The Journal of
The Royal College of General Practitioners
The British Journal of General Practice

Editor
E. G. Buckley, FRCPE, FRCGP
Livingston
Assistant Editors
A. R. Bichard, DPhil
J. M. Bumstead, BSc
Honorary News Editor
E. E. J. Martin, FRCGP
Bedford
News Editor
N. Roberts

Editorial Board
R. C. Froggatt, FRCGP
Cheltenham
D. R. Hannay, MD, PhD, MRCGP, FFCM
Sheffield
M. D. Jewell, MRCGP
Bristol
R. H. Jones, MRCP, MRCGP
Southampton
J. S. McCormick, FRCPI, FRCGP, FFCM
Dublin
D. J. Pereira Gray, OBE, MA, FRCGP
Exeter
N. C. Stott, FRCPE, MRCGP
Cardiff
C. Waine, FRCGP
Bishop Auckland
Statistical Adviser
I. T. Russell, PhD, FSS
Aberdeen

Published by The Royal College of General Practitioners, 14 Princes Gate, London SW7 1PU.
Editorial Office: 8 Queen Street, Edinburgh EH2 1JE.
Printed in Great Britain by Thomas Hill Print (1985) Ltd., Bishop Auckland, Co. Durham DL14 6JQ.

The front line advances

GENERAL practitioners believe that they can deliver the best form of primary health care in the United Kingdom and the recommendations contained in the recently published white paper *Promoting better health* endorse this view.[1] In the white paper the Government recognizes the central position that general practitioners occupy in the delivery of primary health care and places major new responsibilities on their shoulders. In addition to caring for sick people in the community, general practitioners will now be expected to demonstrate that they are providing preventive care as well. Of course, for good general practitioners prevention has been an important part of their practice for a long time. The Government now aims to encourage all general practitioners to take on the task of promoting good health and preventing ill health through financial incentives for those who provide such services and penalties for those who do not.

The message of the white paper is that general practitioners will have to become even more skilled in management and practice organization than at present. Practices will be expected to provide information on their performance and will be at a disadvantage if they do not have an efficient, probably computer based, record system. For example, the paper states that 'the Government will, through changes in the remuneration system encourage doctors to provide comprehensive regular care for elderly people'. To do this practices will need to be able to identify their elderly patients, document their contact with the practice and provide the family practitioner committees with information to substantiate the claim that comprehensive regular care is being provided.

Another aspect of the recommendations which apparently strengthens the position of general practitioners as managers in primary care is the removal of restrictions on the number and type of personnel that can be employed through the direct reimbursement scheme. This should enable general practitioners to identify health needs and employ staff to meet these needs. However, the paragraphs of the white paper which deal with the employment of staff by general practitioners also indicate that cost limits will be applied to family practitioner committees in funding these appointments. Imposing cost limits could undermine all the potential benefits of the recommendations made by the Government.

It is clear that many of the proposals for general medical practice in the white paper closely follow the College's policies as set out in *The front line of the health service.*[2] Apart from the intention to introduce charges for dental checks and eyesight testing, the proposals appear positive and progressive. But they are still outlined only in broad terms and detailed work is needed now to convert the recommendations into actual practice.

The College has been successful in leading discussion and debate in the profession by emphasizing through its publications the importance of prevention as an integral part of general practice and in advocating the introduction of a performance related contract for general practitioners. The tasks now for the College are to help general practitioners become more effective in implementing preventive care and also to coordinate the work necessary to provide the evidence upon which criteria of performance can be based. The white paper refers to peer group review as a method of assessing practice activities and this recognizes that criteria need to be relevant to the needs of particular localities. Through their faculties, members of the College can identify the health needs of particular populations and localities and so recommend local criteria of performance.

© *Journal of the Royal College of General Practitioners,* 1988, **38**, 1-4.

Peer review within small groups is also capable of considering the qualitative aspects of general practice which could be overlooked in the pursuit of measurable indicators of performance. Thus the creation of effective small groups will be an important part of continuing medical education in general practice and crucial in transforming the proposals for better health contained in the white paper into a reality.

E.G. BUCKLEY

References

1. Secretaries of State for Social Services, Wales, Northern Ireland and Scotland. *Promoting better health. The Government's programme for improving primary health care. (Cm 249).* London: HMSO, 1987.
2. Royal College of General Practitioners. *The front line of the health service. College response to 'Primary health care: an agenda for discussion'. Report from general practice 25.* London: RCGP, 1987.

