PRACTICE OBSERVED

Practice Research

Night workload in one health district

PAUL J HOBDAV

Abstract The night work (11 pm-7 am) in primary care in one health district (population 195 212 with 83 general practitioners) was studied over a three month period, starting 1 January 1983. The workload proved to be small (15% of all "out of hours" work for general practitioners). An average of three night visits was done a night in the whole health district, and 26 general practitioners were available for these. On average, over seven doctors were available each night for each patient who required a visit in primary care in the health district. It is concluded that there is only sufficient work for (at maximum) two doctors, and a system is proposed to make more efficient use of the general practitioners' time.

Introduction

The profession has recently been criticised for the way in which its "out of hours" work is organised. It is important that we aim at a uniformly efficient and caring system which does not detrimentally affect most of the work that is performed in the surgery. Before such a system can be planned the workload needs to be known.

The results of other studies have shown night workloads of individuals and within practices, but none has examined a complete health district. Lockstone (Whitby, 1976) calculated a rate of 10.7 night visits per 1000 patients a year. Riddell-Smith (Larkfield, Kent, 1983) 7.7, and Crowe (Leicester, 1976) 7.8. Morton (Berkshire, 1979), however, showed a rate of 15.9, Riddell (Glasgow, 1980) 16.8, Cubitt (London, 1983) 18.

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Cunningham (Hovingham, Yorkshire, 1980) 23.9, and Barley 20.8 (Sheffield, 1979). "This variation was reviewed by Buxton, who showed a nationwide variation in rates between 3.8 and 17 in 1973-4." He attempted to give reasons for this variation.

For this study "out of hours" work refers to the total work done between 6 pm and 8.30 pm, but "night work" more specifically refers to work done between 11 pm and 7 am. In the Maidstone Health District all out of hours work is undertaken by general practitioner principals and deputising services are not available. Most encounters with doctors that are initiated by patients between 11 pm and 7 am are carried out by general practitioners, as there are few casualty attendances during these hours.

I suggest that a more accurate estimation of overall workload may be obtained by studying a whole health district because it goes some way to eliminate variation among practices. The aim of this study was to describe the night workload for general practitioners in a single health district, and in the light of the information collected, to suggest a more efficient system of providing such care.

Methods and results

The number of calls for payment for night visits between 1 January 1983 and 31 March 1983 was provided by the Kent Family Practitioner Committee. By personally contacting at least one partner from each practice, information was obtained on each general practitioner to be on call and the number of patients on lists. Most claimed to be efficient in submitting night visit forms.

Maidstone Health District's 93 general practitioners (13% of the population of Kent). This allows an average of 2099 patients per general practitioner. (Kent's average is 2182 and a recently calculated national average is 2107). The 93 general practitioners are organised into 32 practices (table). On call rota means that 26 general practitioners cover for 195 212 patients each week night (22 cover for this number at weekends). Thus each week night one general practitioner covers for an average of 7630 patients (at weekends for an average of 9132 patients). The average rota size is just over three doctors, and the largest group has seven general practitioners.

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Size of partnerships in the Maidstone Health District

No of doctors in partnership	No of patients	No of doctors	Percentage of all general practitioners
1 (single handed)	1	10	10.8
2	4	16	17.2
3	4	16	17.2
4	2	12	12.9
5	2	12	12.9
6	2	12	12.9
7	2	12	12.9
Total	32	93	100

During this three month period general practitioners did 299 night visits (7% of the total made in Kent). The figures of the Kent Family Practitioner Committee show no seasonal variation (supported by Riddell-Smith), and that, by extrapolation, gives a rate of 6.21 night visits per 1000 patients a year. In Kent 4252 claims were received from 711.5 general practitioners, covering 1 552 484 patients. The night visit rate from these figures is 1.095 night visits per 1000 patients a year. My personal rate was 5.9 per 1000 patients a year.

The maximum total number of forms for night visits relating to patients in the Maidstone Health District and received by the Kent Family Practitioner Committee for one night during the study period was nine. Twenty six general practitioners were available for these visits—that is, approximately three doctors for each patient. The average number of night visits in total was 93 (in 195 212 patients, health district) shared among 26 general practitioners—that is, on average over seven (actually 7.8) general practitioners available for each visit required. Thus one general practitioner will do one night visit roughly every eight nights on duty.

Discussion

The night visiting rate of 6.2 night visits per 1000 patients a year is lower than in other studies. For a true picture of the night workload, however, those night visits not claimed for must be acknowledged, and, obviously, telephone consultations. Without the unknown number of visits for which no fee was claimed the figures presented are the minimum generated. I believe, however, that those visits were few and if included would not be sufficiently important to alter my conclusions.

