

ing calls were managed in this way,¹ with a mean of 0.7 visits made in response to 2.6 calls in the weekday evening period.

In a comprehensive study of out-of-hours work in my practice (seven partners, 13 300 patients), one participant recorded 16 telephone contacts in one weekday evening between the hours of 18.30 and 23.00 and the mean for a six-month period was 6.1 per evening. Some of these are simple requests for advice, but it is clear that to visit all these patients would be difficult, and in addition, would reduce the availability of the doctor to the patient who needs immediate attention, a situation which may also lead to a complaint.

A selection of alternative ways in which out-of-hours work may be structured has been offered recently.² Contributions from the defence societies to this debate are important and relevant, and need to be made in the context of the realities of the workload.

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References

1. Marsh GN, Horne RA, Channing DM. A study of telephone advice in managing out-of-hours calls. *J R Coll Gen Pract* 1987; 37: 301-304.
2. Pitts J. Hours of work and fatigue in doctors. *J R Coll Gen Pract* 1988; 38: 2-3.

Night calls — the patients' view

Sir,

Roused during the night, the field marshal on active service might shave, bathe and take a cup of coffee before addressing himself to his new operational problems. And before getting out of bed at all, he will have quizzed his aide-de-camp to make sure that rising was really necessary.

The doctor on night call is more like the junior officer in the front line, who is expected to give clear-headed attention to local problems within seconds of waking.

We can all sympathize with the doctor whose sleep is disturbed when he is trying to recover from an exhausting day — except, that is, when we are the ones in need of help. Then, our expectations are rather different. Our problem is to keep those expectations within reasonable limits.

It seems to me to be quite reasonable to expect that the doctor answering the telephone in the middle of the night will begin by telling me his name and asking mine. The fact that I have telephoned at all at that hour is evidence that I believe an emergency to exist, and I quite understand that I might be mistaken. But if the doctor decides that a visit is not necessary I would like to feel that he has elicited suf-

ficient information from me to enable him to reach a sound decision.

In short, I would like to be satisfied that his decision to go back to sleep is professional rather than merely human.

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Staff for general practice

Sir,

While in support of Dr Pritchard's editorial on general practice staff (*February Journal*, p.41) I would like to make the following comments.

Dr Pritchard is correct that no mention of practice managers is made in the government's white paper *Promoting better health*¹ nor is the Association of Health Centre and Practice Administrators included by name in the *Statement of fees and allowances*. Despite numerous approaches and appeals to the Department of Health and individual members of parliament, the association and the role of the practice manager remains unrecognized. However, it was gratifying to hear on a BBC Radio 4 interview that the Minister for Health recognizes that practice managers would play a key role in the implementation of the proposals outlined in the latest white paper, *Working for patients*.²

This association, with over 800 members, has been working voluntarily for 14 years in training managers in general practice in the tasks now specified in *Working for patients*. We will continue to train and educate our members to meet the challenges of the future and ensure that doctors are free of concerns over administrative details and able to devote their time to the skills in which they are trained — the treatment and care of their patients.

We are grateful for the support that the Royal College of General Practitioners has given us over the years and we look forward to working together to make the most of the new opportunities to improve the quality of patient care in general practice.

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References

1. Secretaries of State for Social Services, Wales, Northern Ireland and Scotland. *Promoting better health (Cm 249)*. London: HMSO, 1987.
2. Secretaries of State for Health, Wales, Northern Ireland and Scotland. *Working for patients (Cm 555)*. London: HMSO, 1989.

'Brittle' diabetes

Sir,

With regard to Dr Buckley's comments on 'brittle' diabetes (*Digest, February Journal*, p.82), it has been possible to measure the Somogyi effect objectively for many years. A finding of hyperglycaemia in the morning associated with a headache in type 1 and type 2 diabetes should alert the practitioner to the possibility that nocturnal hypoglycaemia is occurring. A morning measurement of creatinine to cortisol ratio will confirm that there has been excess nocturnal production of steroids in response to hypoglycaemia.

It is not a particularly expensive test to do and may help determine treatment in 'brittle' diabetics.

