If I Was Forced to Cut

Consultant physician in geriatric medicine

BY A SPECIAL CORRESPONDENT

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Dr Grawber is a warm-hearted and expansive consultant physician in geriatric medicine from the South of England. His geriatric service, led by two consultants, has 260 beds for a population of about 150 000, of whom about 18 000 are over 75. In 25 years the beds have increased by only 40 while the population over 75 has almost doubled. Better medicine for the aged and improved community services have saved the NHS the cost of providing and staffing 180 beds. "Of course, life is difficult," he says, "but there has been no breakdown in service and there is still no waiting list."

Geriatrics saves money

Far from thinking geriatrics to be the Cinderella of the medical specialties, Dr Grawber is sure that geriatrics can save money for the NHS. He points to a paper from the department of geriatric medicine in Edinburgh suggesting that geriatric skills can reduce the time old people stay in hospital.[1] The study showed that after a physician specialising in geriatric medicine had been attached to a general medical unit the average stay for women over 65 was reduced from 25 to 16 days and for women over 85 from 50 to 19 days. Geriatric medicine, Dr Grawber says, is concerned with simple things and particularly in academic units has a part to play in "bringing people down to earth." His own experience confirms the Edinburgh study, but he prefers to see patients admitted directly to his own unit. In his district there are almost as many admissions to the geriatric wards as to the general medical wards, and the mean length of stay of patients over 75 in the acute geriatric wards (18¼ days) is not much longer than that in the general medical wards (13½ days), where no patient is over 75. But to achieve these results the geriatric wards must be in the district general hospital with ready access to facilities for investigation and consultation with other specialties. "Nothing is more harmful," he insists, "than to try to treat people in isolated hospitals." The morale of the patients and the staff falls, and the simplest investigation—for instance, a chest radiograph—can become a major (and hopelessly cost-ineffective) exercise if a disabled patient has to be moved 20 miles.

Dr Grawber dislikes the classical division of beds into acute and geriatric: he points out that much of his geriatric work is far more acute than the cold surgical cases that take up the misnamed acute beds. He would like the word acute to be replaced by "general." This would help to erode the traditional prejudice against geriatrics and allow recognition of the large contribution that geriatrics can make to the care of the acutely ill.

As a corollary to his concept of geriatrics as a money-saving discipline, Dr Grawber is sure that nurses specially trained in geriatrics are most valuable. He can now, he thinks, provide a better service with his present specially trained nurses than when they were more plentiful but mostly without specialist training.

Political measures

(1) Recognise the potential of specialised geriatricians for saving money
(2) Means-test patients receiving long-term care in geriatric hospital

Household measures

(1) Limit the number of follow-ups
(2) Increase the use of volunteer-driven cars allowing savings on ambulances
(3) Encourage cost-consciousness on the ward
(4) Reduce overinvestigation
(5) Educate doctors to avoid overprescribing in the elderly

Saving on follow-up and transport

In his younger days Dr Grawber was heard to make grand statements like, "No geriatric patient should ever be discharged from follow-up." He could not believe that any other caring agency could find the time or the enthusiasm to keep in touch with his patients. Improved community services and better organised general practice have changed all that and he now keeps his follow-ups to a minimum. A lot of money could probably be saved, he thinks, if every consultant in the country were to consider carefully the necessity for each follow-up.

Follow-up generates investigation and correspondence, much of which are of doubtful value and a major element in the cost is transport. Many of Dr Grawber's outpatients come to him in an ambulance—irrelevantly equipped for accidents, resuscitation, and all kinds of emergencies. Over 90% of ambulance journeys are non-emergency and each journey in his district costs at least £6. Dr Grawber believes that many of his patients could be as well transported in cars driven by volunteers, leaving the ambulances free for the work for which they are designed. Certainly some of the patients are not sufficiently mobile to be transported in a car, but Dr Grawber discovered that during the ambulance strike 17 of his usual 20 patients were able to turn up to his day hospital, though normally all were brought by ambulance. He is sure that volunteers would be forthcoming, and that they would benefit not only in feeling useful but in help paying for their car. The main source of volunteers is the group of people who are newly retired, and at this age particularly a role in life may be most important.

In Dr Grawber's opinion more money could be saved on transport than on any other item of the NHS budget.

