provide minimum resources, or for those who wish to opt for salary. The problems in negotiating a satisfactory salaried service are considerable. Perhaps the BMA may yet, as in 1966, take the initiative from the Medical Practitioners Union and prepare for constructive discussions on this issue.

The continuing obsession to separate general practice from teams both in the hospital and community and by default from the patient is now a major constraint on those who are unable to take the first step and on those who wish to take the next. It is a licence for professional default and governmental inaction. The battle for clinical autonomy—and ultimately this is a battle for more and better resources rather than favoured status—cannot be conducted on a basis of independent contracting. The resources required are too large, the organisation of care too complex, and the task too important to be left to those who stand outside it.

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No future for a salaried service

MICHAEL LOWE

If general practitioners were to be persuaded to exchange their independent status for a salaried service, what benefits would result? Would patients find the GP's surgery a more reassuring place; the staff and facilities more modern and efficient; the GP more friendly and caring?

Your answers to these questions may depend very much on where you live. Undoubtedly the standard of primary care in some parts of London and other large cities is unsatisfactory. So are many other services and facilities. The causes are complex and varied and will take a great deal of money and effort to correct. A salaried service in some of these areas could well improve the standard of health care, but only if accompanied by modern premises and equipment and salaries for doctors and their staff that are sufficiently above average to attract and retain high-quality and well-motivated individuals. You do not need a salaried service, however, to attain Utopia. It could well be achieved within the existing structure. All you really need is cash.

Most patients do not live in the worst parts of our inner cities. Most believe that they get a good service from their general practitioners. Each year there are more than 200 million patient/general practitioner consultations in Britain. Only one in 200 000 consultations results in a formal complaint, and from only one in a million consultations is the complaint subsequently found to be justifiable.

For the general practitioner there are, of course, many attractions in a salaried service—fixed hours, guaranteed holidays and study leave with locum cover, and no staff employment problems or other business worries. All this sounds fine and with a reasonable salary would undoubtedly be attractive to at least a minority of general practitioners. When, however, the idea of an option for a salaried service was last seriously discussed between the profession and the Government in the early 1960s it became apparent that this was not quite what the Government had in mind. The Government envisaged that the doctor would continue to operate in precisely the same way as he does at present, providing full 24-hour cover, seven days a week. He would exchange his business chores for a fixed salary that was related broadly to average net income for other GPs.

An unpublished report of joint discussions in 1965 between the profession and the then Ministry of Health concluded that a system on these lines would require an employing authority with full powers to organise and supervise arrangements for general practice. The family doctor's freedom to arrange his day and methods of working with his colleagues would be curtailed. Both the profession and the Ministry realised that no serious progress could be made, and plans were abandoned. Those who accuse the BMA of blocking progress towards a salaried service on ideological grounds either are unaware of or choose to ignore these facts.

Since the mid-1960s there has been a rapid growth in the availability and use of commercial deputising services. They operate in all major towns and cities and are used by 40% of GPs to provide some relief from out-of-hours services. Some doctors who advocate a salaried service also blame the deputising services for the deterioration in the standards of primary care in some inner cities. The two are unconnected, and the fact is that without deputising services primary health care would no longer be available in some parts of London and other cities, where it is frequently necessary for doctors to live outside their practice areas.

If there were a salaried service there would still be a need for some organised out-of-hours cover, and it is difficult to envisage any satisfactory alternative to the present commercial services, the standards of which are controlled by the profession locally. State-run out-of-hours services would certainly be feasible, but adequate funding and maintenance of standards would undoubtedly continue to be problems. Payments by salaried GPs to deputising services would presumably have to be directly reimbursed.

