DIFFICULTIES WITH DEPUTIES

THE general practitioner's contract with the British National Health Service is unique in the western world. In 1948, for the first time, a group of professional men accepted the responsibility of providing continuing care throughout every day and night of the year.

Such an arrangement seemed ideal from the patient's point of view, and the knowledge that personal doctors would provide a continuing service has undoubtedly been a great comfort to many. Patients normally prefer a familiar face, particularly at times of crisis, and the doctor who has knowledge of the patient's past history is likely to make decisions about diagnosis and management both more quickly and efficiently.

The problem

Nevertheless the provision of continuing care, particularly out-of-hours work, does represent a major problem in primary medical care. However willing, doctors get tired and being on call perpetually can prove a heavy burden. Nor is it fair that the families of family doctors should alone suffer perpetual social restriction, particularly at a time when society as a whole is achieving ever more leisure time.

Even working one weekday evening and night a week means over 1,000 hours on call a year and when combined with every fifth weekend and bank holiday the workload is 1,600 hours a year. Increasing the population served also means that duty sessions become much harder work. Compared with other professional men working a 40-hour week, these doctors work a 61-week year.

In addition many general practitioners are at times on call for over 100 hours consecutively. Meanwhile the hours that pilots and lorry drivers are allowed to work are regulated.

Alternative arrangements

Given such a contract, some form of alternative to the same doctor being on call 168 hours a week was inevitable, particularly in urban areas. Deputising arrangements have come to stay and three kinds of arrangement have developed.

The first consists of a rota between general-practitioner principals, all or most of whom are in active general practice, who take it in turns to do out-of-hours work; money is often not exchanged. The second, which is commoner in the bigger cities, are the commercial deputising services which provide a medical service for the general practitioners, for which they charge. Williams *et al.* today examine the referrals from some of these deputising services to accident and emergency departments.

A recent paper by Harden (1973) describes a third possibility. He reports from the Woodside Health Centre in Glasgow which is one of the largest in the United Kingdom and has 21 general practitioners and a practice population of 45,000.

This unit organises its own deputising service, charging its practices which use it, and paying item-of-service fees to the doctors on duty who are usually practitioners from the centre itself. One feature of this scheme is its flexibility as no doctor is forced to do out-of-hours work, but nevertheless the fees ensure that " the demand for sessions usually slightly exceeds the sessions available ".

Five principles

These three systems are significantly different and opinions vary as to their pros and cons. Nevertheless certain principles are emerging by which deputising arrangements can be judged.

The first principle is that ideally the doctor working out of hours should himself be a general practitioner in active practice, and fully experienced with the medical problems

that patients present in their homes. The second is that it is desirable that the locum doctor should have as much idea as possible of the philosophy and the style of practice of the doctor for whom he deputises. Thirdly, as so much of general practice depends on local attitudes and environment, the locum doctor should be familiar with the area and its medical and social services. Fourthly, the doctor on call should be reasonably close to the area he is serving. Finally, access to the patient's medical record is desirable.

Theoretical principles are not always easy to put into practice but many, both inside and outside general practice, now view with some concern systems which may provide emergency doctors who may not be general practitioners at all, who may be relatively junior and hospital-orientated, who may have no local knowledge of the policies of the practice with which they are involved, or of the services of the area, and who may at times have difficulties with language or dialect.

Of these five principles the first is probably the most important—an experienced family doctor is the best substitute for an experienced family doctor.

If this is so, there are training implications. Although calls out of hours form a numerically small proportion of the total load of a practitioner's week (Williams, *et al.*, 1973) they have a great significance for patients and are relatively more important than their numbers.

As 1977 comes closer it becomes clearer that doctors training to be general-practitioner principals will need teaching and domiciliary experience in emergencies as in all other parts of general practice.

The future

The problem of providing night and weekend cover is a challenge to both the public and the profession. It will be necessary in the future to devise a system where patients receive a reasonable and efficient service and doctors have reasonable hours of work.

The profession is achieving, and can look forward to, shorter hours. Meanwhile perhaps the public will increasingly value and come to expect service from doctors who are vocationally trained for general practice or who have extensive experience of this work.

REFERENCES

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