An estimation of "disturbances" between 11 pm and 7 am—that is, telephone calls for advice plus visits—has been made. Crowe's "disturbance" figure is 13.3 per 1000 patients a year, leading to the quoted night visit rate of 7.8 per 1000 patients a year. The results of Lockstone's study produce 13.1 (my calculation), and Riddell-Smith showed a disturbance rate of 15.9. My personal disturbance rate was 14.7 per 1000 patients a year.

From the results of these studies 84% of phone calls to the general practitioner on call (out of hours) were before 11 pm and 84% of the "out of hours" visits were done before 11 pm. These figures suggest that the general practitioner will be out of bed every fourth night on duty and telephoned after 11 pm every other night if covering for 12 000 patients.

The results of my study show that in the Maidstone Health District a general practitioner will do one night visit roughly every eight nights on call. This lower rate is partly explained by the "average" general practitioner covering for fewer patients—7630 patients on week nights and 9132 at weekends. Thus a small proportion of all "out of hours" work is done between 11 pm and 7 am. About 16% of telephone calls are received and 15% of "out of hours" visits are done during these hours.

I suggest that these figures show inefficient use of expensive and highly trained manpower during unusual hours for a trivial proportion of the general practitioner's work and propose an efficient system both in terms of manpower and patient care.

Night calls (11 pm-7 am) in the Maidstone Health District should be coordinated and operated from a central base. General practitioners would cover for their own patients until 11 pm (thus still doing 85% of "out of hours" work themselves or an immediate deputy—that is, a partner). The figures show that in the health district from 11 pm to 7 am there is sufficient work for only two doctors. All patients would be in telephone contact with the base (probably an area in the casualty department). One general practitioner would remain "on the radio" in radio telephone contact with the other doctor who would stay at the base and deal with cases that could easily be attended to at the base and give telephone advice.

With this system each general practitioner would be "on call" only 43% of all general practitioners participated—that is, eight nights a year (allowing for eight "sleeping" partners). Distance to be travelled should not be a problem. From the base (which is central) to the furthest point is 14 miles. Some general practitioners feel that it is not worth the effort of travelling from one side of the health district to the other takes a maximum of three quarters of an hour. Furthermore, the doctor is already up and alert. Existing on call rota means that seeing one's own patient at night is rare, particularly where relevant cases are known which appreciably alter management in a genuine emergency. By not covering from 11 pm to 7 am, a single handed practitioner who is usually "on call" every night of the year with an average list size will deprive only about 13 of his patients a year of a personal visit. He will still deal with 85% himself. Most of his patients would not even know that he was not on duty during those hours.

The important difference which should eliminate criticism often made of deputising services is that this scheme is operated by a group of general practitioner principals who know each other and can work together. Peer criticism is an extremely powerful force which would help maintain high standards. Schemes based on this formula have been suggested before but not with the benefit of the workload figures of a health district. "As has been shown, there is only sufficient work for two doctors generated by the health district population of 195 212 patients between 11 pm and 7 am. A ratio of one doctor for every 1000 patients is much healthier than most deputising services provide, and this cooperative would be non-profit making. Some have gone a step further and suggested separate "out of hours" contracts."

"On call" work in short shifts can be enjoyable. It is unfair on patients when long shifts and disturbed nights create bad tempered doctors, which can affect detrimentally most of the work done during a normal shift. It is extremely inefficient to have doctors on average at least seven general practitioners available for each visit required every night between 11 pm and 7 am. This change is inevitable and it is better to mould the future than to be moulded by it or by influence outside the profession.

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Life Changes

Death of a spouse

A H ELDER

Personal account

It is nearly 14 years since my husband died. He was 30 and I was 28. We had been happily married for five years, and had two small sons. Strange to think that all that time has gone by and that my life has changed so much, when at the time I felt I didn't want to survive myself. My general practitioner had said "Time heals—little by little it will get easier" and I hadn't believed him, but those words have stayed with me and I can see now what he meant. Even after 14 years small things remind me of him—his handwriting in a book, a similar face on television or in a crowd, places where we had been together. They all stir memories, but the pain has gone, the intensity of grief has faded with the years.

Looking back I can remember so clearly first being told of his illness. He had had to have an operation to remove one of his testicles "because it wasn't functioning properly and might affect the other one." Picking him up from hospital I was called into the doctor's office and told that he had cancer. After the initial shock I asked if he knew. He didn't, and I was advised not to tell him at that time. Going home with him, brightly chatting in the car, and then facing my parents who had come to stay for the Easter weekend was like a nightmare, keeping up my normal behaviour and manner while I kept repeating to myself over and over again that conversation in the doctor's office.

