Letters

All letters are subject to editing and may be shortened. Letters should be sent to the BJGP office by e-mail in the first instance, addressed to **journal@rcgp.org.uk** (please include your postal address). Alternatively, they may be sent by post as an MS Word or plain text version on CD or DVD. We regret that we cannot notify authors regarding publication. Letters not published in the Journal may be posted online on our Discussion Forum. For instructions please visit: http://www.rcgp.org.uk/journal_/bjgp/discussion_forum.aspx

The saviour of the NHS — my cat

Gordon Brown should hold urgent talks with my fat 3-year-old cat Mustafa. She (I am aware her name is a boy's one) can describe without question, the faults of the current out-of-hours (OOH) service and make suggestions for a model that works.

A few weeks ago Mustafa decided to hurt her front paw. This is her diary —

Day 1: Mustafa has done something to her front paw. She won't tell me what, but she isn't weight bearing. A definite bump over her MCP joint prompts a call for help.

One quick phone call to our local vet (they are part of a large chain and easily identifiable with a branch in most high streets), and we are put through to their on-call base in a nearby town. We rush over to the OOH vet base. Happy to be seen quickly, but mid-week night shifts at base are quiet anyway. Thankfully it isn't Saturday!

See a foreign vet who speaks limited English and whose response to my wife's tearful plea for them not to keep Mustafa in overnight was a blunt: 'What else would you like me to do?'. Nice communication skills mate. X-rays done that night show no fracture and no dislocation. She is patched up and discharged the next day after 'other vets look at the X-ray'. Follow-up is planned for 3 days later at another base.

Day 4: This laughable follow-up consultation involves prodding at Mustafa's painful paw and planning follow-up again. Fobbing off does not count as continuity of care.

Day 7: She is seen by a different vet in our local surgery (finally) and deemed to be fine. No limp and the dressing removed. I can see the bony prominence on her paw. Mustafa wants to get out of there, so no arguments. As soon as we are home, she cannot weight bear again.

Day 8: An angry parent (me) calls the vet. I demand that they bring over the X-rays and for her to be seen again. We see the same vet as yesterday. For the first time ever, some continuity of care. Take a bow. I make him feel the bony MCP prominence and show him the dislocation in the X-ray (I did learn something in A&E). He has now arranged for her to have her operation in the morning.

Weeks 2–3: Regular follow-ups with our local vet. Mustafa continues to improve all the time. Harmony returns as vet–cat relationship grows strong.

Mustafa would tell Mr Brown that she is hungry. She would also go on to tell him that OOH services provided by larger, private companies can provide doctors of poorer quality (and cheaper salaries) than is acceptable for patients. In running efficiently with profit, they cut doctor work to a minimum. Nurses are cheaper. They send around memos to staff to promote 'lean-working' (cheap) management babble. Patients travel further to be seen by a random, possibly recently imported, doctor. That doctor may have travelled an impressive distance just to 'cash in' that night. There is no continuity of care or any relationship with the patient. Loyalty is the pay cheque that comes every month. Add dissatisfied and stressed doctors to this pile and you get poor patient satisfaction and, sadly, tragic mistakes.

She would then tell Mr Brown his name is not nearly as funny as her own. She would then quote the model of OOH care in the little Hertfordshire city where she lives. The OOH service is staffed by an army of local GPs. They don't easily employ outside GPs. Having sorted out quality control, they take ownership and responsibility for each other's patients. This is the motivation that keeps the service staffed. Communication and continuity of care are maintained. This service is more expensive. There is no nurse triage and there can even be 'quiet shifts'. There are increasingly few areas where an OOH service is supported so well locally. Patients here do not know how lucky they are.

PCTs need to be able to afford OOH services that deliver for their patients and not for the local funding deficits. Contracts are up for renewal and our local gold standard service is moving with the times to stay alive. Let's hope quality is not lost at the expense of quantity.

Ozan Adali
GP, Watling Medical Centre,
108 Watling Avenue, Burnt Oak, HA8 0NR.
E-mail: ozanadali@hotmail.com

OOH care and locum doctors

The global warming scenario threatens people all over the world. A widespread anxiety about our future on the green planet seems to change our opinion about economy and lifestyle in a way which has never been seen before. So it is not remarkable that even primary health care is now under suspicion of playing a role in the drama of a man-made greenhouse effect.

After the NHS allowed British GPs to hand over their responsibility for out-of-hours services to health boards in 2004, the shortage of out-of-hours (OOH) GPs led to the practice of foreign doctors working as locums in OOH services. As the weekend OOH shifts start late Friday afternoon and end on early Monday morning, European GPs can manage to commute from their home country to the UK for convenient weekend shifts only, and still continue to work in their own surgery at home over the week. Travelling by air is then the cheapest and of course the fastest way to go to 'weekend work' in the UK. Indeed, this may have an impact on the greenhouse effect as