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Advantages of being independent

The new deal for general practitioners in 1966 not only raised their earnings—it overcame the two major drawbacks of being an independent contractor: it removed the disincentives to provide good premises and employ good staff. The rent and rates scheme, particularly the cost-rent provisions, has enabled many GPs to provide excellent purpose-built premises, except in some inner-city areas where land and suitable property are scarce and very expensive. A single group practice or health centre may cost well over £500 000. Direct payments for premises and staff make up about 40% of practice expenses. Under a salaried service all expenses would be directly reimbursed and the nature of such expenditure would consequently be strictly controlled. Controls are not necessary now because the above-average expenditure by one doctor reduces his net income in the year in question. Thus the state has a guaranteed incentive for GPs to be economical. In a salaried service with direct reimbursement of expenses there would inevitably be controls with standards laid down for surgery equipment, type and size of cars, and so on.

As independent contractors general practitioners pay tax under schedule D. There are many more items of expenditure which they are able to set off against tax as compared to their salaried colleagues, who pay tax under schedule E. For example, most GPs are able to claim tax relief on the running expenses and depreciation on their own car and half on their second family car. Most also get relief on salaries paid to their wives for answering the telephone.

Another financial advantage for general practitioners is their freedom to organise their "business" so as to have opportunities to carry out other work at suitable times, such as factory medical officer or hospital practitioner. Not only is this financially advantageous, but it also broadens their experience and results in a general improvement in links between all those responsible for health care in the area. They also have total freedom to earn fees from private practice, though some payments are abated once the income from private practice exceeds 10% of total practice income. Inevitably this freedom would be restricted by a salaried contract.

A salaried general practitioner would need to have premises provided by the state. One in five already practise from state-owned health centres, which have proved to be expensive to build and run. When someone else is paying the bills there is little incentive to economise. Complaints are frequently made by GPs practising in health centres about deteriorating service by health authorities, particularly for maintenance and re-decoration, about the lack of understanding by health authority staff of the confidentiality of medical records, and about the attitudes of ancillary staff, whom the GP cannot hire or fire.

Doctors who practise from health centres have to obtain approval from the Secretary of State if they wish to see patients privately. There was a very real fear when Barbara Castle was Secretary of State for Social Services that such approval would be withdrawn. This could well happen the next time there is a left-wing Government in power.

The Royal Commission on the NHS recommended that an option for a salaried service should be available, but it recognised that it would be costly. This is the major factor that will prevent any Government in the foreseeable future pushing towards a salaried service. I have yet to see any convincing evidence from other countries—most of which spend far more of their gross national product on health care than we do—that employing primary health care doctors on the basis of a salaried service improves patient care.

The present system of gross pay for GPs, based on a mix of fixed allowances, capitation fees, and item-of-service payments (coupled with the important direct help with premises and staff), would be hard to improve upon, except by relatively marginal alterations. It may be complex, but by and large it provides a fair distribution of income for the multifarious types of practice and area throughout Britain.

One of the most important advantages of the independent contractor status over a salaried service is that it gives freedom of choice. Subject to one or two minor restrictions, patients are free to choose their GP and to transfer to another doctor if they so wish. Equally, GPs may accept or reject applications from prospective patients to join their lists. This encourages the GP to provide a good and efficient service and the patients to be reasonable in their demands. Any system of payment by salary would inevitably lead to some geographical restriction for patient and doctor with loss of freedom of choice. This is perhaps the one element of independence and personal service that has been preserved in the "public sector." It also allows doctors to fight for their patients against the bureaucracy of the NHS. The fact that the GP is free to innovate, to change, and not to be controlled in everything he does by an excessive bureaucracy is surely a great advantage that should be preserved.

To quote the wise words of Mr Colin Hurry, who was for many years until his death a public relations adviser to the BMA: "The independence of family doctors is vital, because as the individual tends to become a statistical abstraction the family doctor may prove to be the last defender of the patient's interests."