A few days later I went by myself to see our general practitioner who was very sympathetic and supportive. Throughout the year of my husband's illness I knew that I could approach him at any time, which was a great comfort. I asked him if I should tell my husband that he had cancer, but he said that if he wanted to know he would ask. For all those 10 months he never asked and I never told him. Everyone else knew, family and friends, but he didn't. It was like keeping a terrible secret from him. I used to lie in bed at night crying quietly by his side as he slept, wondering how he would ask so that I could share with him that terror of what was happening, but at the same time being so frightened that if he knew he would fall apart. He was a very outgoing person, full of life and energy, and I was scared that I couldn't cope with him becoming depressed.

All through that year he was off work from his teaching job for long periods, was in and out of hospital having radiotherapy or chemotherapy, new lumps appearing in his lymph glands, his chest, his stomach, or having periods of recovery when everyone said "It's a miracle, he's cured." Once, coming out of the radiotherapy department, he said "Do you know, there are a lot of patients with cancer, but he never outwardly made a connection between that information and himself."

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I suppose that that was his own form of denial, and I went along with it. It is one of my deepest regrets. I will never forgive myself for not having the courage to share with him facing his death, the end of his short life, and parting from everything and everyone he held dear. Death is such an important part of life that, however painful, I realise now that it can't be hidden or disguised. Only at the very end when the cancer had reached his brain and he was on the verge of death did he ask in a lucid moment what was the matter with him. I told him, and he expressed his thankfulness with me for all he had had in life, for everything he had been blessed with, but by then it was the end.

I appreciated the hospital allowing me so much privacy with him. He was in his own room and I was given a room nearby so that I could be with him as much as I wanted. After he had died I remember going back to my hospital room and not wanting to leave it, not wanting to go home and face the children, our two sons aged 2 and 3. My general practitioner had them to stay with his family for that night.

Looking back I realise now how long the grief lasted—not just months, but years. I don't think people understand this unless they've been in a similar situation. The death of someone so close can never be forgotten or "got over" completely. It was a long time before I could hear the word "cancer" without having to run from the room. The emptiness and loneliness was devastating. Particularly being with a crowd of people perhaps at a party. I was aware of everyone else belonging to a couple. I no longer had that familiar reassuring figure nearby whom I felt loved and accepted. By the effect this had on my self confidence took a long time to mend. I desperately wanted to hang on to memories and to keep photographs to remember him clearly.

One night, not long after he had died, I found my 3 year old son crying in bed. "I can't remember Daddy's face," I've forgotten his face. It was in fact having to keep going for the children that helped me. But because they were so young I wonder now whether I was conscious enough of the effect it must have had on them.

One thing that I remember clearly was my awareness of the embarrassment of other people over what I had suffered—their avoiding the subject or distracting or encouraging conversation when I attempted somehow to spare them my distress. Because of this I found myself covering up my grief in front of them, only allowing myself to cry on my own. This feeling of not being able to share, even with very supportive friends, contributed to the feeling of "aloneness" after his death. I remember the intense relief of meeting a woman in her 20s whose husband had also recently died of cancer, with whom I felt I could share aspects of my experience because she also experienced them—things that may seem trivial but in fact would have embarrassed me to have discussed with older friends or family, such as the need for the warmth and intimacy of a sexual relationship. Having suddenly had that part of my life cut off, there were many difficulties in being approached by men again when the only man I really wanted was my husband.

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After his death I realised for the first time that I could never rely on anything being permanent, or safe, or secure again; I could never rely on happiness lasting, or tomorrow everything might change. I became reckless. I would drive and take risks in the car sometimes with my eyes shut, thinking "If I don't make it, I don't," gambling with my own life. I had affairs that were desperate and unrealistic. I couldn't cope with the financial and practical side of life, which had all been organised by my husband, and so stuffed unopened bills into drawers with a sense of panic, leaving them there untouched for months. The sense of responsibility of being the sole parent and provider for my children eventually made me think about the future, about retraining, and I was fortunate in having friends who came forward to help me in this, and I did go on to do so. Things change, and what seemed overwhelming gradually receded more and more into the past.

Something I regret is that if I visit my husband's grave I cannot really feel that he is there to speak to. If he had been buried rather than cremated I believe I might feel more in contact with him—I don't know. Death is so final, and I'm sure one always has regrets and guilt as well as the additional guilt of finding happiness in new relationships. We are left with those feelings which can perhaps be repaired but never completely healed. That is what we carry as the survivors, but hopefully as survivors we can be more in touch with what others suffer.

Doctor's comment

There can be few more painful transitions to make than that following the death of a spouse. In general practice we are frequently, and often unknowingly, helping people to navigate such major changes. We spend a lot of our time in contact with the effects of loss and death. Grief may result from much that is less obvious in life; from the loss of homes, health, ideas, or prestige. But often the loss is more obvious.

