After hours care and the death of urban general practice in New Zealand

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'Not being there' was a beautifully crafted and moving account by Professor Campbell Murdoch in the *NZFP* in April 2002, describing his experiences as a GP in Winton. The traditional 24/7 general practice after hours service had been abandoned for a triage service and an emergency clinic 45 minutes away in Invercargill. The local doctors had joined a 1:12 roster (instead of a 1:3–4). The inevitable happened. A young child died of meningitis, not because of incompetence or contractual failure, but because his parents were put off having to drive into Invercargill and had waited until the following morning to summon help. This was followed by recriminations and a sense of failure and perhaps helplessness. *'Not being there'* for me was not about the GP's role in after hours care but came close to defining our total role as a GP.

Providing after hours care has indeed been seen predominantly as a 'rural problem' in New Zealand over the last ten years. Many rural areas have been unable to replace GPs, largely, but not entirely, because incoming practitioners have been unwilling to provide the after hours cover. Other rural areas have joined together in absurdly large groups, leaving their patients to travel great distances to seek medical help after hours. Other rural areas have simply soldiered on, providing the services that they always have done. The effect of this has been traumatic. Much of this has already been well documented such as in the article referred to above. Little has been written, however, about the part that urban practice has played in this.

I would like to digress a little to a project I undertook a few years ago to catalogue the history of GPs in our rural community. People were delighted to recite amusing, touching or interesting tales of their family doctor. One GP was well known for taking his kettle on home visits after hours and making a brew! Another character was renowned for enjoying a nip of whisky when called out. One legendary doctor was a fine tennis player. During the 1930s he played in the quarter finals of the NZ Tennis Open, returning to Matamata to be present at a maternity case overnight, returning to Auckland to play in the semi-finals the following day. Many times people spoke of a doctor coming after an urgent call to help in some form of crisis. At the time it struck me how many of the stories returned to that issue of after hours care. The doctor, who willingly gave of him or herself for the benefit of others. This earned him the respect of his local populace. Interestingly, many of those doctors themselves remembered highlights of their professional careers as snapshots of incidents that happened after hours. Nobody spoke of how much they remembered the many qualifications or certificates or what a blessing it was to have a patient satisfaction survey. I believe that after hours care has been and always should be an essential part of the whole of general practice. It is not something that can be bolted on, or provided by a faceless after hours centre after 5pm. After hours in many ways is the very essence of general practice, the continuity, the local knowledge, the personal touch during somebody's darkest hour.

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Over the years, particularly the last 10 years, how we perceive our role in after hours care has changed. Somewhere, urban and particularly metropolitan general practice has become synonymous with the idea that less after hours care for GPs is best. A line has been crossed. There

has been, that overused term, a paradigm shift. No longer is a slight reduction in one's after hours commitment due to another doctor joining the roster seen as a blessing. No longer can we accept a night a week on duty as being a rewarding and interesting (if tiring) part of our profession. We have told ourselves that it is a destructive thing that we should not be exposed to. Slowly but surely we have convinced ourselves that we, and in particular our families, are 'entitled' to a life free of night or weekend work. As the years have slipped by, the issue of after hours care is not so much our problem but 'someone else's problem.' At one point we were concerned with our ethical duty to our patients, but somehow as A&E centres have got bigger and more impersonal 'our' has become replaced by 'their.' Initially a metropolitan phenomenon, A&E centres have become the 'norm' in all urban areas. The attraction of less on call though, has not stopped there. Near to Matamata, towns that once provided cradle to grave 24/7 services have dwindled in the last two years. One local practice at a meeting to discuss the ending of 'after hours' services in the town, gravely told residents that such were the technical demands of an after hours centre, that they would be far safer to travel half an hour to Hamilton if unwell. This Orwellian view of health care sadly was not questioned. Other towns have followed suit, or joined with other towns in 'mega rosters,' leaving patients travelling for up to an hour for care.

Nobody could deny that working fewer hours is a good idea for both ourselves and our patients. None of us should be asked to provide every second or third night on call. All of us have felt at some point in our career the stress of working alone at night. On the other hand, is a life providing four to six hours per fortnight in an after hours clinic, seeing all and sundry, providing a good after hours service to the patients in our practice? When asked, many of my urban colleagues shake their heads sadly when hearing of rural doctors getting out of bed at night, rather as one might when hearing of a famine in a far distant land. Such has been the shift in the paradigm that even to discuss personal responsibility for providing after hours care seems 'old fashioned' or 'in bad taste.' In the last edition of the NZ Rural GP Network circular there appeared a letter from a colleague concerned that surrounding towns had joined a 1:14 on call roster and were still claiming a rural subsidy (i.e. should be on a roster <1:6).The letter was signed 'name withheld by request.' It occurred to me that even within the membership of the RGPN, one cannot speak freely and openly about our responsibility for after hours care.