ONE HUNDRED YEARS AGO The annual report presented by Dr Davies, the medical superintendent of the Barming Heath Lunatic Asylum, to the Kent General Sessions, has excited great attention, as it dealt with the results of an experiment in the discontinuance of beer diet to lunatics. It stated that there had been an increase of 60 in the total number of patients left in the institution at the end of 1880 compared with 1879, the totals being 1,193 and 1,253 respectively. This was accounted for by the increased number of private patients, the diminished death-rate, and the smaller number of patients discharged. In 1879, 308 pauper and 12 private patients were admitted, and 137 of the former and one of the latter were discharged, the number of deaths being 193 and 5 respectively. In 1880, 310 pauper and 23 private patients were admitted, 113 of the former and 3 of the latter died, and 146 and 11 were discharged. The proportion per cent of deaths to the total number under treatment in 1879 was nine, and in 1880, 7·5. The causes of death had been verified in every instance by *post mortem* examination, and the asylum had been free from epidemic disease, while there had been no suicide. Four patients (two men and two women) were sent in who were not insane, the number being the same as in 1879, and during the year three inquests were held. Dr Davies, continuing, said that it was in March, 1878, that he first advised the committee to diminish the quantity of beer issued to patients and attendants, and, as the change worked so well, in November, 1879, he again brought the subject under their notice, recommending the discontinuance of the issuing of beer as an article of ordinary diet. He did not advise any substitute for the beer, but by most carefully weighing every patient once a month, and keeping accurate records of the results, he was satisfied of the soundness of his opinion, and did not think any unprejudiced observer could question the good results which had ensued therefrom. Monetary payments had been substituted for the beer, and he had good reason for believing that the attendants and servants were themselves grateful for the change. From careful observation of the effects of alcoholic stimulants upon the patients under his care he became convinced that it was not advisable to continue to supply exciting beverages to them, which he felt sure had a tendency to prolong their malady and conduce to a speedy relapse after their discharge in consequence of those inclined to over indulgence retaining a taste for intoxicants. (*British Medical Journal*, 1881.)

Emergencies in the Home

Organising and training for emergencies

DAVID RAWLINS

The other articles in this series that were published earlier this year looked at the medical problems of dealing with emergencies. This article aims to try to look at organising a response to emergencies, how frequently they occur, and how to learn to deal with them. The equipment that is needed was discussed by Steggles.[1]

Defining an emergency

The first problem is to try to define an emergency. Pacy, in an Australian study,[2] defined a medical emergency as "any condition or message which requires immediate attention, irrespective as to what the doctor would otherwise be doing." This is a rather restrictive definition, since it limits itself to life-threatening emergencies (which are rare). A laceration is an emergency and needs to be dealt with soon but not the moment the doctor hears about it. Similarly, many conditions described in this series need to be dealt with in, say, three or four hours, some a lot sooner, and some possibly later. Some conditions that patients or their relatives consider to be emergencies may not be urgent.

Educating the patient and relatives will also help determine what an emergency is. A patient's first (and second) epileptic fit is an emergency. Relatives usually soon learn how to cope, however, and should be taught to call only if the fit is prolonged. A hypoglycaemic coma is an emergency, but by educating the relatives to give a glucagon injection the medical services may not need to be called.

Some attempts have been made to determine the incidence of diseases, and one can examine more closely those that are likely to result in an emergency call to the home—or elsewhere. Thus there are about five cases of myocardial infarction a year per 1000 of population, with a wide spectrum of presentation—some will die in a few minutes, others may walk to surgery, while others may be stricken away from home—for example, at work.

The way that a practice is organised and how much the patient and the patient's family understand that organisation will influence the number of calls to the home. In a rural area some distance from hospital casualty departments the general practitioner will deal with most of his patients, especially if his patients know he can be contacted and is willing to come. In large towns and cities where there are casualty departments at many hospitals there is a greater tendency to call an emergency ambulance. The skills of the ambulance men who staff these is variable, but only exceptionally does a doctor travel in them. The costs of the service are high, however (£5 a mile or £20-£40 a call).

