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'Oh God, not a Palliative': out-of-hours general practitioners within the domain of palliative care

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Abstract

To date, the experiences of out-of-hours general practitioners with regard to palliative care patients and their management are yet to be evaluated, since the new General Medical Services contract came into force. In 2007 the National Institute for Health Research highlighted the need to identify factors that improve and hinder the delivery of optimum palliative out-of-hours care. By interviewing general practitioners who work out-of-hours shifts, this project explored factors influencing confidence in dealing with symptom control and palliative care provision outside regular working hours. Face-to-face semi-structured interviews were conducted with nine out-of-hours general practitioners employed by Serco. Interviews were conducted by a specialist doctor in palliative care who had in the past worked as an out-of-hours general practitioner. Interviews were analysed using Interpretative Phenomenological Analysis. General practitioners expressed concerns relating to constraints within the system provided by the private company-owned out-of-hours provider. Data from interviews was thematically very rich and brought out many different subject areas, some similar to previous interviews, some different. Sub-themes related to the process-driven aspects of working in out-of-hours:

- Motivation
- Time-pressure constraints and continuity
- The out-of-hours doctor within the domain of palliative care
- Isolation within system

General practitioners stated that their motivation was mainly financial. There was clear concern about the lack of continuity, and inadequacy of notes and follow-up, and there was a demonstrated need for more learning on the topic of palliative care. Pressure from the out-of-hours provider to see more patients was felt to be oppositional with the need to spend adequate time with this vulnerable patient group. General practitioners felt as unwanted strangers who were viewed with suspicion by patients and carers in palliative care situations. It was clear that most of the doctors interviewed felt a strong sense of isolation when working out-of-hours shifts, and some felt less inclined to contact specialist palliative care services.

Keywords

After hours, interpretative phenomenological analysis, isolated working, new GMS contract, out-of-hours, palliative

Introduction

The term 'out-of-hours' in the UK is defined as evenings, weekends from Friday evening to Monday morning, and public holidays.[1] Out-of-hours services are provided almost exclusively by general practitioners (GPs) (family doctors) on local performers lists for each county in the UK, who volunteer to the service and work in the setting either full time or part time.[2]

It is estimated that patients with cancer spend 90% of their last year of life in their home, and at least two-thirds of this falls within out-of-hours-time.[3,4]

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The National Institute for Health Research in 2007 highlighted the need to identify factors that improve and hinder the delivery of optimum palliative out-of-hours care.[5] The introduction of a new contract for National Health Service (NHS) GPs and the reconfiguration of out-of-hours services in 2004 have altered the activities of GPs, and may affect their role in the provision of palliative care.[6,7]

In this study we asked out-of-hours GPs directly how they feel about palliative care situations within their local out-of-hours system, and what affects their confidence.

Methods

Local context

Cardiff is the capital of Wales, a country within the UK, and out-of-hours services in the city in 2008 were covered by a private company called Serco.[8] The patient population is approximately 330,000. Serco has experience in organizing out-of-hours services within other health boards across the UK, and aims to work with the NHS to improve community-based health services. At the time of the interviews they provided out-of-hours GP services to more than one million people in Cardiff, Oxford and Cornwall, handling calls from the public, running clinics and providing home visits to urgent cases. Patients or non-professional carers phone the out-of-hours service, and a registered nurse will then give advice in respect of the most appropriate course of action. Patients can also call NHS Direct, where they will talk to a member of staff who can then refer them on to their local out-of-hours provider.

For GPs working out-of-hours, there is availability via the local hospice of access to an on-call middle grade and consultant grade palliative care doctor, who can give advice and assess patients 24 hours a day, seven days a week, including bank holidays.

Participant selection

Sixty doctors employed by the Serco out-of-hours service in Cardiff were contacted via a letter and participant information sheet. GPs who had worked in the out-of-hours setting for at least 1 year were chosen, to ensure they had, at the point of interview, some experience of seeing palliative care patients in this setting. A total of nine GPs came forward, which was slightly short of the target of 10 (Table 1). No further recruitment drive was undertaken at this stage, due to abundantly rich data from nine interviews. This is explained further in our discussion.

Data collection

Semi-structured interviews were undertaken and audiotaped, and field-notes were taken by the principal investigator (MT). The shortest interview was 39 min, the longest interview was 1 h 21 min, and the average interview duration was 58 min. Interviews were transcribed verbatim.