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It is therefore, I admit, not with just a little schadenfreude that rural GPs have read of their urban colleagues woes regarding after hours clawbacks. Clawbacks occur when a capitated practice's patients are seen (usually after hours) by a different provider. Could it be that city doctors are going to have to pay someone else to provide the after hours care, which they claim to already be providing? I believe that clawbacks represent your wallet's way of telling you that you are providing insufficient after hours care. Could it be that after a decade of believing that after hours care is someone else's problem, urban GPs have realised that it is their problem after all. I am disappointed that PHOs are trying to cap clawbacks, since this will just reinforce the idea that after hours care is someone else's problem.

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It is to me very sad that, despite the destruction of rural after hours care over the last decade, it has taken the issue of clawbacks for urban GPs to really get this issue on the table in the form of a working party. Rural GPs have faced the day to day problems of after hours for years, and frequently looked to their urban colleagues for help. Precious little has been given. Two years ago the Waikato DHB wrote to its urban GPs, asking if any could help with the meltdown in after hours care in Taumaranui among other areas. The response to a direct appeal to urban GPs for helping rural colleagues was, to say the least, shameful.

The draft RNZCGP paper on after hours care points out that the status quo is unacceptable and I believe all of us would agree with that. I believe however that many of my urban colleagues would like to see after hours care separately funded through capitation from general practice and I believe here lies the biggest single threat to our profession in our lifetime. If this were to occur I believe that many urban GPs would simply provide no after hours care and A&E centres would remain viable in urban centres. Under the same formula nothing would change for rural practices where patients are thinly spread.

Faced with a professional life of ongoing after hours care in rural practice or urban work free of after hours responsibility and without financial penalty, I believe what little hope remains for persuading doctors to work in rural areas would disappear. In this scenario, rural GPs would have little option and little to lose looking for an entirely separate GP contract with the DHB from their urban colleagues. I have little doubt that they would be successful in achieving this. Rural GPs already work under a different rural ACC contract.

Once split from their rural colleagues, urban GPs, who would provide only fragmented after hours care, little or no maternity care, and with orthopaedics and a good deal of paediatrics being practised at A&E clinics, would find themselves a dangerously vulnerable group. The public who once saw us as dependable and trustworthy will think again when we are no longer available on call.

The After Hours Primary Health Care Working Party consists of 16 members, of whom three are described as GPs and one as rural representative. We should be very concerned about the recommendations of this group. We should be concerned that what was once an issue addressed by way of ethical guidelines by our own profession is now being addressed by a working party with minority GP involvement. We should be concerned that a large body of GPs would like after hours care to be 'someone else's problem.' We should be concerned that once after hours care along with maternity, mental health, and all those other issues which once made our lives hard is someone else's problem, we will have no profession left. We should be very concerned. I believe that for the welfare of both patients and of our profession, the working party should view providing after hours care as the primary responsibility of the GP with whom the patient enrols. The funding for this should be included in the capitation formula with no clawback protection. There should be no separate funding for after hours care.

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I believe that the majority of after hours care should be provided by local GPs in small groups so that all doctors are providing some care to their practice population. I believe that doing a substantial but not excessive amount of after hours work is essential to the health of our practices and profession. Looked at in a positive light, after hours care provides the most varied and interesting work in our communities and links us in a way to our patients that no other care can. Sending increasing numbers of patients to call centres and after hours' clinics is not without a cost. The present situation, with some GPs providing little or no after hours care, and others trying to achieve impossible coverage, has already severely damaged rural practice and will now be the death of urban practice.

If you are kicking back at 5pm at the local wine bar, having switched your phones to a faceless A&E centre, thanking your lucky stars that you are not a rural GP working a 1:3 roster, think again. The clink of glasses from the neighbouring table may not be the celebration of the end of a working day; they may be the death knell of your profession.

Commercial environment

'No one can doubt that the social setting of healthcare services has changed dramatically over the last two decades. It has become explicitly commercial. Although the tide seems to be turning away from outright commercial entrepreneurial ideology, healthcare is still very much a business. The changes are reflected in the vocabulary used: we speak of consumers, clients, users, service providers and purchasers, managers and accountability modelling. But conceptually all these expressions are predicated on the fundamental relationship: doctor and patient. The common golden thread through all the various changes remains the professional standing, competence, and accountability of licensed healthcare professionals: they and they alone can practise what are quaintly called "the healing arts". It does not matter what the institutional framework is within which they practise. The vocational, practical training, and tradition tracing back to Hippocrates form a cornerstone to all frameworks. More than any other profession, healthcare is properly and literally a welfare vocation no matter how commercial or varied the organisational framework of institutional healthcare provision and maintenance.'

Godlovitch G. Practice structure. In: Alston A, Currie H, Godlovitch G, Johnson S, Powell A, Strang P, editors Medical practice management. Wellington: Brookers Ltd; 2002. p. 2.