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Fry[3] and Hodgkin[4] have given estimates of the work load and incidence of disease in general practice, and from these one may attempt to estimate the number of emergencies a year in a practice of 2500 patients (table). This means about 800 emergencies a year—just over two a day. Very few of these events are life-threatening (and of the 40 deaths many will be expected and a proportion welcomed). Similarly, many patients with emergencies and acute incidents will attend at the surgery.

Emergencies occurring each year in a practice with 2500 patients

Emergency	No each year
Trauma	
Lacerations	40
Fractures	25
Suspected fracture	50
Concussion	10
Sprains and strains	75
Burns	12
Foreign bodies: eye	15
others	7
Suicide attempts	3
Heart	
Myocardial infarction	10
Left ventricular failure	2
Abdominal problems	
Diarrhoea and vomiting	120
Functional	110
Organic	25 (including appendix 5, renal colic 4)
Urinary tract infections	65
Acute back problems	70
Gout	2
Pregnancy	20-40
Death	40
Asthma	25
Other patients with chest problems admitted to hospital	30
Acute psychiatric problems	3
Glaucoma	3
Otitis media	100-150

Various general practitioner immediate care services, especially in rural areas, have estimated call-out rates to accidents and emergencies to be about 25 calls a year per doctor in a scheme: one a fortnight. A third are to road traffic accidents, a third for other cases of trauma, and a third are medical emergencies. These include most of the life-threatening events in a locality. Because of the urgency of the calls the patient may not be attended by his own general practitioner. When a road accident occurs often more than one person may attend—and once again there is a wide range from those who are dead, those who can be resuscitated, those who need skilled intensive care, and those with minor lacerations or bruises (and those who are just upset). Immediate care doctors spend on average about 40 minutes a fortnight on such calls.

Training

Medical students and doctors should be trained in the arts and skills of managing emergencies at all stages of their education. More and more in the United States medical students in their first term of the preclinical course are trained to paramedic standards and are capable of evaluating emergencies, giving cardiopulmonary resuscitation, protecting the air-way, performing intubation and defibrillation, giving intravenous infusion, and doing emergency splinting and bandaging. I think that all British medical students should be similarly trained and the skills renewed and updated for all of one's professional life-time. These skills may be practised in good medical and surgical house-jobs and one should gain a wider understanding of the management of emergencies.

The hospital component of a general practitioner's vocational training should teach more specialised skills—such as in disorders of the ears, nose, throat, and eyes and in paediatrics—and the trainee should learn how people behave and what one can do in practice. For general practitioners who have been unable to learn these skills in their training or who wish to refresh them there are a number of options. A few refresher courses are held annually on emergency treatment. Various immediate care schemes hold study days and workshops on emergency treatment. Basics (The British Association for Immediate Care) hold an annual symposium in the autumn.

In most district general hospitals a friendly anaesthetist will arrange for general practitioners to practice intubation and setting up an intravenous infusion in suitable patients. A busy casualty department will be able to provide a general practitioner with a lot of experience in dealing with patients with emergencies, several of which should have been dealt with in general practice. To learn how to handle ENT and eye emergencies one can get an attachment to suitable departments. Provided that the postgraduate dean gives approval, attachments to casualty and special departments can be funded by section 63 payments. Other doctors may wish to take clinical assistantships when available.

Practice organisation

A practice needs to be organised to cope with emergencies. The practice staff must be able to recognise emergencies—that is, know the possible importance of severe chest pain—and be able to locate and contact the doctor. Patients soon learn if a doctor does not deal with emergencies and will take themselves elsewhere—either by dialling 999 for an ambulance or by going to a casualty department by some other means.

A suitable room is needed in the surgery if patients with emergencies are to be seen and treated there. This is often the treatment room, but a consulting room may be adapted to serve a dual purpose if necessary.