Data analysis

Transcript data were analysed by both MT and AN using Interpretative Phenomenological Analysis (IPA). This research process seeks to 'make sense of the participant making sense of their own world' while allowing the researcher to interpret the participant's perspectives.[9,10] IPA is based on an idiographic approach, beginning with a single case as a basis to develop more general categories developed in a detailed case-by-case analysis.

Each transcript was read and re-read in turn by both investigators to increase reliability, and important comments and reflections, deemed relevant to the overall theme, were highlighted. These comments were then categorized into themes by the principal investigator (MT) and coded accordingly. This was achieved by interpreting them in the general context of the topic. AN then re-read the transcripts and added or grouped topics using the same coding system. Master themes were then identified and agreed upon by both researchers, categorizing individual themes and checking for cross-over of themes in other interviews. AN is an experienced qualitative researcher with a special interest in IPA. AN reviewed emerging findings individually and then discussed the structure of categories with MT. In summary, the transcripts were systematically analysed in the following stages:

- Preliminary reading, where the first transcript was read line-by-line and annotated with initial comments.
- Early analysis, for which initial comments were grouped into themes.
- Higher level abstraction: connections between themes were developed until an organized master list and thematic account of the case was achieved.
- Subsequent transcripts: new emerging themes were tested against the previous transcripts and non-recurring themes were tested against subsequent transcripts. Connections across cases were noted in order to identify a set of superordinate themes for the group.
- Attention was paid to the relationship between language use, including choice of vocabulary and use of metaphor, and the content of speech.

Results

GPs interviewed were keen to talk about the way the system they worked in was set up. The process-driven aspects of working in out-of-hours shifts relating specifically to palliative care were described and discussed. This theme was categorized into the following superordinate themes:

- Motivation.
- Time-pressure constraints and continuity.
- The out-of-hours doctor within the domain of palliative care.
- Isolation within system.

Motivation

The opening question in all interviews was 'why do you do out-of-hours work?'; this was asked as an 'ice-breaker' question to get the interview going, but generated some data on the motivating factors for doing these antisocial shift hours. All bar one of the GPs interviewed stated that money was a key factor for doing out-of-hours work, and not all seemed comfortable in admitting this. Examples of such statements are shown below.

GP1: Why? I mean, the main reason is I have credit cards bills to pay (laughs), obviously extra money...

During the interview the GP appeared to be uncomfortable, stating that money was a strong influence on her decision to do out-of-hours work and then laughing, perhaps signifying embarrassment, after stating her motivation (as did GP3, see below). Nearly all GPs mitigated the financial aspect by giving further reasons immediately preceding or after stating that the good pay was important to them. This indicates that they felt guilt when giving this as a reason for doing this work and therefore needed to qualify it with another motivating factor.

*GP5: (...)to fund expensive habits. It's purely. I do it, because I **can**, and because **it pays**, and because I do quite **enjoy it**, so, if I stop enjoying it, I'll stop doing it.*
GP7: And of course monetary reasons are always there, I mean, all of us work to make a living and it pays quite well. No, but I do enjoy the challenge (...)

It was rarer to find GPs who gave purely financial reasons as a motivating factor, such as GP2.

GP2: Well, I'd say I do out-of-hours, out of necessity really, erm, money (...) I have to supplement my income by working out-of-hours.

Interestingly, GP4 felt that a large proportion of out-of-hours doctors in general were money-oriented and/or could not find work elsewhere.

MT: Just from what you just said, what sort of GPs are attracted into out-of-hours?
GP4: Greedy ones, want more money. Ones who don't get enough work. (sighs)

In summary, within this group of GPs there was a common theme of financial motivation, with some GPs more comfortable admitting this than others, but there were other factors such as the excitement this work occasionally can offer. It appeared that a number of GPs would not continue with this work if it did not pay well.

Time-pressure constraints

All GPs commented on time-pressure constraints within a busy out-of-hours system in the context of seeing palliative care patients. Comments had a common theme, that of clock-watching and need for patient turnover on the one hand, versus the doctor's moral duty to spend adequate time with palliative care patients on the other. These points are illustrated by the pairings of oppositional extracts from several interviewees.

GP1: ...there is a certain pressure when you're on your visits (...) to get them done really.

Versus:

GP1: ...if someone (palliative) needs an hour or even two hours you have to do it.

