LIFE AND DEATH Iona Heath

Out of hours primary care—a shambles?

Far from turning their backs on 24 hour responsibility, it seems that GPs may have been pushed out

Until 2004, general practitioners were responsible for the care of their registered patients 24 hours a day and seven days a week. They did not have to provide that care themselves but remained responsible for arranging and coordinating it. As a result of the new GP contract, most general practitioners have now opted out of this responsibility and are contracted to work for the NHS from 8 am to 6.30 pm and for only five days a week. Since these changes, out of hours care has become more expensive and less efficient, with a profusion of different arrangements across the country. Attempts are being made to replace GPs with a multitude of people from different disciplines, and care is being fragmented proportionately.

How did we get into this mess? There is no doubt that GPs were becoming overwhelmed by an increasing out of hours workload, with people being encouraged to expect that medical care should be as convenient and accessible as a supermarket. However, the government is seeking to portray GPs as having turned their back on out of hours care to the detriment of patients, and this is a dishonourable attempt to rewrite history.

At the time of the new contract, most GPs had already organised themselves into larger cooperatives of groups of practices, which reduced the burden on single practices. Perversely, the new contract awarded little money for continuing to cover out of hours care. As some GPs began to opt out, cooperatives were obliged to pay much more realistic rates to doctors undertaking shifts so that, for those practices remaining opted in, the cost became unsustainable and they too were obliged to opt out in turn. The exception was SELDOC, the co-op for the GPs of Lambeth, Southwark, and Lewisham. SELDOC

set out to provide an all inclusive out of hours service for its members for an annual payment of less than the cost of opting out. Remarkably, they have succeeded and, as a direct result, more than 90% of GPs in these three London boroughs remain opted in for 24 hour responsibility. This suggests that the vast majority of GPs would have retained 24 hour responsibility if they had not been financially penalised for doing so. The opt-out is a one way process: having opted out, practices are not allowed to opt back in again. Why should this be so? The only explanation that makes sense to me is that the government wished to break the GP monopoly and to open up GP services to commercial competition. This is why the individual doctor's name has been taken off the medical card and it is why the opt-out is one way. Far from turning their backs, it seems that GPs may in fact have been pushed out.

What can be done? What are the principles on which a sustainable out of hours service should be based? Firstly, a service funded through general taxation should be predicated on need rather than convenience. I cannot be alone in my willingness to pay tax to ensure that someone taken acutely ill at night gets immediate and appropriate care and my unwillingness to pay for someone to discuss their problems of ear wax at 10 pm.

Secondly, as many people as possible should be asleep at night. We know that working at night undermines health and, as far as possible, the NHS has a responsibility to protect the health of those who work for it. The bulk of out of hours work is triage and immediately necessary treatment. We know that triage is most effective when it is undertaken by the most highly trained personnel and, in the out of hours context, this means GPs. There is no

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need for the full panoply of health professionals to be available out of hours and there are both personal and financial costs to attempting it.

Thirdly, the concept of personal responsibility should be reintroduced into out of hours care so there is someone taking a personal interest in the quality and outcome of each episode of care. It is becoming increasingly difficult to coordinate the care of a practice's registered patients when responsibility is limited to 10.5 hours a day.

Finally, we should acknowledge that if continuity of care is important during the day it is also important at night.

The out of hours problem seems to me to be symptomatic of a wider malaise in the health service that has developed as responsibility vested in individuals has been replaced by elaborate bureaucratic structures. Current systems fail to acknowledge the central transaction of medical care, which occurs when one named individual takes responsibility for the care of another. This is a personal as well as a contractual undertaking.

When people are ill, the fear, loneliness, and suffering are always much more overwhelming at night when there are inevitably fewer distractions and less human company and when, as Philip Larkin put it, “the dread of dying, and being dead, flashes afresh to hold and horrify.” It cannot be beyond the capacity of the NHS to devise and fund a system of out of hours care based on smaller rotas of GPs covering smaller populations so that the possibility of some sort of continuity, of seeing a familiar face, is enhanced. A first essential step would be to allow GPs to opt back in to 24 hour responsibility without financial penalty.

Iona Heath is a general practitioner, London iona.heath@dsl.pipex.com

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THE WEEK IN MEDICINE

Hunting down the H5N1 virus

The avian influenza outbreak in Suffolk has cast an uneasy light on the public health risks of modern poultry production practices

What is the root cause of the outbreak?

