Have We Enough?

The fact that is behind the collective decision of the Ministers is that the ratio of doctors to patients in Canada is rapidly decreasing; on 31 December 1972, it was one doctor to 633 Canadians and by 1981 it is estimated it will be one to 488.¹ The primary reason for this is immigration. From 1964 to 1969 the number of immigrant doctors exceeded the total output of all Canadian Medical Schools. A large proportion of these new Canadians came from Asia, Africa, and the Orient. In addition, under long and heavy pressure from the medical profession, the federal and provincial governments are slowly increasing the output of Canadian graduates. Yet in 1972, 1178 fully acceptable applicants were still turned away. It is very much cheaper to import doctors trained at some other country's expense than to build more medical schools.

Increasing output and heavy immigration combined are pushing the doctor-patient ratio rapidly downwards, especially in the cities and in the more popular provinces of Ontario and British Columbia. Each new doctor costs money; directly in that the average net income of doctors is now approaching \$45 000 per annum, and indirectly in their overhead costs and in their use of expensive hospital facilities.

Because as a nation we have contracted to supply all Canadians with all the care they need, before defining need as opposed to desire, nobody really knows how many doctors are necessary. We are developing statistics which show that in such special fields as neurosurgery and neurology, we can achieve a saturation point² but in the wide-open areas of family practice, paediatrics, and psychiatry, when is enough enough? To attempt to get some answers to these questions the federal government, with the co-operation of the profession, has established a nationwide manpower study. As Canadian doctors are paid on a fee-for-service basis, the computers are churning out an avalanche of statistics which tell us exactly who is doing what, where. Why, is open to cynical comment or emotional justification, depending on where you sit. Nevertheless, the analysis of these data, if

they are to be used as any kind of yardstick of need, must make some daunting assumptions.

Firstly, that all services that have been done were all done of necessity, and, secondly, that nothing that needed to be done was undone. When the unpredictable needs of medical advance are added and the traditional but temporarily decreased emigration of Canadian doctors to the United States is subtracted, and when the unknown impact of the various types of doctor assistants and substitutes is estimated, the final figures of the national manpower study will have to be accepted with a good deal of faith. The lessons of the Willinck Report have not gone unmarked on this side of the Atlantic.

Real Villains

The politicians must realize that they may as well act now under the pricks of increasing cost as wait for the questionable justification of the figures of the manpower study. Not surprisingly, the media have reacted strongly to their decision. Immigrant doctors have always made a considerable contribution to Canadian medicine. The profession, while assuming a posture of pious innocence, is not escaping the accusation that they are the real villains in the background, and that they have conned the innocent politicians into this decision solely to protect professional income.

It remains to be seen if under pressure our masters in Ottawa will stick to their guns. In the meantime, if any aspiring young doctors want to become Canadians, don't despair, there will always be room in Hungry Moose Creek.

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Social Medicine

Cost to National Health Service of Social Outcasts with Organic Disease

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Summary

The hospital medical records of a patient with chronic lung disease and intractable social problems have been analysed. Multiple admissions resulted in the patient spending nearly three years out of seven and a quarter years in Edinburgh hospitals and in the performance of repeated and often unnecessary medical investigations. Such patients are a source of considerable uneconomic

expense to the National Health Service, but at present it is difficult to see how their medical and social demands can be met in any other way.

Introduction

Much publicity has been given recently to the exploitation of the National Health Service by patients with so-called Munchausen's syndrome.¹ These people, for reasons which are not fully understood and are never divulged by the patient, manipulate their admission to hospital at frequent intervals, usually a different hospital each time, by presenting themselves to a casualty department, often in the middle of the night, with symptoms mimicking a medical or surgical emergency.

A less blatant but more common misuse of N.H.S. hospital facilities, for which the patients themselves are not wholly responsible, is made by patients, usually vagabonds or social

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outcasts, with chronic or relapsing disease who gain admission to many different hospitals on numerous occasions. The admission is ostensibly for treatment of a recurrence of the illness, but the patient's real motive may be to obtain a comfortable bed, nourishing meals, and other creature comforts when he is tired of sleeping rough or languishing in a lodging house. When such patients seek admission to hospital they are usually dirty and verminous and often drunk. The doctor who sees them is generally unaware of their medical background, but even if he is, he can seldom turn them away because they clearly have symptoms of organic disease. Once in hospital they are inevitably subjected to all the routine investigations and treatment which their condition seems to indicate, but within a few days when they are feeling better they become intolerant of the restrictions of hospital life and discharge themselves. The same sequence of events is then repeated days or weeks later in the same or, more often, another hospital.

These patients collectively make heavy demands on N.H.S. resources. They occupy valuable beds, and much time and effort is expended by hospital staff on their investigation and treatment, which may be unnecessarily repeated on innumerable occasions as they move from one hospital to another. The problems which these patients can present and their impact on N.H.S. expenditure are illustrated by the following case history.