Long-stay care, cost-consciousness, and prescribing

Dr Grawber is fond of pointing out that long-stay care in hospital is the most expensive form of treatment offered by the

NHS. Although only 5-10 per cent of patients referred to a department of geriatric medicine ever require long-stay care, when they do it probably costs more for each patient than a heart transplant. If a person qualifies for care in a local authority residential home he will be financially assessed and will pay according to his means. A patient cared for long term in a geriatric hospital pays nothing, even if he is a millionaire. Dr Grawber thinks that those who can should pay something for their keep in a long-stay hospital. The problem is when to start expecting a contribution: perhaps financial assessment should start after six months in hospital.

Cost-consciousness is just arriving in Dr Grawber's wards: the district management team is erecting noticeboards in the wards indicating the expense of investigations, simple procedures, and items of equipment. Often overinvestigation is a psychological prop for the doctor, and Dr Grawber thinks particularly that all doctors should understand that there comes a time for accepting that some patients are dying. Once this point is recognised wasteful investigations should be stopped and comfort and relief of pain should become the priorities.

When applied to prescribing for the elderly, cost consciousness might not only save money but also reduce the problems of the old people. Many old people are prescribed inappropriate drugs for what are just the normal processes of aging because they demand it and because the doctor may have nothing else to offer. Sometimes this overprescribing does no harm other than increasing the nation's drug bill but often the drugs can do direct harm to the patient. When I asked Dr Grawber what plans he had for combating this problem, he answered rather half-heartedly, "Well, education I suppose." He sounded unconvinced by the immediate benefits of education. I asked him what he thought of a limited-prescribing policy, whereby doctors could prescribe only from an approved list of drugs. He replied, "We have had for years a policy that allows the pharmacist to substitute cheaper generic equivalents when proprietary drugs are ordered, but still the hospitals drug costs go up and up." He thought that it would not cause him too much distress if he had to prescribe from a limited list of approved drugs, but that others would object on grounds of clinical freedom. Limited-list prescribing would not, however, deal with the problem of overprescribing in the elderly.

Doctors controlling the purse-strings

Dr Grawber agrees up to a point with the Royal Commission on the NHS when they say, "Those held responsible for expenditure were often not in a position to control it"[2]; but he is also convinced that final decisions on the allocation of funds must rest with lay authorities. The emphasis placed in recent years on the problems of the aged is entirely appropriate, but he is worried that if doctors had more say in the allocation of funds they might not agree. He remembers the horror expressed by his colleagues when several years ago, in line with Sir Keith Joseph's recommendations, his region decided to build a new geriatric unit. His colleagues thought that the money could be much better spent, and yet nobody questions now the benefits the hospital has produced for the local community.

Dr Grawber has experienced some of the effects of financial stringency, but he is relatively content with the service he is able to offer the community. He concluded by saying, "I have a fair share of too small a cake."

References

[1] Burley, L E, *et al*, *British Medical Journal*, 1979, **2**, 90.
[2] Royal Commission on the National Health Service, *Report*, cmnd 7615, p 377. London, HMSO, 1979.

Accident and Emergency Services

Design of departments

BY A SPECIAL CORRESPONDENT

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As I walked into the accident and emergency department of a large teaching hospital an unconscious man with an oxygen mask was being wheeled through the single reception area and a nurse was dashing across with a bedpan, while rows of waiting people surveyed the hectic activity. Mercifully such antiquated departments are gradually disappearing.

In a survey carried out in 1958-9 nearly all the departments in the 20 main hospitals visited had a low standard of both accommodation and equipment, even the newer ones being badly planned.[1] Casualty departments tended to have a low priority in the allocation of resources. Ten years later four of the five departments seen during a small study were old and inadequate, while the single new one provided barely adequate accommodation with no flexibility for expansion.[2] Recommendations on the design of accident and emergency departments were published by the Ministry of Health in 1964.[3] Since 1967 in the region of 100 new departments have been built in England.

Of the 13 hospitals providing full accident (and usually emergency) services that I visited, all but four had modern accommodation for these services, and one of the four moved to a new building during my study. Two of the old places were certainly poor in their accommodation; but the other two, though visually somewhat discouraging, were compact and well planned with a high standard of facilities. Indeed, not all the newer departments were so well planned. Twenty years ago the Nuffield Provincial Hospitals Trust deplored the "lack of attention to functional requirements"; but, depressingly, for one department that has moved into a new building the spacious and in many ways excellent accommodation makes the work more difficult in some respects.

Clearly the accident and emergency department must be planned and equipped to deal efficiently with urgent cases at any time. This principle, however, does not seem to be invariably applied: a resuscitation room, for instance, even in a modern department may be designed for only two trolleys, and may serve also as the recovery room. Planning also needs to allow for the presence of a large number of patients, and it must be