TALKING POINT

Patients last?

JULIAN M LEIGH

The consultants in the South West Surrey District Health Authority are totally opposed to the cuts in acute services that they are expected to sustain. During their campaign against the cuts the consultant from the acute unit management team has spoken at three meetings of the district health authority. The editor and health reporter of the local newspaper have been kept informed and there have been interviews on local radio. The Confederation of Health Service Employers and the BMA have campaigned jointly against the cuts, obtained signatures from members of the public, and produced a pamphlet. The petition has been sent to local members of parliament.

We have met the two local members of parliament and a member of the opposition health committee. We are also seeking a meeting with a senior member of the Cabinet. A poster display showing the effects of the cuts in 10 years' time was mounted at a district health authority meeting and the consultants lobbied members before their meeting on the strategic plan. Finally, a document entitled *Patients last?* was compiled by Dr Julian Leigh on behalf of and with the aid of his consultant colleagues. This was submitted to the district health authority and circulated widely to senior politicians and the local media. An abbreviated version of this paper is reproduced here.

Consultants' response

In December 1979 the government published *Patients First*, a consultative paper on the structure and management of the National Health Service in England and Wales.¹ Subsequent events in the health service in this region have led to circumstances that can only be described as "patients last?"

The South West Thames regional framework for the strategic plan for acute services will have a deleterious effect on the quantity and subsequently the quality of health care in south west Surrey.

The budget for acute services is £17.3m and £3.7m is to be taken away (21%). Of this, £1.5m is to be used in our own mental illness/handicap service, but the remaining £2.2m will be lost to the district for ever.

The precise number of acute beds to be lost varies according to the assumptions made (minimum loss 143, maximum loss 183)—about one third of the acute beds. In the region as a whole there will be a reduction of over 1000 acute beds currently catering for over 40 000 patients a year. There will therefore be fewer opportunities for our patients to go elsewhere.

We are required to reduce our throughput in surgery by 31% and maintain our acute medical service with half the acute medical beds closed.

We believe that the rigid adherence to the regional strategic plan by the district health authority represents a dangerous

reduction in health care to the population and is therefore unacceptable.

The prediction for 1993 for South West Surrey from the Office of Population, Censuses, and Surveys is for a population reduction of about 0.7%. This number is within the error of the method and it is therefore prudent to assume no change in total population. There will, however, be a shift in age distribution with an increase in the over 65s by 2300. Of special importance is the increase in the over 85 age group by 600 (23% over the present number). Additionally, there will be an increase in the under 5s by 1100.

EXPECTATIONS OF THE COMMUNITY

General practitioners referred 19 383 new patients to surgical clinics during 1983 and 14 000 cases were placed on the waiting list. Hospitals admitted 16 936 patients from waiting lists or as emergencies, and 14 000 operative procedures were carried out. Thus additions to the waiting lists and operative procedures balance out. As there are roughly 3000 patients on the list at any one time a crude average waiting time of about 11 weeks may be calculated.

Of the 14 000 operative procedures carried out, Hospital Activity Analysis statistics showed that 12 500 were on patients from the South West Surrey district. It was also shown, however, that south west Surrey residents had 14 187 operative surgical procedures in this or neighbouring regions. Consequently, 14 000 surgical procedures will continue to be the requirement in this district.

The suggested target for operative surgery is 10 000 and if 14 000 patients continue to be added to the waiting lists each year and only 10 000 removed there will be about a 10 fold increase in the waiting time (to two years) after a little over four years.

The South West Surrey hospitals admitted 5581 medical patients in 1983, virtually all as emergencies. The regional plan for the medical specialties requires the same throughput in 1993. But the beds are to be reduced from 205 to 117 (43% reduction) and the instruction is to increase the day case throughput to 30%.

Obviously the admission of many medical patients occurs because of the effect of the aging process on their chronic disease and their stay in hospital cannot be reduced, nor indeed can they be treated as day cases. Moreover, they cannot be expected to be ill for half the time. While they may be referred to geriatricians, it should be emphasised that there is to be a reduction of 18 in the geriatric bed allocation.

REGIONAL STRATEGY

The regional strategy has two fundamental assumptions. Firstly, it assumes that patients will be treated only in their own district and, secondly, that greater throughput can be achieved both by the reduction of inpatient stay times and by an increase in the proportion of day cases.

In acute services we do not think that general practitioners

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will or should renounce their freedom and right to refer their patients to the consultant of their choice. The throughput of cases in the non-medical specialties is already higher than the regional target. There is little chance of increasing the number of day cases, especially in relation to general medicine, general surgery, and ear, nose, and throat surgery since not only would it be clinically and humanely unacceptable, but our community service budget is to be reduced by £320 000 in South West Surrey by 1993 according to the regional strategic plan.

At present there are 626 beds providing all the acute patient care. The regional strategy for 1993 requires a reduction to 394. This can be offset, however, by seven oral surgery, 18 thoracic surgery, and 24 day case beds, funded on a regional or supra-district basis, making a total availability of 443 acute beds. The net loss of 183 beds may be alleviated by cross boundary flow funding (possibly 40 beds). This still leaves a minimum reduction of 143 beds (29%).