If the doctor is on the premises or at home there should be no great difficulty in responding to an emergency call. If the practice staff know what visits he is doing, they can often intercept him or leave a message at a suitable point. (It is useful to record all patients' telephone numbers; the staff can then get a patient's number from the notes of a relative at the same address.) This method will serve for many emergencies.

For the most serious and life-threatening emergencies a more sophisticated system using some form of radio link is desirable. In many parts of the United Kingdom groups of interested doctors have formed immediate care schemes, with the expressed intent of going to give medical aid at the scene of serious accidents and medical emergencies. Many of these provide the participating doctor with a radio telephone, and some a radio-pager as well, that is linked to central control. This is often in the ambulance service headquarters, so that the doctor can respond as rapidly as the emergency service to emergency calls. These schemes obviously have to work in close co-operation with the statutory emergency services (police, ambulance, fire, and coastguards). Often the equipment is purchased by monies raised by charities.

Why should general practitioners treat emergencies?

Some may argue that it is much easier not to treat emergencies because there is a fully-staffed and equipped casualty department around the corner. But there is often a long delay for patients there, and the costs of treatment in casualty are usually much higher than those in general practice. To opt out of emergency treatment is to opt out of a vital part of medicine, and the job of general practice becomes much less satisfying. Treating emergencies means that old skills are retained, new ones developed, and one may gain the respect of one's patients.

I am grateful to Dr H M Baird, general practitioner in Glenluce, Wigtownshire, for his advice.

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ONE HUNDRED YEARS AGO The following useful directions to be observed in cleaning out water-cisterns, and in examining sanitary house fittings, are issued by the Society for the Sanitary Inspection and Construction of Houses. 1. In cleaning out water-cisterns, great care must be taken not to allow any of the deposit to get into or pass down the service-pipes; these must be plugged, and the residue of water must be taken out with sponge and bucket. If the cisterns are of lead, or lined with lead, they must not be scraped. 2. After the cisterns have been cleaned out, the covers (if any) should be replaced, the efficiency of the ball taps should be tested, and the ball, levers, and cranks oiled. 3. Examine whether there is a stop-cock in the main service; if so, its description and working condition. 4. Examine whether the cisterns are covered; whether they have overflow-pipes, and if such overflows discharge into the open air or into any soil-pipe, closet or drain. 5. Examine the service-pipes and valves of all water-closets to see whether they act properly, and note from what cistern the water comes, *ie*, whether there is a separate cistern for drinking water, or whether the same cistern supplies the water for drinking and domestic purposes, as well as for the use of the water-closets. 6. Examine the nature and condition of the safes, traps, soil, and waste-pipes, etc, connected with all water-closets, baths, and sinks, to see if they are in good working order or otherwise. 7. Examine the soil-pipe throughout its course, to see whether it is airtight or not; any points of leakage should be noted.—Useful hints to householders are, that all houses should be supplied with a stop-cock, so that in case of severe frost, or in the event of repairs, the water can be easily turned off without having to hunt for the regular official, and causing great inconvenience to neighbours by having to turn off at the main. All water cisterns should have a properly fitted cover. It is advisable, when practicable, to provide a separate system for the storage of water for drinking and household purposes, distinct from the cisterns that supply the water-closets. The frictional parts of all sanitary fittings should be kept regularly oiled. The seats of water-closets should be loose or fixed with hinges, so that the apparatus underneath can be examined without disturbing the woodwork. It is of great importance that all pipes and fittings should be easily come-at-able. To prevent the bursting of pipes in severe frost, the water should be turned off at the main, and the supply for immediate daily use should be stored in buckets. Covering cisterns and pipes with thick boiler felt, or casing them in sawdust, will generally prevent the water from freezing. NB—The pipes burst from the expansion of the water in the act of freezing, and not after it is frozen. Water will rarely freeze if it is kept slightly running from the tap. In order to secure clean and wholesome water for drinking and cooking purposes, all water cisterns should be cleaned out at least twice a year. (*British Medical Journal*, 1881.)