This would be difficult in any one institution, and matched hospitals and an outside assessment team seem mandatory. We would deny vigorously that we squander resources. The establishment of nurses, occupational therapists, physiotherapists, social workers, and speech therapists resulting from the creation of either of our units has not increased. The patients have always been with us and had to be treated—nowadays it is done more efficiently.

Conclusions

The rehabilitation of patients with stroke is poor in most hospitals, and the single most important step in improving care is to collect the patients together so that one group of staff may develop their skills. We have no absolute recommendations whether a hospital should develop a "stroke rehabilitation unit" or a "comprehensive stroke unit" or which medical disciplines should provide the consultant leadership. Much will depend on local circumstances and personalities, though at Greenwich we

believe that the comprehensive stroke unit opened in 1977 has significantly improved the total care of patients with stroke within the hospital compared with the service offered by the preceding stroke rehabilitation unit.

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(Accepted 11 July 1979)

Clinical Topics

Unblocking beds: a geriatric unit's experience with transferred patients

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British Medical Journal, 1979, **2**, 646-648

Summary and conclusions

A study was made of all patients admitted to a geriatric unit over several years. The admission policy included a high degree of priority to requests for transfer from acute beds, which resulted in transferred patients accounting for 25% of admissions. Unblocking acute beds did not lead to prolonged delay in admitting patients from the community to the geriatric unit. Almost 30% of beds allocated to transferred patients were recovered in 30 days.

Introduction

The transfer of patients from "acute" beds to "geriatric" beds is an emotive subject. Departments of geriatric medicine are often accused of dragging their feet in this matter thus leading to blocking of beds by elderly patients.

This unit has given a high degree of priority to requests for patient transfer, and it seemed of interest to examine the effects of such a policy.

Background circumstances and method

The department serves an urban and rural population of some 210 000 and is located in a scattered complex of buildings adjacent to the acute hospital. It has 15 beds per 1000 elderly recommended by the Hospital Plan for Scotland in 1962¹ but is without day hospital facilities.

The study was carried out principally over two complete years, 1974 and 1976. All admissions including transferred patients were recorded. The numbers and sources of transferred patients were examined, and the time taken to effect transfer and the outcome of their stay were recorded. Less detailed studies were made of other years for comparison.

Initially one consultant (CJM) was responsible for transfer arrangements and later two. Apart from the confused ambulant patients, requests for transfer were usually accepted without demur after written or verbal requests. There are no formal or informal arrangements for elderly patients to be seen by the consultants in geriatric medicine before the request for transfer.

Results

Requests to accept transferred patients came from the departments of medicine, orthopaedics, surgery, casualty, infectious diseases, and others in order of decreasing numbers. The "others" included gynaecology and various hospital departments outwith the district.

On average, patients were transferred within six days from date of request, many within a day or two. Accepting transfers did not result in undue delay in admitting patients from the community, most of whom could be accommodated either the day they were visited at home or within a day or two. Only a few people, whose medical and social conditions permitted, had to wait more than a week for a bed. Transferred patients represented almost a quarter of all the admissions to the geriatric unit (table I). The medical unit contributed the largest

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TABLE I—Total annual admissions to geriatric unit and percentages of admissions due to transfers

	1974	1975	1976	1977	1978
Total admissions	659	594	690	641	671
Total transfers	171	162	154	168	163
% of admissions due to transfers ..	25.9	27.2	22.3	26.2	24.2

TABLE II—Sources of transfers with numbers expressed as a percentage of total transfers for each year

	1974	1975	1976	1977	1978
Medical unit	37.4	40.7	40.8	35.1	31.9
Surgical unit	18.7	12.3	13.0	16.1	17.2
Orthopaedic unit ..	21.0	19.7	18.8	23.2	22.7
Accident and emergency ..	4.9	11.1	18.2	14.9	17.8
Infectious diseases and others ..	18.0	16.2	9.2	10.7	10.4

number (table II) and as might be expected² the patients from there included a high proportion with cerebrovascular disease (68.73%). About 60% of all transferred patients were aged over 75.

Within 30 days of transfer almost 30% of the beds were recovered. In 1974 most of these were recovered through death but in 1976 many more transferred patients could be discharged. In a further 30 days almost 15% more of the beds were recovered—that is, over 40% in two months. After a year from 14 to 18% of transferred patients were still being looked after.