A census of all patients in the district was carried out on a single day in the week starting 18 February 1985. The inpatient hospital population has a much higher average age than the general population, although this varies from specialty to specialty. Not surprisingly, the average age for geriatric patients is high—82 years, but it is probably not generally realised that the average age for patients in acute general medical beds is also high. For example, the patients in acute medical beds at St Luke's Hospital had an average age of 78 years.

Taking general medicine as a whole the census showed that there were 123 patients in the care of general physicians: the average age was 71 years. Only 18 were under the age of 60, 74% were 65 or over, and a half were over 75 years of age (table). The census showed that there were 76 patients in the trauma and orthopaedics specialty. The average age of the 71 patients in adult wards was 66. The most common age group, however, was 80-84 years and 10 patients were over 90 (table). The orthopaedic surgeons had one quarter of the 90+ age group in the whole district.

OVERALL IMPLICATIONS

Considering the surgical patients in isolation from medical patients, the implications of the plan are, firstly, longer waiting lists. Although, as has been stated earlier, the average waiting time will rise rapidly and unacceptably, the brunt of the increase will be taken by non-life threatening conditions, even though they may be extremely painful and inconvenient. Indeed, there will be total curtailment of certain types of surgery. For example, the general surgeons will not be able to perform varicose vein or hernia operations unless serious complications have occurred. In the case of the latter, obstruction, strangulation, perforation, bowel necrosis, and even death may follow.

Additionally, we are concerned as to whether the general surgeons will be able to deal with gall stone surgery as dictated by modern practice. Serious complications may result in a similar manner to those for hernia sufferers causing recurrent pain, infection, jaundice, and even death. It is distressing to be in a position where we can foresee that by 1993 patients may die from complications that could have been avoided by early elective surgery.

Since the Royal Surrey County Hospital opened in 1980 the urology surgeons have reduced waiting times for prostate

operations from two years to three months; a reversal of this trend is highly undesirable because it may lead to renal failure in patients with enlarged prostates. Much of the work in this specialty is bladder cancer follow up at pre-set intervals (about 50 cases a month) and 30% of these patients require additional operative treatment. Curtailment of this programme would be unacceptable.

The census carried out on trauma and orthopaedic patients showed that 68.4% were trauma patients while 31.6% were orthopaedic patients. The regional strategy shows a cut of 31% in the bed numbers. This would mean that no orthopaedic surgery could be carried out and the surgeons in this specialty would be reduced to operating an accident service only.

It is regional and national policy to carry out more joint replacements. It is clear from the figures given above, however, that we will not be able to carry out any hip surgery at all.

The one third cut in ear, nose, and throat surgery will exclude a large number of adults who should have nasal surgery for pain, discomfort, and infection and will increase the waiting time for children requiring surgical management of their deafness, with obvious consequences for their education.

In gynaecology the bed cuts will mean the end of sterilisation procedures and introduce delays in the investigation of patients with potentially malignant symptoms and signs.

In ophthalmology the implication of the 26% cut in beds will be a much greater waiting time for many conditions. This will particularly affect children with squints and old people with cataracts. There will be an increase in the population of both these groups by 1993. The consequences for a child with an unoperated squint is blindness in one eye and for an elderly person with cataracts, blindness in both eyes.

The position for the surgical specialties is clearly grave when considered in this way. But because of "overspill" they cannot be considered in isolation from medical patients.

EFFECT OF "OVERSPILL" OF MEDICAL PATIENTS INTO SURGICAL BEDS

The census day showed that six medical patients had over-spilled into surgical beds and two into the infectious diseases unit, with a further eight in the intensive care unit.

The types of patients cared for by general physicians cannot be treated as day cases, nor can their throughput be accelerated. They are mainly elderly and usually have social reasons for not being able to return home as quickly as other patients. They reach hospital, often through the casualty department, when management at home by the general practitioner or relatives, or both and the community service becomes no longer feasible. Once reaching hospital we are obliged to admit them into any available bed. By 1993 the overspill of medical patients will swamp the acute surgical beds.

It is clear from the census day that if the medical patients under the general physicians had to be accommodated on the basis of the 1993 bed dispositions there would be 35 surgical beds left, thus reducing the surgical service to below its requirement for emergencies. An average of 47 emergencies are carried out at the Royal Surrey County Hospital in one week. The highly productive, highly efficient new Royal Surrey County Hospital in Guildford would thus be reduced to the state of a first aid post on the A3.

Patient census for general medicine and trauma and orthopaedics*

	Ages																			
	0-4	5-9	10-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79	80-84	85-89	90-94	95-99
General medicine	0	0	0	1	1	2	3	0	6	1	2	2	14	10	20	27	18	7	9	0
Trauma and orthopaedics	3	1	2	0	5	2	1	3	3	1	3	4	6	3	7	6	12	4	5	5

*Figures for one day in February 1985.

