Medical Reconnaissance Service

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British Medical Journal 1974, 3, 129-130

The introduction of deputizing services as a feature of the delivery of primary medical care has been fraught with controversy. There are two opposing viewpoints. On the one hand, it is claimed that the substitution of a deputy for the patients' own doctor diminishes the quality of care because the deputy lacks records or previous knowledge of the patients. The contrary view is that provision of a 24-hour service by general practitioners is impossible at present levels of patient-demand and that where it is attempted the performance of the doctor is impaired from fatigue.

The discussion almost invariably presupposes that the circumstances under which doctors are called to visit people in their homes at night or out of normal working hours will always justify the use of the skills of a medical graduate. Experience shows that this is not so and that the number of occasions when medical skills are essential in the so-called emergency situation are, in fact, few. The public has come to regard the sending for a doctor as the solution to many problems of a non-medical character when they arise in crisis form, or "medical" problems at a level of severity at which the help of a less expensively trained person is enough.

As they are operated at present deputizing services employ doctors who act for principals in general practice who are off duty. Telephone lines from practice centres are put through to the headquarters of the call service, requests for visits are made and are met by a doctor on the call service rota, the call service accepting the request uncritically on behalf of the practitioner who has contracted with it. Whatever the degree of severity or triviality a doctor is involved. He may or may not be called on to exercise medical skill but his presence in response to a call confirms in the patients' minds the propriety of their making it. Thus the threshold of urgency becomes lowered and increasingly often the "emergency" turns out to be a triviality.

Some contend that this use of scarce medical manpower is unjustified and add that the doctors do their best work on their own premises, properly equipped and with the resources they need ready to hand. In other countries the public accepts this and patients are customarily brought to the doctor in his office or hospital. In Britain experiments with the transport of patients during working hours are in progress in some practices.

Medical Reconnaissance Service

An alternative to the present type of deputizing service might be a medical reconnaissance service using transport, modern telecommunications, and personnel of less elaborate training than doctors and operating from a health service communications centre under the National Health Service.

In principle the system would be based on the interpolation of a filter between the primary source of the call and the doctor wherever he may be placed in the scheme. All outside telephone calls would be channelled to the centre and passed by radio to a mobile observer unit which would be in two-way radio communication with the centre.

The situation would be appreciated by a trained observer, who, with a driver/radio operator, would constitute the reconnaissance unit. The observer should have nursing training to S.R.N. standard and not less than six months' experience of nursing in general practice.

The nurse would be called on to make the same decisions as she would when on duty in hospital—namely, whether or not medical aid was required. In practice she would find herself capable of handling many of the problems met with but would be in two-way radio contact during the visit with a doctor at or through the communications centre.

Discussion of the situation would result in a "triage" process with three alternative courses of action: (1) "doctor required now"—the duty doctor would go to the patient's house; (2) "doctor required sometime"—the call might be referred back to the practice for a doctor to visit later; (3) "doctor not required"—the caller may be advised to consult his own doctor at his practice next day.

Each decision would be reached in consultation between a trained nurse at the incident and a doctor at base who could go at once to reinforce the nurse if needed. When a desperate emergency is found the ambulance service would be alerted at once, with transfusion or defibrillation equipment as required.

This system need not necessarily be operated only as an out-of-hours service. It could be modified so that during the day reconnaissance units could answer first calls occurring out of normal hours or when the practitioner is not immediately available. The observer would report back to a static doctor at the communications centre or possibly by telephone to the general practice direct.

To preserve public confidence both observer and driver should be given special training, the driver in an ambulance unit. Unit transport could be an estate car single-stretcher conversion able to carry one stretcher case or one or two sitting patients to the hospital or general practice centre. The cars should be supplied by area health authorities through ambulance services.

Communications Requirements

The control and communications centre of the service would be based on or operated by the area health authority ambulance service. The reconnaissance units and on-call doctors would be equipped with personalized two-way radio for communication with the control centre. "Talk-through" facilities would be necessary by which a mobile unit can speak direct to the doctor, having been connected by the communication centre. Both radio and telephone links might be used either together or separately.

During the night interception services or direct dialling would enable the general public to contact the control centre. During the day it is envisaged that calls would be filtered by the general practice centre and not every call would be referred through to the service.

There is a place for a specially trained operator at the exchange to control the distribution of calls and messages as well as an experienced doctor. The doctors' duties might be linked with those of the hospital bed bureau. This work would be well within the compass of doctors with a physical disability. Only in exceptional circumstances would the doctor at the control centre be put in direct touch with the patient. Normally he would operate an advisory service for the nurses in the reconnaissance units. In the disaster situation a medical officer at the control centre could divert all mobile reconnaissance units to the site.