*He first deceased, for a little tried
To live without him, liked it not and died.*
Sir Henry Wotton, 1892¹

The surviving spouse is left with a numbed and bleeding half of what was a couple. This involves a considerable loss of "self" or "self in other." If the death is in early life the future does seem bleak and uncertain. If in later life it is more shared pain and all the experiences of a lifetime that lose their other half.

Not surprisingly, this transition has a clear morbidity and mortality. Widows seek consultations with general practitioners for psychiatric symptoms three times more often than expected in the first six months after bereavement,² and close relatives in the first year after bereavement are doubled when the person has died in hospital, as opposed to home. "Perhaps death at a distance" is an increasing modern phenomenon and one that should concern us.

The doctor's first knowledge of the change in a patient's life may be from an scanty call to Mrs A who "needs tranquillisers," or from a delayed and urgently needed discharge note about a patient whom he has known who has died in hospital. But the great strength of the general practitioner's position is that often his contact with the surviving spouse has begun long before the death of the husband or wife. Particularly if the death has occurred at home, a lot will have been shared between the two and a working relationship will have been begun during the terminal care of the spouse. The doctor may have got to know both partners well and helped them to face some of their grief together before the death. To help someone die with dignity at home and enable the spouse and other family members to share in this, as closely as they want to, without deception

and with open feelings, is probably the single greatest contribution the general practitioner may make towards the health and even recovery of the bereaved partner. This is a true preventive medicine. For if the surviving spouse can feel that he has done as much as possible, and been adequately supported in this, so there is no residue of resentment at having been left to cope with too much, and if the two, even at the very end of life, can draw close enough to share some of their feelings about parting, then the whole experience is registered as deeply as possible, and recovery is less delayed by regrets. This kind of terminal care is not possible if the basic relationship of the couple has been too poor.

THE PRACTICE

Nowadays about a third or less of deaths will occur at home. One hundred years ago only 5% of the population died in hospital. What of the surviving spouses whom the doctor knows less well?

Are all deaths discussed at the practice meeting? Is there a practice meeting? Or, like the dead themselves, are "deaths" quickly forgotten and not discussed much? Do the receptionists know what has happened so that they are alert to the importance of a request for a visit or an urgent appointment? Do anyone from the practice call on a recently bereaved family? If so, when and why? Or is this none of the doctor's business? If such a visit is undertaken what are its purposes? It may be an opportunity for the surviving spouse to have information, find things out, and express some feelings about what has happened, perhaps it is also a not too intrusive exercise of concern and may pave the way for future help if and when it is needed.

There may be many mixed feelings for the surviving spouse associated with the medical management of the last illness. The hospital, and often by implication the general practitioner himself, may be blamed for not caring enough or for unnecessary delays and poor treatment. Usually such complaints contain aspects of legitimate criticism but are also coloured with the spouse's present despair and anger and wish to find an authority to blame. The doctor has to allow sufficiently the expression of such feelings without being too defensive and self justifying, or trying himself too much with the criticism. On the other hand, there may be an uncritical attitude towards the doctor as "never having put a foot wrong," and again the doctor must be wary of accepting such a valuation and try instead to achieve a useful working relationship for the bereaved patient.

After the initial stage what of the next two to three years? It is during this time that recovery slowly begins to occur or not occur, and many aspects of the general practitioner's function may be called into play. He calls on his knowledge of helpful organisations in the local community, recognising the severity of social isolation that may follow bereavement; he may need to be in touch with other people concerned with the family, such as the local health service, social work, or social services department; he will need to recognise the differences between appropriate grief, which is within an expected pattern for a particular individual, and a more complicated or prolonged depressive reaction that may need treatment with antidepressant drugs. He may need to collaborate with the local psychiatric day hospital or other nearby psychiatric resources. And, particularly with elderly people, he will need to know something of the wider network of supportive relationships they have to rely on.

The general practitioner is also in a strong position for the early diagnosis of any ensuing physical illness in the surviving partner.

It is tempting to "organise" an approach to the management of the "surviving spouse," and in so doing give a deceptively oversimplified "strategy" that may be appealing in its ordered approach, its marshalling of the resources at the doctor's disposal, but ignores the complexity of the situation. We must be careful not to regard everything as a treatable

condition, far less a preventable one. Whatever resources the doctor's organisation contains—counsellors, health visitors, community clubs, or whatever—much help still rests with the sensitivity and awareness for the people concerned. There are no experts. The forces of evasion are very powerful and pull all of us away from recognising the needs of others, particularly if that recognition requires us to face some pain ourselves. The extent of the doctor's network may have its drawbacks, making it too easy for the patient to get lost. The doctor may suggest another member of his team for the patient to see just at the point when the patient still needs the doctor, who has been more closely concerned already. He must be aware of the dangers of referral at a time when the patient is particularly sensitive to rejection.