Disastrous effects of cuts on teaching and research

Effects of cuts in funding by the University Grants Committee, medical manpower, the struggle to maintain parity between the salaries of clinical academic staff and their National Health Service colleagues, and the problem of preclinical staff who are medically qualified were all covered during the Conference of Medical Academic Representatives on 3 June in BMA House. The meeting was chaired by Professor J P Payne, research department of anaesthetics, Royal College of Surgeons, who was re-elected to chair the 1986 conference. The president elect, Lord Pitt, addressed the meeting and answered questions (p 1757). The meeting paid tribute to Dr W L Whitehouse, who was chairman elect until his death in October 1984.

The Medical Academic Staff Committee has been requested to look carefully at ways of bringing pay negotiations for medically qualified preclinical staff into the BMA. At present the Association of University Teachers negotiates for these doctors. A motion calling on the BMA to abandon its policy of seeking a salary for medically qualified preclinical staff that was different from the salary paid to non-clinical university staff was defeated, but in view of the large pro-

portion of these staff who teach in a clinical context the meeting called for a redefinition, extension, and superannuation of clinical teaching allowances.

COMAR...

- deplored the proposed reduction in annual funding to the University Grants Committee, with its consequent disastrous effects on medical education and research.

- drew attention to the detrimental effect on patient care already resulting from cuts in university funding of medical academic departments, which cooperate with and complement NHS departments.

- criticised the reduction in funds made available to the Medical Research Council and urged the BMA council to bring pressure on the government to ensure the restoration of funding to its previous level.

Several motions on the agenda dealt with medical school intake, the meeting supporting an appropriate reduction in student intake "in view of increasing medical unemployment" and in order to match the projected number of career posts available. It decided to pass to the next business, however, on a motion that mentioned a reduction to below the 1979 levels, which is current BMA policy. The council has been urged to take urgent action to ensure swift and effective implementation of the proposed sponsorship scheme for overseas doctors.

The conference reinforced MASC's opposition to the establishment of a private medical

school in London. Dr Colin Smith pointed out that the school would have to be attached to a university and the curriculum would have to be approved by the General Medical Council. This could not be done until after the first qualifying examinations. Furthermore, there would not be sufficient private patients to give the students the necessary clinical experience.

Many of the motions on the agenda had been transferred from other constituencies—for example, BMA divisions, regional hospital committees, and local medical committees. The conference supported a motion from Forth Valley division, which reiterated the BMA council's stance on the list limited by regulation. Like the Liverpool division it was totally opposed to any restriction of clinical freedom by regulation and without consultation with the profession. It agreed with Leeds local medical committee that generic prescribing should be encouraged, provided that the preparations were monitored and the quality assured. A motion from the Central Committee for Community Medicine and Community Health was supported welcoming the BMA's campaign on tobacco.

In his address the president elect had referred to transfer of care to the community and the agenda committee of the representative meeting had prepared the following motion, which COMAR supported: "That this meeting urges the government to fund adequately community care services for the old, the mentally ill, the mentally handicapped, the handicapped, and the chronically ill so that patients and doctors will be able to choose patterns of care most suited to their needs."

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Solution

We propose a solution based on the district's record and the tenets of *Patients First*.

Since our district general hospital opened five years ago the district has met all its efficiency savings and yet considerably raised its throughput of patients. Total deaths and discharges have increased from 12 968 to 15 640 (20.6%) while bed days have only increased by 9.7%. The figure shows the increase in theatre cases over the first five years together with the regional target for operative procedures, thus showing the considerable effect of the cuts.

Our high productivity can be illustrated, whether measured by cost per patient treated or cost per inpatient day, and we have lived within the district's budget. The cost per inpatient day

Number of patients treated in theatre in the Royal Surrey County Hospital, 1980-4.

at the Royal Surrey County Hospital in 1983 was £74.92; the average cost for a district general hospital in the region was £78.62. The cost per case treated at the county hospital was £568.38; the average cost at a district general hospital was £669.57.

The increase in productivity of the Royal Surrey County Hospital has offset price inflation so that the cost per patient treated has remained constant for the past three years.

We wish to confirm our accord with the sentiments expressed in *Patients First*.

"The needs of patients must be paramount. . . . The closer decisions are taken to . . . those who work directly with the patients, the more likely it is that patients' needs will be their primary objective.

"We are determined to see that as many decisions as possible are taken at the local level . . . with the minimum of interference from any central authority.

"Where change is needed it should accord with the local needs of local communities.

"The pattern we propose . . . will fail if it does not embody within itself the ability to respond flexibly and positively to the future needs of the people."

In South West Surrey we stand by our management record. The cuts we are expected to sustain are too severe and the pace of change is too rapid and insensitive. This is not to say that we do not recognise that it is the prerogative of central government to distribute resources. The district health authority, however, must have the right, having taken the advice of the professional staff concerned, to apportion the resources at district level according to the needs of patients.

Reference

1 Department of Health and Social Security and Welsh Office. *Patients first*. London: HMSO, 1979.

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