RAWP and the Oxford Region*

Part II—The hub of the problem

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From last month (January 1978) hospital doctors in the Oxfordshire Area Health Authority (Teaching) were to be given a list of cheaper "recommended drugs" to prescribe for a series of common conditions. Any doctor who wants to prescribe a costlier alternative will be free to do so, but he will have to make the extra effort of filling in a special form. "So doctors will think twice," said Professor David Weatherall, Nuffield Professor of Clinical Medicine at Oxford University Medical School. "It will mean that most clinicians will use cheaper drugs, unless there is a clear clinical indication for a more expensive alternative."

The teaching centre has also introduced a "prescription of the week" assessment, in which a team of clinicians from the Department of Clinical Pharmacology reviews the efficacy of various drugs used for specific conditions and any adverse reactions. "Doctors who have not got time to study *Which?*-type reports on drugs then see what is involved in ordering fancy trade names," said Professor Weatherall.

Best buys

This cost-orientated attitude to medicine with clinicians urged to look for best buys is part of the new money-centred approach to medicine imposed on the Oxfordshire AHA by the economies and cuts that have flowed from the Resource Allocation Working Party (RAWP) proposals. Unfortunately, the economies came at a bad time for Oxfordshire, which was in the midst of a major reorganisation of its health care and medical school. The most acute problems are now centred on the £25m John Radcliffe Hospital Phase 2 at Headington, which is due to be completed this year. Originally this modern hospital was planned to provide 470 beds to take over the functions of an acute hospital from the Radcliffe Infirmary in North Oxford, an overcrowded, partly huttred hospital, much of which was outdated and run down. Now the planners have had to look at fresh options.

With the prospect of £4m less (at 1976 prices) in the Area Health Authority's annual budget of £42.5m it seemed possible that the AHA would have to keep the new phase 2 hospital closed. But (as I mentioned last week) the Secretary of State rejected outright the idea of the building's becoming a white elephant, and that now seems an unlikely course. Somehow the administrators have to find an extra £750 000 per year to open and run the new hospital on an economy basis.

Over the last 25 years the population of Oxfordshire has increased by 52% to 543 000. The burden of a population all but bursting its seams and an expanded teaching role has fallen heavily on the Radcliffe Infirmary, the only emergency hospital in Oxford. A plaque inside proudly proclaims that an original part of the hospital, opened in 1770, has "never closed." There are huttred wards (which occasionally get waterlogged in wet weather) and the corridors team with human traffic in the main building. As the only district general hospital, the Radcliffe Infirmary takes the bulk of the emergencies from the Oxford

area. It has roughly 140 surgical and 150 acute medical beds, and a variable further number of beds spread over specialties such as paediatrics, neurosurgery, and the accident service. A 16-bed "holding ward" with a maximum stay of 24 hours does much to relieve pressures from overnight admission of patients who, for example, are suffering from drug overdoses.

"Because there is no other acute hospital in the immediate vicinity, the emergency admissions can put an almost intolerable strain on the hospital organisation," said Professor Weatherall. "The turnover of patients is rapid, and many patients are discharged earlier than the physicians think right. A patient with an uncomplicated coronary, for instance, may be discharged in less than a week." Though the clinicians take pride in their professional skill that has earned them the record for one of the fastest rates of bed turnover in the country, they now feel they are pushing the danger limits.

Staff shortages have closed wards, and the constant reshuffling of patients in wards and the poor facilities in huttred wards have all helped to bring down morale, especially among junior medical staff and nurses. Yet, despite its troubles, Radcliffe Infirmary gives an appearance of confidence and manages to avoid an air of pervading crisis. The accident department exemplifies the hospital's problems. With a higher-than-average incidence of traffic accidents, the casualty attendance varies from 80 to 100 a day. "With present staffing it can mean that it is not unknown for a child who has a skateboard accident to wait six hours with a broken collar bone before he is seen by a doctor," said Mr John Spivey, a consultant orthopaedic surgeon. A tractor driver with a lacerated thumb, among those in the busy department, confirmed the long delay: he had waited several hours to see a doctor that day.

Mr Spivey spoke of tensions that had built up among clinicians, particularly those who believed that insufficient attention had been paid to their problems by the planners. For example, the opening of the new phase of the John Radcliffe Hospital will mean a transfer of some 470 beds, leaving the rest behind. "When we move to the new hospital we will have to reduce our 80 beds for trauma to 60," he explained. "Everyone, naturally, is fighting for his own specialty—but as we have 600 beds, moving to a hospital with only 470 beds is like trying to get a quart into a pint pot."

"One specialty that has been squeezed out completely is neurosurgery; so patients with suspected head injuries will have to be brought from the casualty department of John Radcliffe two miles by ambulance to the neurosurgeon at the infirmary, and maybe back again."

Effects on teaching

The factors which make the Radcliffe Infirmary so stressing for the practice of medicine make it also less satisfactory for teaching students and house staff. How can students schooled in the need for the highest standards and scrupulous care for detail be turned into good, safe clinicians when they see with their own eyes their mentors daily "cutting corners" and not doing things quite by the book? That was one of the anxieties voiced by Professor Weatherall. With such a rapid bed turnover students had real difficulty in catching the patients on whom they were to

*Last week's article (p 426) described the economies being forced upon the Oxford Regional Health Authority by the DHSS's reallocation of resources (RAWP).

learn. There were no beds for research either. Outpatient tuition is often a communal affair, with four clinicians, each with two students, and four patients crowded in one small room.