Examination of the duration of stay in all acute wards before a request for transfer was made showed that a surprising number had been in those wards more than 30 days already. This applied, not unexpectedly, particularly to orthopaedic and surgical patients (table III).

TABLE III—Percentage of patients in acute wards over 30 days before request for transfer received

	1974	1976
Medical transfers	31.6	39.6
Surgical transfers	51.8	52.6
Orthopaedic transfers ..	63.3	46.2

Requests for transfer came at varying times.

Early (0-15 days) in the patient's stay, particularly if admitted primarily to the casualty department, or when the patient was already known to the geriatric department, or when the patient had been discharged recently and had to be readmitted because patient or family were unable to manage.

After a medium stay (16-30 days), when rehabilitation had been tried and progress indicated that prolonged treatment would be necessary.

Late (over 30 days), when perhaps complications had ensued or death had several times seemed imminent and the need for transfer had appeared unlikely.

At almost any stage in care when there was pressure on acute beds.

The reasons expressed for the need for transfer varied but fell into three main groups.

For rehabilitation, including assessment of fitness for discharge. This group increased as the awareness of services provided by a geriatric unit became more generally appreciated.

For continuing care—This might have been for medical reasons or where there were social problems or both.

For terminal care—This was the least common reason, contrary to the popular idea of a geriatric unit being a place where the elderly go to die.

Transferred patients gave the various members of the geriatric team considerably more work in organising discharge than did those patients admitted in the usual way after a home assessment visit. The preadmission visit enables not only the medical standpoint to be determined but also allows patients to be seen in the context of their home surroundings, establishes a relationship, and allows relatives, friends, and neighbours to be interviewed. With the transferred patient such information has to be acquired later. At present a social report seldom accompanies a patient transferred from the acute units. These difficulties may reflect the local shortage of hospital-based social workers.

Discussion

According to various authors,^{3,4} a major cause of friction between clinicians in general hospitals and doctors in geriatric medicine is the low priority given by the latter to patients already in hospital compared with those in the community. Indeed, acute hospitals may be reluctant to admit the elderly sick lest they block beds more urgently required by younger patients.

The expression blocked bed is difficult to define. Various authors^{3,5} have ascribed different durations of stay varying from 30-49 days before applying the term. In practice, it could be appropriately used when a person of any age occupies an acute bed for longer than the consultant in charge deems reasonable. In this article I have chosen 30 days as an arbitrary time, well over the average duration of stay for all ages in acute wards. As stated earlier, a high proportion of patients had been in hospital over that time before a request for a geriatric bed was received. With all consultants there is a natural desire to finish the job started. When this was to take a long time, the choice to continue and so "block" the bed was that of the consultant.

Accepting transferred patients does not necessarily impose great delay on admission from the community. The delay naturally fluctuates from time to time; the waiting list in this unit may lengthen as well as shorten but it seldom exceeds 20 people and may be in single figures.

As transferred patients represent about a quarter of the work load clearly many of the acute problems among the elderly are being dealt with by other departments. The geriatric unit might, therefore, reasonably be expected to recognise this by accepting transferred patients readily.

Early transfer of patients benefits everyone. Once the decision to seek transfer has been made, delay brings only apathy and depression. Interest in the patient both from medical and nursing staff may flag in the face of more urgent clinical problems. The patient may become aware of this. Transfer without a long wait is important in maintaining an enthusiastic approach and preventing avoidable deterioration.⁶

Why is transfer to geriatric care of those already in hospital delayed? Perhaps the most usual reason is the shortfall provision of beds in many geriatric units. A further factor is the slowness of the social work department to make places available to rehabilitated patients who no longer need hospital care. These patients then become true bed blockers. In every geriatric unit and also in acute beds some rehabilitated patients are always awaiting social welfare accommodation.⁸ Often, in this unit, the number waiting for such accommodation equals the number waiting to come in from the community. In this district the provision of places for the elderly in social welfare homes is in the ratio of 13-14 per 1000 (recommended norm 25 per 1000 elderly⁹) with sheltered housing about 10 per 1000 (recommended norm 25 per 1000 elderly¹⁰). As a result crises in the community are apt to develop before admission is obtained. Admission from hospital to social welfare accommodation regrettably is on an exchange basis with often a prolonged wait before a place is secured. Getting a patient a sheltered house is likewise a tedious process.