"A widower, who hardly ever consults, came to see me two years after the death of his wife. Margaret had been a frequent attendee and a great talker. He was dressed in dull clothes, near Christmas, and came with a croaky cold." At that moment he seemed to need this particular doctor who had known the whole situation, to understand his croaky (tearful) cold (and) the lack of warmth he had felt in his life since his wife's death. "Simple treatment was necessary for his cold and a few minutes of time, tears, and shared memories of the unexpectedness of her death and the shock. . . . No prescription, no organised follow up; a simple but complete piece of general practice."

OTHER EMOTIONS

Death doesn't result only in feelings of loss and grief. There are many much less acceptable emotions—hated, guilt, relief, or what seems like a shameful lack of feeling, and regret about secrets or other important things that were never shared. The doctor mustn't make assumptions about how a survivor feels. He has to try and be aware of the difference between how he feels about the death of his patient and how the surviving partner might feel.

Deep grievances may be held towards the doctor, particularly where management has seemed to go wrong; the doctor may become "dead" to the surviving spouse for many years, causing her to switch to one of the other doctors in the practice. Such a profound reaction must be recognised and the doctor's own trivial consultation may break the silence and have much

importance for both the widow and the doctor. If this is handled sensitively it may help to accelerate her reintegration.

There are paradoxes. Too often we encourage the bereaved, through counselling, to give and give up the memories of the dead spouse; we see it as treatment with an aim of freeing the survivor. Instead we should respect the strength of the need to "hang on" and "keep alive" the dead person, which if recognised may facilitate a more natural process of "letting go," and living again.

The doctor must have a respect for privacy, a belief in the natural timing of things, and an awareness of what's being said when it's being said and not everything into a condition "requiring appropriate treatment." He must also recognise the truth of another paradox. In any difficult emotional transition the patient is only helped to emerge from it and gain more independence by the doctor accepting the patient's need to be dependent for a time. The bereaved, particularly, may need their symptoms in order to remain in contact with the doctor, while they slowly come to terms with their loss. The doctor may have become an important person during the terminal illness of the patient. If the contact has been close, or lengthy, and there is the family of the doctor and the events connected with him may in part, or by association, help to keep the memory of the dead person alive in the survivor's mind.

If the doctor is aware of his understanding of the patient's feelings may accompany his management of the various aches and pains and illnesses that the patient brings. The danger is that the doctor, sympathetically, tries to rid the patient of his or her symptoms too avidly; he feels charged with the need to cure the illness and treat the symptoms and becomes irritated by the patient's wish to keep them (as they may also wish to keep their grief). In trying too hard to "do things" for the patient he deprives him or her of his most valuable service—what he is and what he represents, someone who stays around, is available if needed, and was intimately concerned in events of great personal importance.

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Diary of Urban Marks: 1880-1949

I have already mentioned that during the war Reg and I were chairman and secretary of the Medical War Committee whose duty was to select doctors for service. The war came as a welcome break to my secretarial duties. I arrived in Mesopotamia on 18 August 1917 and was drafted to Number 2 British General Hospital at Amara. I was having quite a good time when towards the Christmas day of that year I had a command from the colonel to attend at his office. Wondering what was going to happen, I made my appearance at the trying place and being admitted I duly sat down. The colonel asked me to sit down. Said he "I am about to ask you to do something which I cannot command you to do." This promised to be interesting and I asked him to proceed. Quoted the colonel: "As you are aware, Ashleigh, the most exemplary, is leaving us for other duties and I find that the mess is in debt to the tune of £2200 rupees."

I quickly calculated this to be in the neighbourhood of £200. Through my calculations came the colonel's droning voice informing me that Ashleigh had mixed his own accounts with the mess accounts and although the CO did not impute any dishonesty to Ashleigh, he

wished me to take charge of the mess and try to liquidate the debt. I felt flattered at the request, thinking that my fame had travelled East. No one in the mess could possibly know of my secretarial work. Suddenly the colonel's face became stern. He said, "I asked the colonel why I had been singled out, to which he replied that at a meeting of the senior officers it was felt that I should be a suitable person. I asked him whether the reason was quite that and rather was it that they thought I was a Jew and therefore must have a fair for finance. Now colonels do not blush as a rule. In fact this particular one was the only one I ever saw even flush. He admitted that my guess was right and when I informed him that I was only an apology for a Jew, nevertheless insisted that I should take the position of mess secretary. I did so joyfully more because it was something to do in a country where no one does anything. I continued in this capacity during the rest of my time in the army, which was until February 1919, by which time the mess was out of debt and had money in hand.

GPs and Their Staff

Dismissal: fair or unfair?

NORMAN ELLIS

Mere mention of "dismissal" strikes a note of fear in the hearts of many employers, and general practitioners are no exception. It conjures up a vision of the unpleasant task of sacking an employee and the ensuing risk of defending your action in public at an industrial tribunal. This article seeks to offer reassurance on a vexatious subject.