In these statements, GP1 sees a busy out-of-hours system in opposition to the needs of an out-of-hours palliative care patient population; they are antagonistic and in her mind cannot be married together.

GP1: ...she (patient) needed a lot of time and you probably don't really have that usually.

Other GPs made similar statements, reflecting on this antagonistic relationship.

GP2: Because I may have other calls, I may not have the time to ring around and ask for people to come to the phone, much as I would like to.
GP3: ...the doctor might be already out with six calls, of which that will be the next call, the seventh call, so whether they read what they get, whether they have the time...

GP4 was particularly descriptive when reflecting back on out-of-hours palliative care experiences, using words like 'under pressure', 'anxiety', a 'little time-keeper' on his shoulder, and the service 'breathing down his neck', perhaps indicating the potential for emotional distress these time pressures could have for the out-of-hours doctor, especially when seeing a palliative care patient.

GP4: . . .under pressure to see the next case. . .
GP4: . . .they (palliative care patient) take longer, so there's a certain amount of anxiety if it's busy.
GP4: . . .always that little time-keeper on your shoulder saying 'Oh, you're taking too long'.
GP4: . . .they may be breathing down your neck saying 'you're going to breech'.
GP4: The only thing that didn't look good was that I was there for over an hour. . .and I don't think the out-of-hours (service) were too chuffed about it.

Interestingly, GP5 felt guilty during the interview about calling palliative care patients '*time-consuming*' in the out-of-hours setting, seeing this as her putting her own selfish need (that of getting through the list of patients to be seen), as a direct contrast to what palliative care patients deserve.

GP5: Just from my, just on a very sort of selfish way, personal way, it's it is, I perceive it as much more time-consuming. And I don't mean that critically and I know it has to [be done].

GP6 saw it from the point of view of the triage doctor at the base (who allocated house calls to the mobile doctor) and that palliative care calls lost a doctor from the service for about an hour.

GP6: Problem with that obviously is, it's again, mobile doctor goes in there and then you lose one mobile doctor, which usually, that can take an hour out of their time and that's not good for the whole service.

GP7 made the same observation from a telephone triage doctor's point of view.

GP7: That makes it easier, but then you sometimes think you can't get the GP out every time, because there are limitations, limitations to how many people they can see and they haven't got so much time and so on.

GP9 went as far as stating that the time-pressure factor meant that palliative care patients out-of-hours were 'heart sinks' for her.

GP9: . . .if you're having a really busy night and you're perhaps felt under pressure to be getting round and you knew, perhaps, anticipated that it might be lengthy, errm, then maybe a heart-sink moment.
GP9: . . .might briefly think 'oh God not a palliative!'

She also gave reasons for why these consultations take longer; she appears to be not entirely comfortable talking about this, perhaps because it reveals her more sensitive side.

GP9: . . .my heart, I, you know, doesn't sink too much, because errm, you know, I just, I know I'm just going to have to approach the situation in a, (silence 2 seconds), sensitive (says this slightly mockingly) way, more sensitive and tip-toey than other out-of-hours stuff, and that we'll get there in the end (laughs). . .

Therefore, a few common threads become apparent running through the sub-theme of 'time-pressure constraints'. GPs felt rushed, and juxtaposed this need for speed and efficiency against the needs that palliative care patients and their carers might have in out-of-hours settings. This begs the question as to how out-of-hours doctors feel within the domain of palliative care, which is covered in the next sub-theme.

The out-of-hours doctor within the domain of palliative care

This theme emerged in a later interview and prompted a review of previous data with this area in mind. How do out-of-hours doctors see themselves within the domain of palliative care, or how do they see themselves fitting in, if at all? What views do these doctors have of palliative care, and how confident do they feel dealing with patients? GP5 found it difficult to bring together the ethos of out-of-hours and that of palliative medicine; one being an acute, fast-paced service, the other requiring time and listening skills.

*GP5: . . .the hardest things to deal with is the families, with a lot of these patients, errm, because, (silence 2 seconds) (sighs loudly) because it's **their** expectations of what's necessary and with all the turmoil that is going on it's just not like many of the other things you see in out-of-hours, and while quite rightly palliative care is making things as easy and as comfortable as we can, there's some things that we can't do, or we can't look at or haven't the time for.*

GP4 felt similar, actually dissociating palliative care from acute care ('proper doc') completely, therefore seeing them as opposites on a spectrum with little cross-over. He does retract half-way through (perhaps realizing that the interviewer is a palliative care doctor),

but the acute versus non-acute (i.e. palliative) message remains.