Although the infected processing plant reopened last week, government investigators are still trying to root out the cause of the H5N1 virus outbreak in Suffolk, which led to the culling of 160 000 birds earlier this month.

Initially, the finger of blame had pointed to the infected droppings of migrating wild birds. There had been an outbreak of H5N1 among captive geese in the Csongrád region of Hungary in January, but there was no obvious link to the outbreak at the Holton farm, which is owned by UK poultry tycoon Bernard Matthews.

By the eighth day of the outbreak, genetic tests confirmed that the Suffolk virus was the same pathogenic Asian strain found in Hungary. That in itself didn't prove that there was a direct link; the infection still may have come from a third country. But it had also become clear that Matthews not only had a processing plant in Hungary but that a consignment of partly processed turkeys, originating 30 miles from the source of the Csongrád outbreak, had been delivered to the Suffolk plant days before birds there had started getting sick.

The key question asked in the press at this point was, how could the virus have transferred from poultry meat imported from Hungary into live birds at the Holton farm?

According to the *Telegraph*, "Because imported meat is kept cold, any virus would have survived the journey." The *Sunday Times* reported that government investigators were examining whether any such infected meat was then left out in the open in Suffolk. "If the meat was infected, the virus could have been picked up by wild birds and rats and carried into the rearing sheds and the wider countryside."

Other possible routes of infection are dust, feathers, and dirt on vehicles, equipment, packaging, or the boots of workers.

Is H5N1 in the human food chain?

Despite saturation coverage of the bird flu outbreak, there have been no signs of panic by the media, or from consumers, about the safety of eating poultry and eggs. The Food Standards Agency's advice is that properly cooked poultry, even if it is infected, is safe to eat.

No Bernard Matthews branded goods have been recalled from the shop shelves. The *Times* reported a drop in poultry sales of only

10% at supermarket chains Sainsbury's and Morrisons, and Tesco claims only a slight reduction.

Andrew Wadge, chief scientist at the Food Standards Agency, posted comments during the outbreak, emphasising that there was currently no threat to public health. "As far as bird flu goes, the science shows that it isn't contracted by eating food. Flu viruses rely on receptors in the body to cause illness, and those that flu latch onto are generally found in the respiratory tract. Those people who have contracted bird flu—currently about 270 worldwide—have been in very close contact with sick birds."

Even if someone did eat an infected product, a number of factors should prevent them from becoming infected, he added. "Firstly, cooking meat thoroughly is more than enough to kill the virus. Secondly, the body has a number of other barriers that would protect us, including saliva, gastric acids, and the lack of suitable receptors in the gut."

Media reaction

Officials continue to investigate possible breaches of biological security measures at the Holton farm, but the exact cause of the outbreak may never be known. The scare has given rise to questions in the media over where the main threat to public health lies. Was the blame initially put on wild birds to keep the reputation of big business farming intact?

Under the headline "Time to ruffle some feathers," an *Independent on Sunday* opinion

piece collared intensively farmed poultry as the main health risk. "Industrialised farming not only involves large, overcrowded flocks of potentially contagious birds, but poultry products are transported around the world, sometimes in poor conditions and with poor bio-security. This means a hard look at the scale and intensity of what is becoming a global business is needed."

In the *Sunday Times*, an unnamed ornithologist and government adviser said the wild bird link had always been unlikely. "I find it quite incredible. Everybody who knows anything about birds would be shocked if this was the source. They would be scratching their heads and going 'man, this is bizarre.'"

The health scare has also ignited concerns about food labelling. Under UK law, food that is processed in the UK can be labelled as made in the UK. Hence, a turkey reared in Hungary but processed in the UK can legally be sold as British meat.

The *Telegraph*, in a critical feature called "Not Made in Britain," questioned the ethics. "For millions of people, cheap white meat has replaced red meat as a healthy option. But the truth is that cheap white meat comes with a hidden price tag. As we are now seeing." An *Observer* editorial warned that "Bird flu is the price of your £5 roast."

The outbreak also gave rise to some wild speculation, including an alarming story in the *Sunday Times*: "If bird flu grips the nation, doctors will need guns." This item suggested that doctors treating patients who had avian flu may need security guards to shield them from violent relatives should they be forced to decide which patients to prioritise during a pandemic.