Questions general practitioners ask

There is no better point to start from than the anxieties often expressed by general practitioners. Firstly, some doctors believe that the provisions of employment law have so tied their hands that it is not only difficult, but virtually impossible, to sack an employee. Secondly, some doctors are so reluctant to contemplate dismissal, even when this is clearly necessary, that they compound their problems by delay and a failure to follow a proper procedure. Indeed, some doctors are so reticent that they are unwilling to dismiss a newly recruited employee who (even after adequate training and supervision) is quite unsuited to the job. Reluctance to dismiss may be associated with a failure to give proper notice of the dismissal and to follow the required procedure. These omissions almost always create greater difficulties and may so easily lead to a successful claim for compensation for unfair dismissal. Other problems arise if doctors try to use redundancy as the grounds for dismissal when the actual reasons are to do with misconduct or inability to do the job.

Sometimes a general practitioner fails to consult his partners before taking action, even though the decision should be taken (or at the very least confirmed) by the partnership as a whole. A more unusual (almost bizarre) problem occurs when a general practitioner tries to dismiss someone who is not even his employee; the most common example is an attempted dismissal of a health authority employee attached to a practice.

The content and quantity of work is always changing; your employees change through normal wastage, and their own domestic circumstances, health, and capabilities will also alter. More generally, there will be changes in the way in which a practice is run; practices may combine or divide, premises may be acquired or closed, and new work may be taken on. All these changes may lead to a position where an employee is either unwilling to do the work that is required or incapable of doing it.

The need for change and for your employees to accept and adapt to it inevitably creates many "grey areas" which do not seem to fit easily into the formalities of the unfair dismissal legislation. Other articles discuss ways of handling this continual

process of change and adaptation, in particular those on "How to change a contract of employment" and "Absence from work." The crucial guiding principle is that you should ensure that your staff are aware that change is an inevitable feature of practice and that you are willing to ask you to do something which I cannot command you to do. If they fall short in either of these respects then the procedures outlined below may have to be applied.

What is dismissal?

In most circumstances it is clear to both the employee and the employer when a dismissal takes place. But note that a dismissal may also occur when: (a) An employee's fixed term contract expires and is not renewed. (It is not normally advisable to work with fixed term contracts, particularly if these are extended on a year by year basis.) (b) An employer does not allow an employee who has qualified for reinstatement to return to work after pregnancy. (c) An employee resigns for reasons that relate to certain conduct by the employer—this is known as "constructive dismissal." (d) An employer does not make his intentions clear—for example, if his language or expression is unclear. Although a dismissal may not be intended, certain phrases—such as, "You know what you can do!"—in fact may reasonably be interpreted as notice of dismissal.

Fair reasons for dismissal

There are several aspects to any dismissal that determine whether it is fair or unfair: (a) Is the reason for the dismissal valid? (b) Has the employer acted reasonably in treating that reason as sufficient grounds for dismissing the employee? (c) Is the procedure followed by the employer fair?

The legislation refers to five specific types of reason that may justify dismissal.

Conduct—This is the most usual reason for dismissal and the one that is most likely to lead to a complaint of unfair dismissal.

Capability—The employee cannot satisfactorily do the job. Additional problems that may arise when illness has led to an employee being unable to do the job are discussed below. **Redundancy**—Normally an employer has no grounds for claiming unfair dismissal if the dismissal was because of redundancy—that is, because the employer has no work (or insufficient work) for the employee to do and is unable to provide suitable alternative work. It is not uncommon, however, for redundancy to be used improperly as an easier alternative to "misconduct" or "incapacity" to effect a dismissal.

A statutory requirement—The most obvious example is when the loss of a driving licence prevents an employee from doing the job and there is no suitable alternative job available.

Some other substantial reason—This may sound like a Catch 22 option, but in fact it applies to the specific and important range of circumstances described below.

Grounds for dismissal

MISCONDUCT

If you dismiss a member of your staff on the grounds of misconduct this will usually be the final stage of your disciplinary procedure. When contemplating or taking this action you need to consider the following:

(1) Did your employee know an offence was being committed? Your disciplinary rules should be sensible and clear and your staff should be aware of them. It is essential that they should know of any conduct which constitutes *gross misconduct* because this could result in suspension from work on full pay, pending an investigation that may precede summary dismissal—that is, without notice. Obviously, anything you label as *gross misconduct* must be serious enough to warrant summary dismissal. For general practitioners' staff a serious breach of confidentiality, an act of theft, or an abuse of drugs are examples of *gross misconduct*. It is advisable to give examples of these in your written code of employment.