Hours of work and fatigue in doctors

ONE contentious aspect of many discussions about the criteria for good practice is the suggestion that 24-hour availability of general practitioners, without recourse to the employment of deputizing services, implies a better standard of care. The emotive divide between practices that use such services and those that do not is particularly noticeable in the urban areas where usage is concentrated and widespread. In 1985–86, in England and Wales, nearly 50% of general practitioners had consent to use deputizing services, and nearly 50% of night visits were carried out by deputizing doctors.[1]

This use of deputizing services may be related to several factors, including out-of-hours workload, the age and sex of the doctor, doctors choosing to live outside their practice areas for social reasons and fear of physical violence, rather than the doctors' perceived impairment of performance through fatigue. A range of night visiting rates of 1.2 to 46.1 visits per 1000 patients per year have been described,[2] and although they represent a small proportion of doctor–patient contacts, the physical and emotional burden that stems from this work is significantly high. Records[2] refer to night visits carried out, rather than telephone calls where advice alone is given but the disturbance of sleep may be equivalent.

Little research has been carried out into performance impairment through lack of sleep. A literature search showed that the information available refers largely to junior hospital doctors and young American interns. The position of general practitioners who may be older and in poorer health does not appear to have been studied at all.

A study of young American interns demonstrated psychological problems occurring with sleep deprivation that included difficulty in thinking, depression, irritability, referentiality, depersonalization, inappropriate affect, and recent memory deficit.[3] Impaired performance, assessed by the doctor's interpretation of electrocardiograms, was also shown.[4] The authors concluded that the internship functions as an initiation rite into an elite society, and that doctors, by accepting such regimes without question, are acting out an unconscious wish to possess abilities and powers that transcend what is ordinarily thought of as human.

A study of junior hospital doctors, using tests of grammatical reasoning, showed that a sleep debt of three hours of more consistently reduced efficiency. Interpreting laboratory tests under similar circumstances did not show any rise in errors, but there was a greater range of variability in the rate of work.[5] Focussing on such specific tasks appears to be less affected by tiredness. It has been shown that when radiology residents were tested in their ability to identify a nodule on a chest X-ray, no significant difference was demonstrated between rested doctors and those who had worked for a minimum of 15 hours.[6] In a review of the literature on doctor performance, the authors suggested that as research demonstrates negative effects with sleep deprivation, night call duties as part of residency training should be re-evaluated.[7]

Other groups of workers have statutory limitations on hours of duty. Current legislation limiting pilots' flight times have evolved over a series of reviews by the Civil Aviation Authority.[8] While the document has some scientific background, it has basically come about by pressure from the British Airline Pilots Association (personal communication). An opinion from the Medical Defence Union (personal communication) states that no case is known in which fatigue has been put forward in a doctor's defence in a negligence claim, but that a judge may not look favourably on a doctor who performed 'non-essential' tasks when his judgement was impaired through fatigue. The Automobile Association (personal communication) states that a driver who allows himself to be overcome by sleep can be guilty of careless driving. If evidence were found that the defendant continued to drive when there was a risk of falling asleep then a charge of reckless driving could be brought.

The effects of a variety of stresses on doctors' attitudes and performance are currently being studied,[9] and recent research has looked at workloads, job performance and quality of care.[10,11] Most of these stresses are well-defined, but new sources of stress described in a group of American physicians include fear of malpractice suits, having to practise 'defensive' medicine, fear of violence and pressure of peer review.[12] These categories may well be appearing in the UK. It has been pointed out that the USA loses annually the equivalent of graduates from seven entire medical schools (approximately 700 physicians) from suicide, drug addiction and alcoholism,[13] and the mortality and morbidity statistics from British doctors show similarly disturbing figures.

A nationwide workload study carried out by the British Medical Association and the Department of Health and Social Security demonstrated that the 'average' general practitioner is on duty for 73 hours a week.[14] The effects of such hours on a doctor's delivery of high quality, cost sensitive care surely merits further study. If deleterious effects are shown, what then should be changed? Should an out-of-hours cover system take into account the age, sex and physical health of the doctor, or the demography/demands of the population? How do we take into account the great range of night work when my personal experience varies between having an occasional undisturbed night and a night with five night visits and two additional telephone calls? Over 10 years ago, the nettle of out-of-hours work was grasped in an editorial which looked at the advantages and disadvantages of the shift system, the extended cover system and the alternative of commercial deputizing services.[15] To these we can add the use of local casualty departments — the 'emergency room' system. Would this system discourage the unnecessary