Case Report

A 68-year-old man of no fixed abode was first admitted to hospital in Edinburgh in 1956 with bronchiectasis involving the left lower lobe and chronic bronchitis. He described himself as a self-employed dealer, having given up work as a labourer in 1944. He was separated from his wife and three step-children. In 1957 he served a prison sentence, after which his whereabouts were unknown until 1963, when the first of numerous admissions to Edinburgh hospitals with exacerbations of chronic bronchitis was recorded. In 1966 he received inpatient treatment for 10 months for pulmonary tuberculosis, and from then on he presented himself with increasing frequency to casualty departments in the Edinburgh area and usually had little difficulty in persuading medical staff to admit him. He claimed to have travelled widely throughout Scotland, and inquiries revealed that he had been admitted to almost every Glasgow hospital and also to hospitals in other parts of Scotland.

He was living rough or in lodging houses and usually arrived at hospital in a dirty condition, infested with lice and fleas, and often intoxicated or in police custody. He habitually produced purulent sputum, often with slight haemoptysis, which usually guaranteed his admission to hospital. On some occasions he had an acute exacerbation of his chronic bronchitis and bronchiectasis with some wheeze and systemic disturbance, but under normal circumstances many of these episodes could have been managed on an outpatient basis. Though he always complained of shortness of breath on exertion this obviously did not restrict his antisocial activities. Normally he did not have carbon dioxide retention, the partial pressure of oxygen in his arterial blood was seldom below 7.9 kPa (60 mm Hg), and his electrocardiogram never showed any evidence of right ventricular hypertrophy.

Attempts by various social work departments to provide him with sheltered accommodation always failed because he either refused to take up this accommodation or absconded a few days later. He often needed a new set of clothes when he was admitted to hospital because his own had to be incinerated. Sometimes his behaviour was meek and mild but at others it was paranoid and abusive. A sure way of precipitating self-discharge was to forbid him to smoke.

His case records from January 1967 to March 1974 in all the Edinburgh hospitals to which he was admitted were analysed for length of stay, investigation, and treatment. During this time he spent a total of 1000 days in hospital (table I). He spent 554 of these days in one hospital alone during the course of 64 admissions, in another he spent 242 days in 14 admissions, in another 132 days in five admis-

TABLE I—Number of Days spent in Edinburgh Hospitals each Year

Year	1967	1968	1969	1970	1971	1972	1973	1974 (Jan.-March)
No. of days in hospital ..	54	123	195	72	120	146	255	35

sions, in yet another 45 days in seven admissions, and the remaining 27 days were spent during the course of three admissions at other hospitals. The type and number of investigations performed are shown in table II and the nature and duration of antibiotic therapy he received in table III.

TABLE II—Number and Type of Investigations Performed 1967-74

Chest x-ray examination ..	134	Full blood count ..	120
Other radiological procedures ..	11	Urea and electrolyte measurements ..	106
Electrocardiography ..	46	Cardiac enzyme estimation ..	17
Forced expiratory volume measurements ..	57	Plasma protein electrophoresis ..	5
Routine sputum culture ..	273	Serum amylase estimation ..	3
Sputum culture for tubercle bacilli ..	70	Streptomycin level measurement ..	9
Sputum culture for fungi ..	11	Mid-stream urine examination ..	5

TABLE III—Antibacterial Therapy 1967-74

	No. of Days Given		No. of Days Given
Ampicillin (2 g/day) ..	326	Clindamycin (1.2 g/day) ..	30
Co-trimoxazole (4 tabs/day) ..	144	Chloramphenicol (2 g/day) ..	14
Benzylpenicillin (2 MU/day) ..	89	Cephaloridines ..	14
Oxytetracycline (2 g/day) ..	85

Rising cost of treating patient in hospital.

Discussion

The patient we have described was not a case of Munchausen's syndrome nor was he a malingerer in the usual sense of the word. He undoubtedly had genuine symptoms and proven pulmonary disease, but on most of the occasions when he sought admission to hospital his symptoms could probably have been managed on an outpatient basis. His case, however, shows the difficulties facing medical staff when they are confronted by a dirty, inebriated, and obstreperous patient with respiratory symptoms who may have been brought into the casualty department by the police. Even if the doctor knows the patient's record he cannot safely ignore complaints of purulent sputum, haemoptysis, and breathlessness with a chest radiograph showing "inflammatory changes" and seldom has any choice but to admit him to a medical ward. Such decisions, however, resulted in this particular patient spending nearly three years in Edinburgh hospitals over a period of seven and a quarter years, and numerous referrals to medical social work departments during this period achieved nothing.

Most of the many x-ray examinations contributed little to the patient's management, though in view of his past history of tuberculosis some of these examinations were necessary, as were some of the 70 sputum examinations for tubercle bacilli. Nevertheless, the 120 full blood counts and the 106 urea and electrolyte examinations were a waste of expensive laboratory facilities, for few showed any abnormality that could have influenced the patient's treatment. The 273 routine sputum examinations and sensitivity tests seldom altered the antibiotic therapy prescribed, since apart from occasional isolates of pseudomonas *Haemophilus influenzae* was the only pathogen reported in the sputum. The burden which the patient placed on medical staff is illustrated by the fact that he came under the care of 20 different consultant physicians in Edinburgh alone and that his case notes weighed 12 Kg at the time of writing.

