A weekend on call in Canada

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I am a general practitioner in a group practice of eight general practitioners with the support of six full-time consultants and two part-time consultants.

It is the duty of every general practitioner, in rotation, to do housecall duty during a weekend. I cannot say that this is a weekend that I look forward to with relish, anticipation or excitement!

Saskatoon has a population of 130,000. It is in the very centre of Canada situated in the prairies. It is the site of the medical school and University Hospital of the University of Saskatchewan, within the confines of its beautiful campus overlooking the South Saskatchewan River; there are about 12,000 students. The surrounding prairie is wheat growing. In addition the Canadian National Railroad has a large depot on the outskirts of the city, thus many of our patients are university, farming and railway people.

Our practice represented some 20,000 people at risk during the study weekend. It is safe to say that 100 per cent of our patients have easy access to a telephone and pay a monthly rental; there is no extra charge for intra city telephone calls. The ambulance service is really poor and intolerably expensive compared with that of the United Kingdom, however, it is indeed a rare patient who does not have a motor car—a necessity when one lives on the prairies with winter temperatures as low as 40° F. *below zero.*

Consequently, 'house calls' are much rarer than seeing one's own patients in the outpatient department of the nearest hospital.

Finally general practitioners and consultants of our group, pool their incomes and we pay ourselves a salary. The consultants represent the following specialties—internal medicine, surgery, psychiatry, ear, nose and throat, radiology, obstetrics and gynaecology and two part-time consultant-advisers in pathology.

Our role as general practitioners is wider than in the United Kingdom in that we admit and look after our own patients in either St Paul's Hospital or Saskatoon City Hospital.

I therefore hope that an analysis of a weekend on call in Canada might be of interest to my erstwhile colleagues in the British National Health Service.

A weekend on duty starts at 08.00 hours on Saturday. The doctor on duty for the weekend meets one of his general-practitioner colleagues at 09.00 hours and the two work together until 13.00 hours in the clinic building, dealing with 'drop-in patients'. At 13.00 the doctor on duty for the weekend takes over and his colleague who has been on duty from 09.00 until 13.00 hours goes off duty for the next 43 hours.

During the study weekend I recorded the number of incoming calls and the number of calls I made. The number of incoming calls that I recorded was identical to that recorded by the clinic's telephone answering service, through which all incoming calls were routed. As incoming calls are those most likely to be inadequately recorded, and as the correlation was exact it is probable that the outgoing calls were also accurately counted.

Results

TABLE 1

Total number of telephone contacts	*Number of incoming telephone calls*	*Number of outgoing telephone calls*
101	46	55

Patient need led to 46 telephone calls to me. I made 55 although some of these represented my checking in with the telephone answering service and asking them if there was anything more and telling them where I was (Table 1).

TABLE 2

PATIENTS ASKING FOR ATTENTION AND SENT BY ME TO THE OUTPATIENT EMERGENCY DEPARTMENT OF A HOSPITAL

Seen by me	*Not seen by me. Dealt with by an intern*
10	2

An odd occurrence took place that weekend. Contrary to usual experience there were only two calls for repeat prescriptions, whereas the usual demand for this service varies from between 20 to 30. This may have been due to 36 hours of continuous rainfall, unusual for the prairie provinces. This was entirely atypical. Among the 46 incoming telephone calls during the 48-hour period, there were seven telephone calls from the outpatients' emergency department, either from an intern or a nurse, asking for advice. However, of these seven telephone calls, three related to one patient. This does not represent a 'slough-off' of responsibility, they represent, for example, "you have a patient here who has been bitten by a dog, is it alright if we give him a tetanus toxoid injection?" Such problems as these are dealt with over the telephone without the physician on duty going to see the patient.

TABLE 3

HOUSE CALLS DONE AFTER THE 46 TELEPHONE CALLS

Urgent	*Non-urgent*
14	5

Table 3 shows there were five non-urgent housecalls. Why were they seen during a weekend? The answer is that, while a doctor may be at an emergency department of a hospital, the telephone answering service contacts him and says that another patient wishes to talk to him. He will discuss with him and say "Well, I'm at the emergency department of such-and-such hospital, why not come and see me immediately?" Such patients I regard as non-urgent house calls in that I did not actually disturb myself from my routine to go and see them. Hence, these patients, though legitimately included in the statistics, are charged at a much lower rate since they were patients who came to see me while I was dealing with another patient in the same part of the hospital building.

Frivolous calls

Being somewhat authoritarian, my judgment concerning the need of a call from a patient which he regards as an emergency is probably harsher than that of some of my colleagues. It is fair, therefore, to report, that of the 46 telephone calls made I regarded two as entirely frivolous.

One was at 1800 hours on Saturday, a pharmacy student rang stating that his daughter had been feverish for two hours. This young lady is ten years of age with a fairly sophisticated and intelligent father who was told, (*pace* Shelley Berman) "Give her an aspirin and ring me back at 0800 hours if necessary". The father seemed quite happy to accept this advice!

