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Rotating GPs

INVITERT KOMMENTAR

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In rural Norwegian municipalities, the GP service is increasingly staffed by doctors on work-leave rotation. What do we gain from this, and what do we lose?

'When I grow up, I'm going to be a country doctor,' says Linus in the Peanuts cartoon to his big sister Lucy. 'Ha! I can just see you living in the country', she responds, whereupon Linus retorts: 'I didn't say I'd live in the country. I'll commute from the city in my sports car!' (1).

Work-leave rotation – also known as 'North Sea shift' – would probably have suited Linus well. This form of working has become fairly common among GPs in rural Norwegian municipalities, where two weeks on and two weeks off is a frequently used schedule. Prestgaard et al. at the National Centre for Rural Medicine have now surveyed this form of working in 25 municipalities (2). An unpublished survey conducted by the Norwegian Association of Local and Regional Authorities (KS) in the autumn of 2023 including 205 municipalities found that 18 % practised work-leave rotation. In municipalities with less than 2 000 inhabitants, the proportion was as high as 38 % (2). The number of Norwegian municipalities that base their GP service on work-leave rotation is thus considerable, with an increasing tendency over the last decade.

The explanation for this development may appear simple: it's merely a solution that has pushed itself forward. The recruitment crisis in GP services in small and remote municipalities has been critical for many years (3). The medical profession is changing, and recently qualified doctors do not permit their professional role to define their entire identity and family life (4). The workload involved in being a full-time 'country doctor' may be perceived as unacceptable, for example due to frequent duty periods. Entering a work-leave rotation

scheme is significantly more attractive. In the study by Prestgaard et al., there were as many as ten applicants for each vacancy. In this way, the municipalities can solve their staffing problem, and the doctors are in a job situation that they prefer. In other words: a clear win-win situation for employer and employee.

> ***«The municipalities solve their staffing problem, and the doctors are in a job situation that they prefer. In other words: a clear win-win situation for employer and employee. But what about the service users? And how much does it cost?»***

But what about the service users – the patients and the doctors' various cooperation partners? And how much does it cost? None of this has been identified, including in the study by Prestgaard et al. We can therefore only speculate. It seems obvious that relating to multiple doctors who work on a rotating schedule rather than to a single contract GP is more demanding for the patient, and it can also have negative consequences for diagnostics and treatment.

The work of a contract GP is characterised by brief consultations, but in a long-term context (5). This means that the same patients come in over time, be it because of new symptoms or for scheduled check-ups. In this way, a relationship of trust is gradually established between the doctor and the patient. It is claimed that the doctor-patient relationship accounts for 30 % of the therapeutic effect (6). Continuity in the doctor-patient relationship is so crucial that it prolongs life expectancy, to the greatest extent in patients with chronic diseases (7). In another study, which showed that low continuity in contract GP relationships was associated with increased mortality in patients with various chronic conditions, good methods for transfer of information and administrative procedures from one doctor to the next largely served to counteract the effect of changing doctors (8). Doctors on work-leave rotation therefore ought to put some effort into familiarising themselves with what the previous doctor has done. The same applies to cooperation partners such as the Norwegian Labour and Welfare Administration (NAV), the home-based services and the public health nurse.

'The current schedule costs us dearly', said the director of health and welfare services in Bindal municipality to the local newspaper (9). The exact figure is hard to determine, since the doctors' contracts are negotiated locally and there is no common system of agreements for such positions. Whether doctors in work-leave rotation schemes will have their service approved as specialisation training remains unclear, and practices vary (2). 'What's positive is that now we have stable contract GPs,' the director of health and welfare services continues. She is thus in agreement with the informants in the study by Prestgaard et al., where there was broad consensus that permanent doctors are the best solution, and that rotating doctors are better than locums. Being as it is, the situation calls for a national contract framework and unambiguous rules for specialisation training, as well as quality assurance of how doctors in a work-leave rotation scheme can provide the best possible health services.

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