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Quality of care

Sir,

Nick Bosanquet's editorial (*March Journal*, p.88) rightly gives great credit to the family doctor charter of 1965. As he says, quality has emerged 'as a result of professional cooperation rather than economic competition' and the best hope for further progress still rests upon that factor. The College's own drive for quality review throughout the last decade has paved the way; money comes into the equation as it did before the charter, when income was effectively reduced by just those measures which would promote quality.

However, change in medical practice is a continuous process and Bosanquet seems unaware of the earlier changes which made the charter possible. The Dankwerts award of 1952/53 first gave general practitioners a fair level of remuneration in the National Health Service. After negotiation, the additional money was deliberately distributed in a way that favoured group practices, lists of moderate size and the establishment of new entrants to practice. The profession voluntarily set aside some of the award money to provide interest free loans for the improvement of group practice premises, something the Pilkington Royal Commission said the government should have done and should reimburse. As a result general practice was substantially reorganized and the new development of associating health visitors and home nurses was far advanced by 1965. The Gillie committee of 1963 had produced the guidelines and the pressure for the

charter came mostly because the old method of distributing a fixed percentage for expenses from the central pool penalized just those practices which were trying to provide better premises and more ancillary staff in order to improve their services to patients. Practitioners like John Wigg, Guy Ollerenshaw and Ekke Kuennberg had shown the way, but two men, James Cameron and Kenneth Robinson should be remembered for their quiet persistence in the charter negotiations.

Another important change followed the Nuffield sponsored Christ Church conference on postgraduate education 1961. A remarkable drive for continuing education was released within the profession, which resulted in the establishment of postgraduate centres in every hospital district with funds partly contributed or collected by the profession itself. The NHS only accepted the main financial responsibility two years later. We have George Pickering to thank for that initiative, supported by Gordon McLachlan, but sadly the minimum requirement negotiated in the charter was allowed to lapse in the 1970s.

Bosanquet rightly emphasizes the need for further investment in information technology now, but it should be remembered that the NHS in the early days also introduced open access to diagnostic services which general practitioners had never had before. John and Valerie Graves' personal initiative of the audio-visual library with College support was an early essay in information technology.

Bosanquet's final comment that 'the agenda for action has to be set by profes-

sional commitment rather than by the crude market forces which operated to lower standards under the panel system' is most apt. Those lower standards were cruelly exposed in the Colling's report, slanted though it was. The agreement of 1953 changed the old National Health Insurance pattern of capitation payments and large lists which so impeded practice development. The new pattern of practice that then emerged demanded the changes the profession sought and the charter made possible. What is now needed is a system that will ensure that quality review used by many better practices becomes the accepted obligation of all. There is an opportunity to secure that which competition for ever larger lists would destroy.

Having been a participant in all the earlier negotiations I would not like them to be seen as originating so much as mediating and endorsing progress.

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Working for patients

Sir,
Having considered the government's white paper *Working for patients*,¹ we are concerned about the far reaching implications of the health service review. Far from extending patients' choice, we believe that the effect would be to restrict patient choice from its present level. As district health authorities rationalize and contract out their hospital services there will be a

steady reduction in the variety of services available at local level.

For the first time since the inception of the National Health Service, there will be financial restrictions on the delivery of primary care. Since the demand cannot be restricted this can only result in a rationing of care for patients in terms of drugs provided, investigations carried out and hospital referrals. The implications of this for the doctor-patient relationship are grave.

There are aspects of the review which parallel the aims and principles of the College and which have merit. It is appropriate for the College to be seen to encourage such proposals but at the same time the College must speak out against the inevitable decline of patient care that will occur with the movement back to the days before the 1966 charter and the greater emphasis on capitation.

The College has always stood for improved patient care and pioneered the educational development of general practitioners. It must remain true to these principles and not hesitate to state publicly and unequivocally the consequences to our patients of this review.

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1. Secretaries of State for Health, Wales, Northern Ireland and Scotland. *Working for patients* (Cm 555). London: HMSO, 1989.



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