The second frivolous telephone call was at 0300 hours on Sunday when a young lady, (whose charming voice nevertheless seeped through to my dulled appreciation) "I have had my contact lenses in for five hours longer than I should, do you think I might hurt my eyes?"

I suggest that these two calls would probably be unanimously assessed as 'frivolous'. This figure can be interpreted in two ways. Firstly, two out of 46 telephone calls represents a little over four per cent. This is high, but is an incorrect appreciation as I think it essential to recognise that these two frivolous calls to the duty doctor for that weekend represented an infinitesimal fraction when it is recalled that there were 20,000 people at risk. I think it necessary to stress and possibly belabour this point.

TABLE 4

THE DISTRIBUTION OF TELEPHONE COMMUNICATIONS BY TIME OF DAY DURING WEEKEND OF 5–6 JUNE 1971

Time	*Asking for prescription or advice*		*Asking for attention. Sent to emergency hospital outpatients*		*From outpatient emergency and not dealt with by me*	*Repeat prescriptions*	*House calls*	
	Reasonable	*Frivolous*	*Seen by me*	*Not seen by me*			*Urgent*	*Not urgent*
Saturday 08.00 to 13.00 hrs	7	–	2	–	2	2	2	1
13.00 hrs to midnight	35	1	1				3	
Sunday midnight to 08.00	10	1	1	1	1		1	
08.00 to midnight	45		6	1	1		8	4
midnight to 08.00 hrs *Monday*	4				3			

One hears from physicians the constant, repetitive complaint about the frivolous nature of the problems that patients present to a doctor once a medical service is under some form of government-sponsored insurance programme. I admit, as a physician favourably disposed towards tax-financed medical services, that I too remember mainly the abuses of my services and 'good nature', entirely forgetting the relevance and importance of the remainder of the calls. While these frivolous calls represent the pinpricks of life, nevertheless, with sufficient pinpricks one can bleed to death!

TABLE 5

HOURS OF SLEEP AND MILES TRAVELLED

Hours of sleep during weekend 3 + 6 = ...	9
Total hours of 'nonsleeping'	39
Miles travelled in the 48-hour period	50.8
Patients seen who were not clinic patients but friends or relatives	2

Table 7, shows the diagnoses I made and I think explains the excitement and grandeur of being the physician of primary contact.

TABLE 6

DOLLARS EARNED

Patients seen by me in the clinic 09.00 to 13.00 hours Saturday ..	$62·00
Patients seen from 13.00 hours on Saturday to 08.00 hours on Monday	$230·00
Deterrent fees*	$56·00
Dollars earned for clinic per nonsleeping hours 292/39	$7·25 per hour

*The previous provincial government had a $1·50 'utilisation fee'. This was a levy that patients had to pay when they went to see a doctor. It was an attempt to stop 'abuses of the medical service'. Since June, 1971, these deterrent fees have been removed following a change of government.

TABLE 7

DIAGNOSES MADE

Brittle diabetic in early diabetic coma	1
Drug overdose, alcohol and barbiturate in a woman of 74	1
Circumcision at request of an obstetrician in our group	1
Cauterisation of Little's area	1
Cholecystitis	1
Otitis media	1
Epidemic vomiting	2
Renal colic	1
Acute pancreatitis and congestive heart failure in a woman of 72	1
NYD acute polyarthritis	1
Trichomonal vaginitis	1
NYD abdominal pain	1
Acute labyrinthine upset	1
? Coronary thrombosis admitted to intensive care unit	1
Inevitable abortion for D & C	1
Herpes zoster of face	1
Bolus of food impacted in oesophagus	1
Acute sciatica requiring immediate admission to hospital	1

Earning capacity

The earning capacity of doctors is an important aspect of our work, especially when one is working in a group practice when the specialty workers may begin to feel an overweening sense of their own importance purely based upon the financial earnings that they are capable of bringing into the partnership when compared with their general-practitioner colleagues. It is my hope that our profession may shortly grow out of this puerile set of value judgments and may look instead at the almost limitless expanse of work of the family physician.

Summary

(1) One middle-aged practitioner, who does not particularly relish a weekend on house call duty, presents an analysis of incoming telephone calls and the work generated in a group practice.

(2) The monetary return to the group practice is reported.

(3) The extraordinary scope and breadth of the problems presented to a physician of primary contact are listed.

GENERAL PRACTICE IN CANADA

The pendulum is definitely swinging in favour of the family Practitioner. Student publications from the University of Western Ontario report that 71 per cent of the 1972 graduates will enter family practice, at Dalhousie 91 per cent.

Wright, Donald I. (1972). *Canadian Family Physician*, **9**, 10.

PHYSICAL FITNESS

Physicians and physiologists agree that the ability to utilise oxygen during effort is the most reliable indication of physical fitness.

Percival, Lloyd (1972). *Canadian Family Physician*, **18**, No 7, 57.