The Review Body concludes that "a measure of adjustment if justified at this time to avoid a situation in which a further underpayment might result". It recommends that "the provision for average practice expenses for 1975–76 should be £3,575. This represents an increased provision of £200 which should be reimbursed through the basic practice allowance and capitation fees, so as to maintain the current relationship in average gross remuneration between these items."

CORRESPONDENCE

OUT-OF-HOURS WORK

Sir,

The problem of out-of-hours work has again received attention in the *Journal* (January) and I write to offer some personal observations about deputising services:

I worked for the Tees-side service for 18 months whilst a vocational trainee in that area from 1971–74, making over 2,000 home visits. At first I attempted to classify these into 'reasonable' and 'unreasonable' calls; but so subjective was this that I abandoned the attempt. There were exceedingly few unreasonable calls, considering all the factors, including the patient's personality; and most of these few were made by relatives without the consent of the patient.

I wish that I had been able to go with Dr Roger Gabriel and explain to him the reasons why the 132 cases judged not medically necessary by him had called the doctor. They did not of course require the services of a physician from the Royal Infirmary, but a doctor trained in primary care.

Herein lies the crux of the problem. A doctor working for a deputising service needs some experience of, and greater awareness of, general practice. I do not believe that previous knowledge of the patient is necessary, and in very few cases did I find lack of it a handicap. I found the experience of deputising exceedingly useful, not least in the M.R.C.G.P. examination, where multiple choice questions so often relate to a 'new' patient. Some months my cheque from the deputising service was greater than that as a trainee, and I do not believe that any deputising doctor is exploited.

Let us distinguish any shortcomings of an alternative service itself from personal shortcomings of its employees. The commercial nature of these services means that they must become efficient, and to this end radio telephones, well equipped cars with experienced local drivers, and switchboard staff who are state registered nurses are used. Were their doctors always suitably experienced and trained (ideally practising local general practitioners and trainees) their standard of care could not be less than the extended-cover system in which I now participate.

As I try to find addresses in the dark, without driver or radio to obtain directions or further calls, and seeing patients of other local practices, of whom I have no personal knowledge, access to records, or continuity of care, I often reflect on these points, as does my wife, tied to the house and telephone not only at night, but throughout a fine Saturday or Sunday.

If we only treated patients requiring urgent medical aid most of us would be redundant. We must see patients who feel they need a consultation with a doctor; few will abuse us; all accept that their personal doctor cannot always be available. It is up to us to organise out-of-hours work, and a commercial service often seems better able to do this than individual and individualistic practices and practitioners.

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Sir,

I was most interested in your January *Journal* in which you discuss various methods of providing for night calls. The real problem seems to me to be the difficulty experienced by general practitioners when the same doctor is forced to work, not only during the night, but all day on either side of the night and often consecutive days and nights at weekends.

Even one telephone call, not requiring an actual visit, strategically placed at 0100 hours can completely ruin a whole night's sleep. This must present a danger to patients, since a tired, irritable doctor, is not a good doctor. Can you imagine the public outcry if other public servants like bus and train drivers, who hold other lives in their hands, were permitted to work continuously for 96 hours.

The solution, if we are to avoid Government direction and salaried service with set shift hours, must be worked out between ourselves. I have not heard these suggestions made elsewhere and they may be of interest to others.

In any urban population of approximately 140,000 to 150,000 people, there will be 50 or so established and experienced general practitioners. It can be shown that the average night call rate that such a population will generate is of the order of seven to ten calls per night. If all 50 or so general practitioners agreed to a rota, it would be possible for each general practitioner to be on for