic patients suggest that many consult their general practitioner more than any other health professional.[8] The present system of patient-initiated consultations in general practice is inadequate for monitoring these patients since the first sign of a relapse of illness may be to cause patients to be inactive and slow to complain.

The report recognizes the essential interdependence of primary and secondary mental health care and the need to develop a shared understanding of local needs and priorities. People who are socially disadvantaged, such as those who are unemployed or living in overcrowded or poor housing and ethnic minorities, are more likely to suffer mental illness.[9] It is difficult and undesirable to separate health care from social care. We should not only recognize the interdependence of primary and secondary medical care but now focus on the trilateral interface between social services and community- and hospital-based mental health care.

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