What next?

The outbreak comes during a "relative lull in cases" in European poultry, according to Reuters, since hundreds of turkeys were infected

and died in France last year. Although the UK outbreak had the potential to become lethal—if the virus had developed the ability to spread to humans—the real threat from avian influenza lies elsewhere, in the developing world, commentators warned.

In a leader article, the *Observer* said: "While governments in rich countries have been worrying about whether or not their millions of doses of vaccine will suffice, virtually nothing has been said about the fate of poorer countries. Deaths from bird flu in developing countries are almost certainly going undiagnosed. Indonesia suffers regular human deaths from bird flu, but has not implemented basic quarantine measures. China is stubbornly closed to international attempts to track the disease. Already blighted by Aids and malaria, many African societies may be devastated by a flu pandemic."

Rebecca Coombes, journalist, London
rcoombes@bmjgroup.com

WHAT'S ON BMJ.COM

How much are doctors worth: how much do doctors really earn?

"How long is a piece of string?" goes the old saying; how do you determine the value of anything? There's the old cliché about supply and demand; there's also the old marxian notion about the social determination of the "value" of money and commodities. And there is of course the time honoured labour theory of value.

So, how do you determine value? For example, how valuable is education? Most people would say that a good education is very valuable—then, how is that teachers are so poorly paid if what they do is so valuable? Most people would agree that good medical care is very valuable—so why the fuss about doctors being paid well, why the endless scrutiny? Why do we not see the same preoccupation with pay for lawyers and businessmen?

With education and health, we speak about value to society. In the case of business, accountancy, and law, value refers to how much profit can be generated. Those who provide socially valuable services—such as nurses, teachers, firemen and doctors—are expected to be "dedicated" rather than interested in money; therefore their claims to better remuneration are taken as rather distasteful since their goal is supposed to be to provide a service and perform a "duty." Coupled with that, at least in the case of doctors,

is a traditional notion that "doctors are rich."

Some doctors are rich, and relative to other equivalent professions, doctors might once have been comfortable. It is no longer true that in general doctors are rich. But doctors are important, and there has been a campaign in recent years to render them unimportant, disempower them, and control them. I know of no doctor who gets a multi-million pound sign-on bonus, nor any who after being struck off might walk away with a multi-million pound severance package. Yet these practices are common in the upper echelons of industry among heads of companies.

This debate is full of ideologically determined straw men. It should be clear that no one has had an honest discussion about value or values. The same people who have the knives out for doctors' earnings are rolling out the proverbial red carpet for those in the finance sector. This should tell us all what values are considered more important. It does not seem to cross too many pundits' minds that these values are utterly distorted.

The same honesty should apply to discussions about others who provide essential, valuable services to our society. Perhaps if doctors,

firemen, nurses, teachers, and cleaners withdrew their services for a while, their value might be appreciated.

Richard Rosin attending psychiatrist, Vancouver, BC, Canada

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The Quality and Outcomes Framework has rewarded GPs for doing work that they don't like and that their patients don't want or value. Part of the QOF has made us streamline the professionalism in the back offices. It has put us through hoops to improve processes such as staff management and risk assessment.

The other half of the QOF has rewarded us for improving surrogate outcomes such as blood pressure and cholesterol in high risk patients. It has also rewarded us for clinical work that is less evidence based, like providing checks for people with newly diagnosed cancers.

What the QOF has not done is ask us to provide, and fund, what patients really want. Sadly, people don't value preventive medicine. People don't appreciate a GP's surgery tracking down men in their

40s who have been lost to follow-up after a coronary bypass operation. Even less do they value their GP's work in preventing them from developing heart disease in the first place. What our patients want is immediate access 24/7.

The QOF has made us work harder. I believe we earn the money we are paid. I am dismayed that our employer is out to discredit the contract it has foisted on us—and that the media is gunning for the workers rather than the employer.

My solution would be to renegotiate the QOF. Throw out the bathwater, but keep the baby of rewarding performance in areas of evidence based medicine. Throw out the clinical areas that look like they were decided by lobby groups. Throw out most of the practice management and allow us to manage ourselves. Finally, make GPs work evenings and weekends. And then leave us alone for 10 years. Please.

Ian Quigley, GP principal, Romford

Competing interests: IQ is a GP principal in England, enduring and benefiting from the QOF in equal measure.

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