A graph of the cost of this patient's hospital treatment in Edinburgh from 1967 to 1973 is shown. The average cost of

keeping a patient in the hospital to which he was admitted 64 times rose from £53 to £98 per week over this period, and the 1000 days which he spent in Edinburgh hospitals must have cost the N.H.S. about £10 500. What is even more alarming is that the graph appears to be rising exponentially.

Conclusions

Patients of the type we have described may number several thousands, and they must account for a sizeable proportion of N.H.S. expenditure, particularly in the hospitals of our major

cities and towns. It is difficult to see how such patients can be handled differently in a democratic society, but the problem they present is clearly one which should engage the attention of community medicine specialists.

We thank the many consultant physicians who have treated this patient for their permission to make this report and Miss J. Williamson for secretarial help.

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Conversations with Consultants

Non in Arcadia Ego

FROM A SPECIAL CORRESPONDENT

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"When I read your talk with Dr. Pinkerleigh five years ago,¹ it struck a responsive chord in me," said a consultant physician. "I'm also one of those men 'at the end of the line,' where nobody from the D.H.S.S. ever visits and it's a question of which comes first—one's initial coronary or a C merit award. But if you'd talked to Pinkerleigh today you'd find the hospital picture much bleaker than he painted it; in fact, I know that he would agree with this, for I identified him without much difficulty and talked to him about current problems only a few weeks ago." Wasn't his disillusion, though, part of the current malaise in society in Britain general—in effect, waiting for North Sea oil? "Certainly we consultants are disgruntled about pay," he said. "When I'm called out to the hospital, say, six times over a weekend on duty I get nothing extra—whereas the laboratory technician whom I have to call in to help me gets about £40, and his senior in the department is on a regular salary of over £6000 (well over the earnings of a junior consultant, who might well be the senior technician's titular boss). But there's a much more serious cause of our malaise, which the press has played down, seeing the present crisis entirely in its normal black-and-white terms of only another union claim for more money. The fact is that hospital doctors are totally disillusioned, and the events of the last six months have lowered morale to a level from which it will never recover."

But surely, I said, morale was impossible to measure, and sweeping statements like this had been appearing in the medical press ever since the Health Service started. Certainly, he replied, it was always difficult to distinguish mere sabre-rattling from true mobilization, the braggadocio from the serious argument. The evidence, however, was in doctors' behaviour: five years ago his housemen and registrars had got their Membership and then left for a London teaching hospital to start on the ladder; now they went into general practice or to Canada or Australia, and "I'm not surprised to hear that the B.M.A. has been deluged with a record number of inquiries about emigration prospects. Even men in their 50s have left the hospital service, and it's no idle threat that once my children are off my hands I shall look seriously at the prospects in somewhere like Vancouver myself."

The Reasons Why

The physician was at pains to re-emphasize that poor pay was only one of several factors for hospital doctors' discontent: in

particular, the gross underfinancing of the Service meant that there was no light at the end of the tunnel—that projects which had already been talked about for five years and given priority would now never be realized in the remaining 15 years of his professional life. "The result is," he said, "that consultants won't sit on planning committees any more: they say, quite justifiably, that their time would be better spent on the golf course. Because there's never likely to be enough capital money for new wards and outpatient departments we can't attract new consultants, and in my area we're busy raising the money to build a private hospital on a site we've already got—though personally if there was a new consultant contract I'd be happy to go full time."

I mentioned anecdotes I had heard about the effect of nursing shortages—of consultants in teaching hospitals doing ward rounds without a nurse in attendance and finding helpless patients unwashed or even unfed with their breakfast still in front of them; of an ex-nursing sister who, finding that only one S.E.N. would be in charge of an acute surgical ward for the night, had, Eastern-style, arranged to stay at her son's side as he recovered from his operation so that she could ensure that he didn't aspirate any vomit into his trachea. "Certainly many of our wards are staffed by one S.E.N. and one nursing auxiliary at night," he told me. "We reserve such qualified staff as we've got for our intensive care unit. I don't want to be the usual bore about the effects of the Salmon scheme, but, combined with the nurses' 40-hour week, the extra holidays awarded by the Halsbury report, and block release scheme for those in training, this has meant a tremendous decline in the number of nurses available—it's unusual, for instance, for me to do a round with my ward sister more than once a week: she's always legitimately off duty. These facts have also particularly affected the distribution of nurses: there's a relative posse around between 10 a.m. and 2 p.m., but few outside this period. But, on the bright side, our present economic slump has had one good effect: in our area, staff such as porters and cleaners are now flocking back to the hospital in search of secure jobs."

All Snakes and No Ladders

I objected that the withdrawal of the physician and his colleagues from committee and medicopolitical work was bound to make matters worse rather than better. Surely Cogwheel and Re-organization had been introduced to enable "ordinary" doctors to get such difficulties across. Why weren't they lobbying those