With the need for training more doctors, the University Grants Commission agreed to contribute £4m plus £250 000 a year towards student accommodation when the medical school was transferred to John Radcliffe Hospital, boosting the student intake from 70 to 100. Despite this, Oxford University had not been successful in negotiating any beds specifically for research or teaching in either the new hospital or the existing infirmary. "This is an intolerable state of affairs for a major teaching centre," said Professor Weatherall. If perpetuated, he believed it would make it difficult to attract staff of high calibre and teaching standards would fall. Faced with little alternative, the university was inclined to believe that the so-called level transfer of existing beds at the infirmary to the new hospital would be the best start. But teaching and research activities needed to be given high priority in the expansion of beds as soon as possible. Even so, there is going to be an embarrassingly high student:patient ratio of 1 to 2.6 compared with 1 to 3.7 at present.

Professor Weatherall had not given up hope of finding more money. It was possible that if the AHA made a fresh approach to the Department of Health with its problems and the university were to add its weight on the educational needs of the clinical school, then the DHSS might relent, he thought.

Zero growth—zero hour

There is, however, another aspect to the financial problems. Though there is still confusion and undisguised bitterness in some quarters, a remarkable feature of the crisis—dubbed by one report as "zero growth-zero hour"—is the way administrators and doctors have put their heads together to tackle the common challenge, showing in the process that necessity can be the mother of innovation.

As well as the move towards a standard drugs sheet, economies include an attempt to save much of the £186 000 spent on outpatient drugs by referring patients back to their GPs for their prescriptions. Delighted as the area is at the prospect of saving at least £50 000 a year from an annual drugs bill of £1 376 000 by such moves, Dr Alexander Gatherer, Area Medical Officer, is still troubled.

"The speed at which we have got to balance our budget is forcing us to accept decisions which raise broad questions of principle," he said. "We were going along with a well-thought-out strategy. There was a clear need to bring together on one site specialties and facilities that had been scattered around the City of Oxford, and that was the rationale for the new John Radcliffe Hospital."

Shopping list

"The biggest setback has been the speed with which the brakes have gone on," he continued. The AHA "shopping list" of possible solutions to the gap between income and expenditure included many possibilities that seemed to be counter-productive. They included:

(a) Solving the overcrowding in the Radcliffe Infirmary by transferring all but a few departments to the new hospital (and overcrowding that instead), giving a saving of £600 000 per annum.

(b) Closing most of the 478-bed Churchill Hospital, an old, mainly one- and two-storey military hospital built during the last war, and transferring the patients to the vacated infirmary. That, however, would save nothing—it would cost an extra £1.5m a year.

(c) Services could be generally reallocated—by using some smaller hospitals such as Watlington, Burford, Bicester, and

Brackley as day units and reducing the beds available in smaller hospitals. If the Slade Hospital were closed and some psychiatric services amalgamated the overall saving would be about £350 000 per annum.

Other possible alternatives under consideration, which would save money but which could lead to serious reductions in present services, included a 2% reduction in staffing levels (£600 000 saving), closing all cottage and community hospitals (£1m), and closing Warneford and Park Hospitals (£1m).

"We have the new John Radcliffe hospital nearly ready and I think it is a national scandal if we don't bring it into use," said Dr Gatherer. The AHA was frustrated by the fact that carefully integrated plans—particularly those to do something at last for "Cinderella patients" at the back of the queue—have been left in shreds. These patients include those with psychogeriatric conditions and handicapped mentally and chronic sick young adults. A start was being made to free them from outdated decaying premises, but all that had come to a halt.

Nor were all the dilemmas in the less glamorous specialties: physicians had found themselves philosophising about the relative merits of reductions in coronary bypass surgery and in expensive drugs used for Medical Research Council trials in childhood leukaemia.

More optimistic

After much recent discussion, both within the region and at the DHSS, Mr Donald Norton, the Regional Administrator, is more optimistic that the RHA will be able to overcome its financial difficulties. "I believe there are indications that the region is going to see an upturn," he said. "People are recognising that we are trying to manage our affairs in a responsible manner. We have succeeded in bringing our spending down, but staff have taken some very hard decisions. How soon population expansion will mean that we qualify for more cash is debatable. Even with the present likelihood of more cash in the immediate years ahead, it is unlikely we will receive the 1½% we need just to stand still. To some extent the DHSS has recognised the problem of Milton Keynes—as is shown by the additional allocation of £400 000 each year, divided equally between Northampton and Buckinghamshire. We must not keep calling woe. The DHSS considers that the region should do more to help itself by transferring capital funds to revenue and by using the proceeds from land sales and savings in management costs to ameliorate the effects of the problems being faced. This is now being looked at."

(to be concluded)

What should one do to survive when caught in a blizzard?

Survival drill under blizzard conditions is well established and is taught routinely in Scandinavia and other countries with large tracts of snow-covered country in winter. The first principle is to stop as soon as it is clear that it is not practicable to reach a fixed shelter. It should then be possible to prepare a snow shelter capable of maintaining life for several days. In its simplest form, this will be a pit dug in the snow, and roofed over so far as possible with skis and spare fabric for protection against the wind. A more advanced procedure is to dig into the side of a snowbank, angling the tunnel upward to keep warm air in, and to dig out a chamber at the end. With warm clothing, sleeping bag, and food there is no difficulty in surviving many days in these conditions. The essential point is to start to search for a suitable snowbank before the party is too exhausted for the work of preparing a shelter. Sometimes there is insufficient snow to dig a shelter; this is dangerous, and all that can be done is to find the best available shelter from the wind. People trapped in cars should have no trouble surviving provided they are warmly clothed, keep some air passage open through the snow, and do not gas themselves with carbon monoxide by running the engine.