GP4: It may be that they've got a UTI, so you've got to try and think part is palliative care doc, part is proper doc, well, not proper doc, well, not proper doc that's a rubbish thing to say isn't it, but part of it is this sort of more usual out-of-hours thing, the acute side…

When it came to discussing goals with patients, GP4 had also clearly had some experiences out-of-hours that he had been uncomfortable with, ever aware of himself as a 'stranger' in the patient's care trajectory.

GP4: …and then, one of the things I find difficult in palliative care, is you have to be honest about what you're trying to achieve, errm, you got to say 'look we're not going to cure you', and, I've had one or two situations in the out-of-hours palliative care which were quite bad, where it's clear that somebody hasn't realized, because they're not going to be cured. And no one's really told them that and if they have they haven't really taken that on board for whatever reason.
GP4: …and you might be the wrong person to do it, they might get quite upset when it's a stranger who doesn't really know them.

This lack of familiarity with patients in the out-of-hours care system appears to be a problem within the domain of palliative care. GPs commented on the difficulties this unfamiliarity brought, and the feeling of stress evoked by it. GP8 acknowledged that the out-of-hours doctor sometimes came into the patient's life at a time of drastic change, and that an unfamiliar face did not ease this transition.

GP8: …you probably think it's going to be a stressful consultation, because, errm, because just you don't know that patient, don't know the relatives…
GP8: …they didn't anticipate what the next step would be and you're coming as a new face to do it, I think that's really a challenge, that's really something I'm not confident about.

GP4 made comparison with the in-hours system, where a deeper relationship had been allowed to develop, explaining that this allowed for more honesty or perhaps candour when it came to difficult decision making in palliative care situations.

GP4: …a much better relationship with patients (in-hours), you can be much more frank perhaps, and that's more difficult if you just snow in for the first time with your out-of-hours hat on, you can never be that familiar as with your own patients who you know.
GP4: You just don't have the background information to be honest and say 'look, this is how it is'.
GP4: Others will say 'No, send me in, send me in' and you say 'Do you really mean that? Are you going to be disappointed by this later?'. You don't know the patient and that can be challenging.

For GP8 there was a prevailing attitude of suspicion towards out-of-hours doctors amongst patients and carers, and felt this was reasonable given that the doctor was not a regular face in the patient's health world.

GP8: …they're much more likely to errm, to trust people who they know already like their regular doctor, rather than a new face and they could be a bit more suspicious of that, I think.

This theme also came up in other interviews. It demonstrates the doctors' awareness of their reputation within the media and the general public, and appears to affect their confidence, certainly when seeing palliative care patients as a group out-of-hours. GP6 describes his frustration at coming to households where patients and relatives expect to be 'fobbed off' by the out-of-hours doctor, whilst GP8 talks about a built-in suspicion that people have about out-of-hours services.

GP6: And half the time, that's the other problem, errm, half the time the relatives get their arms up before you see them, because they're expecting a bad service because they heard about out-of-hours this, out-of-hours that, they basically have, they basically don't expect they're going to get a good service and that you're going to fob them off.
GP8: And people have a built-in suspicion of out-of-hours anyway, they've maybe had bad experiences or they've been told something bad about it.

GP9 felt that she had to prove extra competence and assuredness in light of these low expectations of her. Again, the words 'fobbed off' come up, and she describes a phenomenon where patients and carers feel that 'out-of-hours doctor' and 'locum' are dirty words, implying that patients find the irregularity and lack of continuity both frustrating and untrustworthy. The fact that the out-of-hours doctor has to deal with these preconceptions does not help the mutual trust needed in an out-of-hours palliative care scenario.

GP9: …but with out-of-hours you've often then got a family and they've been waiting and they may have low

expectations from an out-of-hours doctor and they're already on the defensive.
GP9: So you have to, errm (silence 2 seconds), you may have more of a thing to prove yourself, don't know if that's the right word, but you want them to have confidence in you.
GP9: Because for some patients, not all but for some out-of-hours is a dirty word, bit like locum doctor (laughs). They assume they'll get a bad service and be fobbed off.
GP9: Because there's been so much bad press about out-of-hours and patients can't get access to their own GPs these days etc I wonder, or I worry I guess that when it's a complicated situation that their GP knows so well, and they've got someone turning up they don't know.

