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Trainees' forum

Role of the duty psychiatrist

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Recent changes in psychiatric services have produced a movement away from large hospitals to management within the community. A successful home treatment service with 24-hour cover has been described for severe acute psychiatric illness, though hospital admission was not entirely avoided (Dean *et al*, 1990). It is difficult to manage violent patients or those who will not comply with medication at home. If relatives are not supportive hospital admission will be required. Although living alone is not a contraindication to treatment at home, those who require constant supervision because they are, for example, suicidal need to be admitted. Concurrent physical problems may also necessitate hospital admission. Any future services must therefore include some in-patient care.

One possible model of service delivery is to have a number of resource centres within a district, each one incorporating a small number of in-patient beds. This would undoubtedly lead to changes in working practice. To assess manpower needs for new services there is a need to examine current working practice. There have already been studies examining traditional (Brown & Ward, 1989; Donnelly & Rice, 1989) and alternative service delivery (Kingdon & Szulecka, 1986). The aim of this study was to describe current working practice as a way of providing information about the need for resident psychiatric cover in future services.

The study

The study was based at a traditional psychiatric hospital with a catchment population of 466,000, serving parts of six districts. There was a total of 527 beds, comprising 163 beds for adult functional illness, 227 for EMI (elderly mentally infirm) patients, 131 for rehabilitation (including old long stay) and 6 for psychotherapy patients. There were 13 junior doctors of senior house officer and registrar grades who took part in the on-call rota. When on duty they were responsible for accepting acute admissions and for the care of all in-patients. Over 42 days the doctors logged all 'out of hours' calls (after 5 p.m. on weekdays and all calls at weekends). The calls were categorised as either external (from a general practitioner, consultant psychiatrist, casualty department, patient or relative outside the hospital) or internal (from nursing staff). Further data were collected including the time of the call, the caller, the reason for the call, and the outcome in terms of any action taken by the duty doctor. Complete data were collected for 41 of the 42 day study period, an indication of the high compliance rate by the participating junior doctors.

Findings

The total number of calls was 382. The overall mean was 9.3 calls per day with a mean of 7 (range 2–14) calls per day on weekdays and 15 (range 4–23) calls per day at weekends; 13% occurred between 11 p.m. and 9 a.m.

There were 76 (20%) external calls; 21 from the local casualty department, 27 from GPs, 7 from the duty consultant and the remaining 21 from relatives, patients outside the hospital and the police. Of these external calls, 54% were requesting admission, 46% of which were felt to be appropriate and therefore accepted.

The remainder of the calls were internal. Admission arrivals constituted 42 (11%) calls. Of the 42 patients who arrived, 38 were admitted, 30 of them informally and 8 under Section 2 of the Mental Health Act. The arrangements for the admission of 67% of the patients had been made either by the duty doctor or consultant on call. The remainder, although arranged during normal working hours, arrived after 5 p.m.

There were 64 (17%) calls about psychiatric problems and 83% of these required assessment by the duty doctor. A large number of these were due to acutely disturbed behaviour or attempts at self-harm. Over the entire study period section 5(2) of the Mental Health Act was invoked just once.

There were 145 (38%) calls about medical problems and in all cases the patient was assessed by the duty doctor. Overall, 37% of these problems required further action to be taken after the initial examination. Falls accounted for 33 of the medical problems, but only 12.5% of these required further action. For 29 of the days we were able to establish that 74.3% of the falls had occurred on EMI wards.

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The remaining calls (14%) related to miscellaneous problems such as missing patients and requests to rewrite drug charts. Only 25% required any further action to be taken after the initial telephone call.

Comment

The aim of the study was to document the workload and practice of junior doctors' 'out of hours' work and assess the need for resident cover. The necessity for resident cover is dependent on two main factors: the workload, and the need for a doctor to be available within minutes for emergencies. During the period of study there were no such emergencies but the workload was considerable, with 83% of internal calls resulting in either a physical or mental examination. Thirty-three per cent of the 'out of hours' admissions had been arranged during the normal working day. This and other examples of the duty doctor carrying out normal day to day work could be avoided by better organisation. The medical problems were mostly minor and if these could be excluded, by redefining the role of nurses so that they accepted greater responsibility for assessing the seriousness of such problems, the workload could be substantially reduced.

Given the results of the study, it might be envisaged that GPs could provide medical cover and psychiatrists provide psychiatric cover to resource centres incorporating a small number of beds. The use of GPs would have financial implications, with the distinction being made between the calls before and those after 11 p.m., which incur different rates of pay.

The study has shown that the over-65s and those with challenging behaviour make the largest contribution to the workload of the duty doctor. These patients could be placed in separate specialised units so that the major workload would be concentrated on one particular site. If nurses were to take more responsibility and GPs provided medical cover, resident psychiatric cover would then not be essential though rapid availability would be desirable.

There are a number of methodological problems with studies of this nature. There is no perfect measure of clinical workload. In this study the number of calls and nature of the work were used whereas Brown & Ward (1989) used time spent and the nature of the work. It is, however, possible to spend longer with a minor problem than a serious one. This study looks only at on-call experience. There is a need to review, in future studies, how junior doctors spend their normal working hours, the experience gained and attitudes to on-call work.

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