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Reports on all contacts would be communicated back to the appropriate general practitioner via the control centre. Facsimile reproduction facilities would be of considerable value both for direction of mobile units to patients and reporting the action taken. This facility takes the form of remote photocopying using existing telephone lines. Conceivably similar procedures and instruments could be used for the transmission of laboratory reports and other medical communications if sufficiently large networks were installed.

Discussion

A service of this kind would at first sight appear to deprive the public of what they consider to be a right, an instant doctor on demand. It would meet opposition also from doctors who are

wedded to the traditional pattern of personal service.

Experimentation, results, and time would, however, bring the conviction that a service of this kind would economize on medical manpower and use it selectively where need existed for it. Sick people might receive skilled medical care more quickly and those less sick but equally demanding might acquire an improved perspective.

Deputizing services as we now know them would cease to exist. Medical reconnaissance services should be developed not on a commercial basis but as an integral part of the National Health Service, coming under the area health board or other such body as may be appropriate. Such a service might to a certain extent replace the emergency ambulance services.

Initiative could be taken by the D.H.S.S., after discussion with the profession, to introduce experimental services in both urban and rural areas to evaluate this proposal.

Recommended Salary Scales for Industrial Medical Officers

Set out here are the new recommended salary scales for industrial medical officers arising from the recommendations of the *Report of the Review Body on Doctors' and Dentists' Remuneration 1974*. The new

figures are intended to operate from 1 April 1974.

The figures shown in table II are minimum annual salaries and in individual cases the value of the medical services given or the

seniority or experience of the doctor will justify higher remuneration.

TABLE I—Whole-time Salaries

Assistant Medical Officer (Training Grade)	First Year—£3,897 Second Year—£4,197 Third Year—£4,497
Medical Officer	Initially at least £4,413 p.a. where the appointee is relatively inexperienced, with a commensurately higher salary for a doctor of greater experience in occupational health or other medical employment, rising by annual or biennial increments to at least £6,456 p.a. over not more than ten years.
Senior Medical Officer	Initially at least £5,445 p.a., rising by annual or biennial increments to at least £7,707 p.a. over not more than ten years.
Chief Medical Officer or Director of Medical Services	Commencing minimum at least £8,121 p.a.

TABLE II—Part-time Salaries

Hours per Week	Minimum Annual Salary (£)
0-1	243
1-2	435
2-3	612
3-4	789
4-5	963
5-6	1,152
6-7	1,323
7-8	1,461
8-9	1,593
9-10	1,728
10-11	1,854
11-12	1,980
12-13	2,100
13-14	2,229
14-15	2,367
15-16	2,490
16-18	2,637
18-20	2,763

Underfinancing of N.H.S.

Joint Meeting of Health Professions

The chairmen and secretaries of the British Medical Association, the British Dental Association, the Royal College of Nursing, and the Royal College of Midwives met at B.M.A. House on the afternoon of 3 July. The reason for the meeting was the common concern of these organizations about the underfinancing of the N.H.S. The meeting lasted for two hours, and at a press conference afterwards—attended by Dr. Derek Stevenson, Secretary of the B.M.A.; Mr. R. B. Allen, Secretary of the B.D.A.; Miss Catherine Hall, General Secretary of the R.C.N.; and Miss Brenda Mee, General Secretary of the R.C.M.—it was announced that the four organizations would seek a meeting with the Prime Minister. In advance of the meeting a document would be prepared based on information available to the organizations about the underfinancing of and shortages in the N.H.S.

Dr. Stevenson said that substantial sums of extra money were needed for the N.H.S.

and he declared that if the Government was not able to provide the necessary money then it should tell the public so. The delegation would be asking for an independent inquiry into the financing of the Health Service. In reply to questions he said that if the money was not forthcoming then there would have to be a re-ordering of priorities for the Health Service. Miss Catherine Hall commented that the increasing workload in the Health Service was stretching manpower and resources so thinly that it was becoming dangerous.

After the meeting Dr. Stevenson said:

"The meeting decided that an immediate approach should be made to the Prime Minister expressing the concern of all these four professions about the serious situation in the Health Service and including the very low state of morale in which all the professions find themselves. This approach should have the object of explaining to the

Prime Minister just exactly what our worries and concerns are. The meeting will ask for at least two things. It will show where the shortfall is hitting most and will demonstrate that an immediate holding operation is necessary to provide more money for the hospital service to keep it going in the last two to three months of this year. Secondly, we have in mind to ask the Prime Minister to agree to set up an urgent inquiry into the way in which the Health Service is financed. I shall be writing a letter on behalf of all the groups concerned tomorrow morning and sending this off to the Prime Minister and we shall stress the urgent need for the meeting.

"Those present at the meeting decided to form a joint steering committee. It will be the job of this committee to see the thing through. Each of us has got a great deal of information collected and it is a question of collating it in documentary form and having it available."