These statements make for interesting reading next to the following extracts about GP3's attitude towards her own in-hours patients and the out-of-hours service. She does not want to 'leave them' to the out-of-hours system that she works for herself.

GP3: (Talking about her in-hours GP role) . . .and they've (palliative care patients) gone down hill and you've been looking after them all the time (. . .) you don't want to leave them to an unknown system (out-of-hours service).

Thus, the topic of 'out-of-hours doctors within the domain of palliative care' gives an insight into some of the prevailing attitudes within this select group of doctors, and how they see themselves within a subspecialty (palliative care) that has a lot of cross-over with their own, broader field of out-of-hours general practice.

Isolation within system

Contributing to doctors' feeling of isolation in the out-of-hours system was a perceived lack of communication with the in-hours GP. Only one example is given here, but all interviewees perceived this as a major problem.

*GP5: . . .there's always room to improve things (silence 2 seconds) for getting things set up, I think, one of the real problems, of what **doesn't** happen is, if you've got someone who's going off, even if it's just a fax to the out-of-hours on a Friday evening from the in-hours GP saying 'this person's not very well', you know, and I think maybe getting more into a routine of doing that so it means you've got rough idea of what's going on.*

Many GPs felt that written notes at the patient's home should be compulsory. GP9 implies in another statement that a lot of doctors need to be forced to do things, and that they are intrinsically bad at keeping notes, and that it is rare to find an entry by a doctor in the patient's nursing file. For her, this contributes to the feeling of isolation for out-of-hours doctors asked to assess someone at home. She qualifies this with a more specific example, that of finding herself in a nursing home and asked to complete a 'do not resuscitate' form for a patient she does not know.

GP9: . . .that that would be useful for is, 'do not resuscitate' orders, errm. Mainly, because, it's just not a very nice thing to have to talk about out-of-hours, somebody's not very well, like that, and errm (silence 2 seconds). I have been called to situations perhaps I've, in nursing homes, where there's not been a 'do not resuscitate' order on people, that should have had them, that had been palliative cases.
GP9: . . .(reflecting on a nursing home patient) would have been useful to have some kind of notes. With some kind of plan, 'if this happens don't transfer and I've discussed with the patient'. That would have been very useful if the GP could have made at least some sort of basic plan.

It was felt that one of the downsides of isolated working out-of-hours was the lack of face-to-face interactions with other healthcare staff, but also with patients.

GP7: . . .lack of confidence or lack of trust on the part of GPs, if the nurse is asking 'Can I increase the dose of Haloperidol?' or 'Can I increase the dose of Metoclopramide or Diamorphine?' or whatever, the trouble it starts, because you haven't seen physically the patient.
GP7: . . .you don't (says this loudly) know the patient, you have not seen the patient, and I find it unsafe doing this. . .

There is a strong sense of this isolation from most of the interviews, as exemplified by the use of vocabulary in the following excerpts. The use of words like 'alone', 'isolated', 'no one else around', 'out there', 'just me', and 'desert' clearly demonstrate the vulnerability experienced by participants.

GP8: At least people can advise you and then you feel a bit less alone out there.
GP6: . . .no one else around to prescribe it but me. . .
GP5: . . .I suppose it can feel quite isolated out-of-hours errm, probably wouldn't want to do it all the time really.
GP2: . . .when I'm doing out-of-hours basically it's just me, there isn't much contact, you feel like you've got to get through it alone a bit more.
GP2: It sort of becomes like, once working times are over it's like a desert. So you're pretty much restricted in what's available to you.

This GP (GP2) uses the description of the weekend as a desert, with most of the normal services and contacts being gone. GP2 then goes on to paint us a very grim picture to describe his feeling of isolation in out-of-hours: it's raining; it's three o'clock in the morning; he's in the middle of nowhere.

GP2: . . .So the knowledge is there, but it's the question of drawing it out at that time, when it's you know three o'clock in the morning, and you know, it's raining and in the middle of nowhere, where you know it's difficult to access things. . .

Table 2 gives examples of isolation in the context of not accessing specialist advice. Therefore, isolation within the out-of-hours system manifested itself for these GPs in descriptive accounts of a lack of face-to-face contact with other health professionals, of the fact that a lot of work had to be done over the phone and that it was not always clear to them whether to call someone, and whom.