(2) It is quite unreasonable for someone to be dismissed for a first offence, except where there has been *gross misconduct*. If you are considering dismissal your employee should have been warned on a previous occasion when misconduct occurred that further offences might lead to dismissal. It is advisable to give written warnings to an employee in line with the ACAS code which is mentioned below. These may have an impact, particularly if it is made clear that it is a final written warning and that a further repetition will lead to dismissal. You may wish to ask your employee to confirm in writing his receipt of your letter. It is certainly advisable to keep a written record of all your warnings not only for your own use but also as evidence if you should be faced with an industrial tribunal hearing. (It is normal for written warnings to be kept "on record" for only a specified period—say, for 12 months.)

(3) You must investigate all the facts of the case thoroughly, particularly if it is likely to lead to a summary dismissal.

(4) Finally, if your procedures are reasonable your employees should have an opportunity to put their side of the case. There might be an acceptable explanation for the behaviour. The Advisory, Conciliation and Arbitration Service (ACAS) has produced a code on disciplinary practice and procedures, and industrial tribunals have to take this into account when deciding whether a dismissal was fair or unfair. It is recognised that the small employer cannot be expected to follow this code to the letter. If your approach to a dismissal takes account of the issues discussed above, the main points of the ACAS code will have been covered.

INABILITY TO DO THE JOB

There are various grounds on which an employee might be considered unable to do the job—ill health, lack of skill or qualifications, poor standard of performance.

Before you contemplate dismissing an employee on grounds of inability you should consider the following: (a) Have you provided adequate training, including guidance on how the work should be done and the standards you expect? (b) Has your employee been properly supervised? Have you provided regular opportunities to discuss and review progress? (c) Has your employee been told of any shortcomings as soon as these became evident? Has there been an opportunity to improve? (It is important not to allow matters to drift on.) (d) Is the employee in the right job? If not, within the limited opportunities available for redeployment, could you offer something more suitable? (e) Have you given a final warning, stating that if there is no improvement the employee will be dismissed?

Most difficult problems arise when employees are absent through ill health. An employee who has been absent for a long time through ill health, or for a prolonged absence, the employer may be unable to keep the job open indefinitely.

(4) Employees who have already reached the normal retiring age for their employment or, if there is no normal retiring age, men who have reached age 65 or women who have reached age 60.

Unfair dismissal in perspective

It should be the aim of any employer to act in a fair and reasonable way in all his dealings with staff. This is in the interests of good management, and employment legislation is designed to encourage and support it.

Note these three features of the legislation:

(1) An employee cannot normally bring an unfair dismissal claim to an industrial tribunal until she has been with you for one year, or, if you have 20 employees or fewer, for two years.

(2) Industrial tribunals must take into account the size and administrative resources of the employer when considering whether a dismissal is fair to reduce the burden on small employers.

(3) Although rare in general practice, an dismissal based on discrimination against trade union activities, or concerning action against anyone who has made a claim of sexual or racial discrimination, will be judged automatically unfair.

Some recent statistics offer reassurance. Less than a tenth of all dismissals in any year lead to unfair dismissal claims, only 3% of all dismissals actually lead to a tribunal hearing, and less than 1% are found to be unfair. Some two thirds of unfair dismissal claims are settled before any tribunal hearings, many are withdrawn, and the rest are settled by agreed compensation, often by using the services of an independent ACAS conciliation officer.

Where cases went forward to a tribunal hearing, in only about a quarter of these was the dismissal found to be unfair. The most recent statistics show that in 1982 the amount of compensation awarded by tribunals was less than £750 in over one third of the unfair "cases," and less than £1500 in over half of them. In only 4% of cases was the award over £6000.

Although these figures are reassuring, a tribunal hearing may be a harrowing experience and the work required to prepare your defence and attend the hearings is both costly and time consuming to you and the practice. Thus it is advisable to take some simple precautionary steps, particularly since these may also help you to manage your practice more effectively.

Preventive measures

Dismissal should be a rare event if you have already followed the steps below, which have been described in previous articles.¹

(1) Make sure that your selection procedures are adequate so that you find the right person to fill your vacancy. Ensure that your practice manager fully participates in selecting a new member of staff.

(2) Relations with a new employee should be put on a proper footing from the outset. You are legally obliged to issue a written statement of the main terms and conditions of their employment within 13 weeks of the employee starting work in your practice. This statement should specify any disciplinary rules (or refer to another document containing these) and state to whom the employee should go if she is dissatisfied with any disciplinary decision affecting her, or if she has a grievance about the job. The importance of having adequate disciplinary and grievance procedures has been emphasised in a previous article.²

(3) Try to ensure that your training arrangements are satis-

REUNDANCY

Fortunately, redundancy is a rare occurrence in general practice, although it has been known to happen. Although it may be fair to dismiss an employee on these grounds because you need fewer people to do your work, you must be in a position to show that your method of selecting who should go was fair. This is vital. You should decide on the criteria of selection—for example, length of service, skill, an objective assessment of work performance, attendance, disciplinary warnings, or some combination of these; you should then consider whether there is any other job available for the person who is being dismissed; and finally you should try to give as much warning as possible.