A more determined effort by the social welfare and housing departments to provide accommodation would do much to relieve the difficulties and would enable the hospital geriatric service to function more effectively.

Conclusions

(1) When the bed complement is in accord with the Hospital Plan for Scotland recommendations—that is, 15 beds per 1000 elderly—transfer of patients from an acute bed to a bed in a geriatric unit may take place without undue delay and without extending the waiting time from the community.

(2) In this hospital 25% of admissions are patients transferred from acute wards and about 30% of those beds are recovered within 30 days.

(3) Even with quick transfer arrangements, consultants in acute specialties often still try to effect discharge even if this means retaining patients over 30 days.

(4) Transfer within a few days often benefits both patient and interdepartmental relations.

(5) Acute units will have less anxiety about admitting elderly patients if transfer is relatively easy.

(6) Better support from social welfare and housing departments would facilitate bed availability in both short and longer stay units.

I thank my colleague Dr D N Ropper for allowing me to include his cases in my figures. I also thank my secretary Mrs C M Storie for her invaluable help.

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(Accepted 29 June 1979)

USSR Letter

Aspects of ethics (2)

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British Medical Journal, 1979, 2, 648-649

In last week's article on medical ethics in the Soviet Union I discussed fairly general topics; here I examine two specific points where the discretion of a Soviet clinician has been severely limited. In any country it is probably inevitable that doctors should act on behalf of the wider society through the issue, or withholding, of sickness certificates to members of the economically active population. Nevertheless, there are stark differences in the extent of supervision exercised over the medical validation of temporary withdrawal from the workforce. In the Soviet Union, unlike Britain, a doctor's opportunity to err on the side of generosity is at an almost irreducible level.

Sickness certification

Drastic curtailment of the individual practitioner's responsibility has been brought about in two main respects. Firstly, he is not permitted to issue a sick-note for a period lasting longer than three days—except during influenza epidemics—and has no authority to excuse a patient from work for over six days at a time for any one episode of illness. Secondly, if he considers that an extension is necessary, he must normally obtain consent for this from a small committee—termed a medical consultative commission—which is convened, as required, at polyclinics and hospitals. Meetings are chaired by the unit's deputy head doctor, whose specific function is to control sickness certification; other members are the patient's own doctor and the head of the relevant department. As "the highest organ" for decision-taking,

the commission enjoys wide-ranging powers, which include transferring a worker to another form of employment or arranging for "easing of conditions of work." Decisions about certification in difficult and complex cases appear to be made primarily on the basis of published case lore—which further reduces the chances of a patient getting the benefit of any doubts. Patients who have no chance of recovery are referred to another type of commission, which assigns them to one of the three categories of invalidity.

From the relevant publications it is clear that great importance attaches to ensuring that the number of work days lost because of illness should be kept as low as possible. This longstanding preoccupation has acquired added urgency in recent years because of labour shortages that affect various sectors of the economy; these threaten to become more serious owing to the low birthrate throughout most of the Soviet Union (the major exception is Soviet Central Asia). Although the costs of "policing" sickness certification are clearly high in terms of time and manpower, the Soviet leadership may well consider them fully justified by the results—at least for the period 1965-74 (more recent data are not available). According to the annual abstract of statistics, the trend was then moving very much in the right direction: in 1965 the average industrial worker had 15.2 certified days absence in connection with illness or childbirth, and by 1974 the figure had declined to 13.5 days.¹ Fairly obviously, several questions can be raised about issues such as the relative impact of improvements in standards of living, housing stock, and conditions at work. It would also be useful to have evidence from longitudinal studies to establish whether chronic illness has resulted from premature return to work. It seems most probable, however, that the Soviet authorities would not publish such evidence if the findings had proved unfavourable.

Unfortunately, no reliable assessment can be made of the impact which the strictness of sickness certification makes on relations between Soviet doctors and their patients. But a useful indication of the bureaucratic pettifoggery which clinicians endure is conveyed in a passage from a short story by Yuri Krelin. One of the surgeons has an encounter with the battleaxe

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