Discussion and comparison with existing literature

Financial motivation was a strong focus for entering out-of-hours work. It appeared that a number of GPs would not continue with this work if it were not paid well. This is consistent with studies before and after the 2004 General Medical Services (GMS) contract in the UK, looking at GPs' job satisfaction in England. Prior to the new contract, when most GPs were still doing out-of-hours work, GP job satisfaction had fallen to its lowest point in over a decade, according to a survey published in the British Medical Journal.[11] Compared with a study 3 years after the introduction of the new contract, views had changed and there was an overall increase in job satisfaction, which was associated with an increase in pay and being able to *opt out* of out-of-hours provision altogether.[12] This suggests that out-of-hours provision is not popular amongst GPs, and that the Cardiff-based out-of-hours GPs questioned for this study were amongst a minority who were willing to continue working antisocial shifts, for appropriate pay. Interestingly, one GP interviewed in the research project suggested that the out-of-hours setting might attract doctors who could not find work elsewhere.

Time-pressure constraints within a busy out-of-hours system were seen as a problem. A common theme was that of the need for patient turnover on the one hand, versus each individual doctor's moral duty to spend adequate time with palliative care patients on the other, and this caused out-of-hours doctors some distress.

Out-of-hours doctors had differing views about finding themselves within the domain of palliative care, some finding it difficult to bring together the ethos of out-of-hours and that of palliative medicine – one being an acute, fast-paced service, the other requiring time and listening skills. This is consistent with Worth's qualitative study prior to the introduction of the new GMS contract, where GPs expressed 'concern about delivering good palliative care within the constraints of a generic acute service, and problems accessing other health and social care services'.[1] Furthermore, doctors commented on their difficult position of being 'strangers' in patients' palliative care trajectories, and being eyed with suspicion by them and their carers. Out-of-hours doctors felt that they were perceived as second-rate doctors by the media, patients and carers.

Isolation was in part caused by lack of knowledge about who to call for help in palliative matters on the one hand, whilst missing face-to-face interactions with professional colleagues and feeling that out-of-hours was like a desert on the other hand. GPs working out-of-hours shifts also expressed concern at not having a plan of care or handover information available to them. Access to shared electronic care records and implementation of handover via forms sent from in-hours practices to out-of-hours providers (as provided by the Gold Standards Framework) could address this isolated work pattern. This is already being implemented in some parts of the UK and should become standard practice for all regions. It would be worth considering why some regions are not implementing the available handover systems.

Lack of knowledge from some out-of-hours doctors on how to contact specialist palliative care services should be addressed urgently; one way of addressing this is to make familiarization with palliative care advice services, such as telephone numbers, mandatory for GPs who work in out-of-hours settings.

These interviews provided a useful platform for doctors working in a UK out-of-hours setting to evaluate what they felt was important in the palliative care encounters they face, and the data lent support to the notion that out-of-hours doctors lack confidence in this aspect of their out-of-hours work.

The study had nine participants, which was short of the desired target of 10; however, no further recruitment drive was undertaken. As complex 'creatures' (or a very specific group of doctors), the focus needs to be on a smaller number. IPA offers a detailed account of human experience. Historically, researchers seeking to make an impact in research settings are more familiar with quantitative paradigms, and this has meant using larger sample size numbers to appease reviewers.[13] Smith now suggests just 3–6 participants as a reasonable size for a student project. This number allows the identification of similarities and differences per group without overwhelming the rich description.

For this study, nine GPs were interviewed to allow for differences in perspective (gender, location, age or

Table 1. Participant details

Interviewee	Gender	Age	Year Graduated (UK or overseas)	Number of years worked as GP	Any palliative care work or junior doctor training posts?	In-hours job and sessions per week	Out-of-hours sessions per month
GP1	F	35	1997 (UK)	6	Diploma, short hospice placement	GP partner 6 sessions	4
GP2	M	41	1991 (overseas)	3	No	Locum GP 3-7 sessions	6
GP3	F	51	1980 (UK)	24	No	GP partner 6 sessions	2
GP4	M	37	1995 (UK)	2	No	Salaried GP 9 sessions	4
GP5	F	40	Could not remember at interview (UK)	15	No	GP partner 6 sessions	4
GP6	M	39	1995 (overseas)	5	No	Locum GP 6-8 sessions	8
GP7	M	58	Could not remember at interview (overseas)	18	No	Locum GP 3-5 sessions	8–12
GP8	F	28	2003 (UK)	3	No	Salaried GP 3 sessions	4
GP9	F	34	1998 (UK)	5	No	Salaried 4 sessions	2–4

Table 2. Isolation and not asking for specialist advice

GP4: . . .not every out-of-hours doctor actually knows who to ask for help. . .
GP4: . . .they (out-of-hours doctors) just try to trouble-shoot themselves, leave it to the next shift or the patient's own GP next day, rather than picking up the phone.