LEGAL IMPEDIMENTS TO CONTINUED EMPLOYMENT

An employee may be fairly dismissed if continued employment would result in a breach of the law. The obvious example is when someone who is employed to drive loses his or her licence. Nevertheless, even though this case may seem straightforward, it is still necessary for you to be able to show that you have acted reasonably. In particular, you would need to consider whether driving was essential to the job and whether alternative work would be available, albeit on a short term basis, until the licence is restored.

OTHER SUBSTANTIAL REASONS

There are other grounds that justify dismissal not covered by the headings above. It is difficult to specify these with precision but industrial tribunals have accepted the following as "some other substantial reason" for fair dismissal: (i) difficult relationships with other staff; (ii) changes of duties or conditions that were not anticipated by the employee; (iii) false information (which has importance) on an application form; (iv) reorganisation of a business; (v) when a temporary replacement for another employee—for example, during maternity leave—is no longer required.

In all these circumstances you should ensure that the dismissal is carried out in a reasonable manner, giving a proper explanation and due warning. Your reasons for the dismissal should be put in writing, and you should make some provision in your disciplinary procedure for your employee to appeal against your decision.

Who may not complain of unfair dismissal?

The main circumstances where someone cannot complain of unfair dismissal are:

(1) Anyone who is not an employee—for example, an independent contractor. It should be noted that there have been recent industrial tribunal cases where a general practitioner has been able to lodge a claim for unfair dismissal (following the termination of a partnership) because the contractual agreement between the partners did not meet the criteria of a partnership as defined in the law of partnership. In such circumstances the consequences may be more far reaching and serious than just the risk of a successful claim for compensation on the grounds of unfair dismissal.

(2) Employees who have not completed one year's continuous employment by the date on which dismissal takes place. But any employee working in a practice that has employed 20 or fewer employees cannot complain of unfair dismissal if the employee has not completed two years of continuous employment.

(3) Employees who normally work fewer than 16 hours a week, unless they have been employed continuously for at least eight hours a week for at least five years.

factory. It is important to act without delay if the standard of work falls below what you require. Difficult and almost intractable problems may arise if you allow unsatisfactory working practices to persist simply because you are reluctant to take corrective action. Your employees will assume acceptance of unsatisfactory performance if no action is required to improve it.

(4) Written records are most important. You should keep notes of any disciplinary warnings (oral or written warnings) since these may be required as evidence if your actions ultimately lead to dismissal and a subsequent tribunal hearing.

If these steps are followed you are unlikely to face problems over dismissal. Nevertheless, even the most conscientious employer may have to consider a dismissal if such a situation happens. It cannot be emphasised too often that if you employ 20 or fewer staff there is a two year qualifying period before a claim of unfair dismissal may be made. This should provide ample time for you to assess someone's capabilities. Even if your staff numbers more than 20, and the qualifying period is one year, this still allows enough time for your assessment to be made. A new employee will serve a specified probationary period, but you have at least 12 months to monitor performance before the statutory rights are acquired. Your employee should be given the chance to improve before and after the qualifying period, whether this is 12 months or two years.

Reassurance

As I have stated above, unfair dismissal is a rare occurrence. When it does happen it is often a consequence of an ill considered approach to the necessary disciplinary action that must precede dismissal. This in turn usually arises from the general practitioner's reluctance to act decisively (but reasonably) when this is necessary. Indeed, it may have been the doctor's own kindness and unwillingness to upset one of his staff which has subsequently led to serious legal difficulties and even a tribunal hearing. Preventive action is crucial, not only because it is a necessary part of good management, but also because it will avoid the trauma of a claim of unfair dismissal.

Remember that your handling of any dismissal has both "procedural" and "substantive" aspects. It is necessary to show that your approach to it has been fair and reasonable and that the reasons for the dismissal are reasonable, and therefore defensible, if you should be required to justify your actions.

Lastly, if you have the misfortune of being the subject of an industrial tribunal application (and hearing) you should seek advice from your local BMA regional office without delay. Whether you win or lose the case, it is advisable to consider whether any lessons may be learnt from the episode. Was your selection procedure lacking in some respect? Is your disciplinary procedure effective, especially your arrangements to give an early warning of unsatisfactory performance or behaviour?

I am most grateful to Dr John Ball, Dr Ewen Bramwell, and Mr Peter Sykes and his colleagues of ACAS for their comments on this paper. I am, of course, responsible for any omissions or errors. This article can only provide a general guide to the provisions of existing legislation. It does not offer a definitive statement of law.

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