Isolation in the out-of-hours system gets accentuated perhaps by GP's lack of knowledge of who to ask for help and advice, and a culture of doing everything alone is allowed to develop.
GP2 is interesting in this context and gives little evidence of knowing how he would go about getting specialist advice out-of-hours. He goes on to recount a patient encounter where specialist advice may have been useful, but it does not enter the conversation that he could/should have attempted to get a second opinion.

GP2: Errm (silence) shortness of breath I've dealt with on one occasion, but errm, there wasn't much I could do, because the patient didn't want to go in. You know symptom control was bad and I wasn't comfortable in writing anything up that could help the patient, errm, so, because it was getting close to morning hours, I made sure a message was sent to her GP, errm, to make sure he could pay a house visit before starting his surgery. . .
MT: So this was an out-of-hours visit in the early hours of the morning?
GP2: Early hours of the morning, I think it was nearly five or six o'clock.
MT: You said you didn't feel comfortable to prescribe?
GP2: She, was short of breath. I can't remember exactly what she had, she was short of breath, I asked her, that I, I explained to her that I couldn't find anything to try and help her, to ease her symptom, how would she feel about going into hospital, and I suppose I didn't feel happy at the fact that, errm, I hadn't been able to provide a solution to her problem, to, you know, hadn't been able to actually achieve or do anything, the only thing I could do was respect her and her families wishes, and I suppose, pass the buck on to her GP. It wasn't satisfying; I didn't feel like a satisfying talk. But I suppose what the patient wanted was more important than what I, how I felt about it.(silence 2 seconds)

He comes back to this patient later in the interview:

GP2: I felt bad at the fact that in a way I was, I felt I was passing the buck on, rather than errm, providing her with a solution. Errm. I would say that was difficult. I didn't know what to do for that patient's shortness of breath and I probably should have.
MT: Mmh (silence 1 second)
MT: Is there anything that you would change now if you would go back to that, anything you would do different?
GP2: I suppose, errm, having had this little chat today, I think it's made me think, I'd ask maybe where I work to have a list of numbers for the out-of-hours palliative nurse available. I'd also, I suppose make an effort to get to know them, you know so that errm, here's a name and here's a number and here's a face.

This GP's solution for his feeling of isolation within out-of-hours seems to be putting a face to a name (of another healthcare professional), and he is keen to try and get to know people he may have to contact by phone. Perhaps he is used to this from his in-hours GP work, and not knowing on-call palliative staff out-of-hours is such an issue for him that he is less inclined to call for help.

other). In fact, the sample was a consistent group with no real differences emerging, meaning that the final number of nine did not have to be increased.

Limitations of study

A weakness of this study is the fact that all nine GPs did both in-hours general practice work in addition to out-of-hours work. It would have been interesting to interview GPs who work exclusively out-of-hours, and this could form a future project. A further weakness is the study's geographical focus (South Wales, UK), which may make generalizability more difficult. However, many out-of-hours services across the UK are structured similarly and, having been in the media's focus for some time now, they should draw important lessons from one another.[14,15]

Future research

Some of the comments made by GPs expressed concern about their isolated working patterns, and this is something that needs to be addressed. Figures published by the General Medical Council have shown that GPs who work on their own are six times more likely to attend a disciplinary hearing than those working in group practices,[16] and the NHS is aware of the problems that can face lone workers.[17] Future research should focus on an organizational review of how out-of-hours doctors could feel less isolated and more included in decision-making processes for out-of-hours palliative care situations. Improving knowledge of how GPs can access specialist palliative care day and night and using examples of excellence could be a further area of research. Change management should focus on the reasons why some areas of the UK are succeeding in creating handover systems between in-hours and out-of-hours services, while others are not.

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Ethics approval

This study received ethics approval from South East Wales Research Ethics Committee (Tel. 02920 376822) on 31 March 2008.

Competing interests

All authors declare that there is no competing interest.

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