Rising emergency admissions

Managing emergency admissions is no longer the first priority

EDITOR,—Further to Richard Hobbs's editorial on the increasing numbers of emergency medical admissions,¹ I write to highlight another problem associated with the delivery of acute services. The white paper *Working for Patients* clearly stated that "emergency treatment should be available immediately and without question."² It is self evident that managing emergency conditions should be the first priority of any system of health care, but I contend that the changes resulting from the white paper mean that this is no longer the case.

The demands made on the NHS have always exceeded the available resources. As a consequence, emergency care has been the first priority of the service and patients with less urgent conditions have had to wait for outpatient appointments and operations. The changes brought about by the white paper have made the money to fund many elective surgical procedures directly available to the providers of primary health care, and the independent trust hospitals now compete for this money. As a consequence, emergency care no longer seems to be a priority; what has become important is earning the cash to fund hospitals by fulfilling contracts for elective surgery.

This problem has been exacerbated further by the recent reductions in the number of beds available for inpatient surgical care. Part of this reduction has been necessary to keep pace with changes in surgical practice that have reduced the length of stay for many procedures. Some of the reduction, however, has been to contain costs. The number of patients needing emergency treatment has not fallen. The beds remain to deal with surgical inpatients have high levels of occupancy, and wards and hospitals are frequently closed to admissions. For a hospital to close once or twice a year may be acceptable, but to close once a week is not. General practitioners are experiencing difficulties in admitting emergency patients and often have to contact more than one hospital, sometimes in a different district from that in which the patient lives. Will they one day fail to have patients admitted?

Unless the present funding arrangements of the health service are altered it may become necessary to ration emergency care.

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1 Hobbs R. Rising emergency admissions. *BMJ* 1995;310:207-8. (28 January.)

2 Department of Health. *Working for patients*. London: HMSO, 1989.

Age, distance from a hospital, and level of deprivation are influential factors

EDITOR,—In his editorial on the increase in emergency admissions Richard Hobbs mentions the wide variation in general practitioners' referral patterns.¹ He does not, however, consider the impact of the distance from a district general hospital on these referrals, the level of deprivation, or the age distribution of the patients in each

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practice; these three factors are often thought by general practitioners to influence their referrals.

In North Worcestershire we have investigated the relation between the number of general and geriatric medical emergency admissions in 1993-4 and many characteristics of general practice. These characteristics included the distance of the main practice premises from the nearest district general hospital, the level of deprivation experienced by the practice (based on the Townsend score), and the proportion of the practice population aged over 65. When correlation analysis was used the proportion of the variation that could be explained by these factors singly was 11%, 23%, and 2.5% respectively. When multiple regression was used with these three factors as independent variables 55% of the total variation in rates of emergency admission was explained.

Hobbs therefore does not mention three factors that together explained over half of the variation in emergency medical admissions among general practices in North Worcestershire. These factors should be considered by others in the NHS who want to understand the factors that affect the rates of emergency admission in their locality.

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GPs must take some responsibility

EDITOR,—Richard Hobbs fails adequately to address two reasons, which he himself cites, for the increase in emergency admission—namely, raised expectations of general practitioners and worries over litigation.¹ It would be difficult to argue that the rise in emergency admissions in recent years bears no relation to the increased demand for home visits by general practitioners, among other factors, as general practitioners pass on some of this workload to hospital doctors. In addition, faced with an increasingly litigious public, general practitioners are more often (not surprisingly) playing safe and admitting patients if in doubt.

While sympathising with the increased pressures that general practitioners are facing, we must also recognise some of the more disturbing factors that are fuelling this problem. In some situations it

seems that fundholding general practitioners, who have a financial incentive to avoid paying for outpatient appointments, admit patients with semiurgent problems as emergencies. In addition, a minority of general practitioners have unacceptably high referral rates; Hobbs's justification that a threefold to fourfold variation in referral rates is acceptable because the variation in prescribing is greater seems suspect, even if allowance is made for demographic factors. Furthermore, Hobbs's assertion that hospital doctors, not general practitioners, decide on admission would probably be disputed by most junior doctors, who are wary of upsetting the general practitioners whom their consultants (and future referees) serve. Besides, many doctors would concede that most verbal referrals, if suitably phrased by the referring doctor, will be accepted whether from outside or within the hospital.

The health service will clearly not be able to cope with the rise in emergency admissions at the current rate without further compromising patients' care and increasing pressure on junior doctors. I believe that many junior doctors disagree with Hobbs's apparent view that the trend is not inappropriate and think that more rational referral policies for emergency admissions are required. If we want to avoid our health service turning into the type of expensive, demand led service seen on the Continent then general practitioners will have to take some responsibility for curbing this phenomenon.

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Patients have rising expectations

EDITOR,—Richard Hobbs's editorial on the increase in emergency admissions—one of the most difficult and important problems facing doctors in district general hospitals—is disappointing in its bland analysis.¹ The problem is certainly the rising tide of acute medical admissions, which reached a peak in 1993-4 but has been going on for a long time.² A good deal is known about these admissions (Welsh Health Planning Forum expert workshop, 1994).

In my hospital, which serves a population of 140 000 and has an integrated service (that is, no selection on grounds of age), acute medical admissions have increased by 42% since 1986. The largest increase (10%) was in 1993-4. We can now expect over 6000 admissions a year (an average of 18 a day); 53% of patients will be over 65 and 6% over 85. Currently 85% of the patients are referred by general practitioners and 18% are admitted direct from the accident and emergency department (self referrals or patients brought to the hospital by the emergency services), but the proportion of the latter is increasing. Patients seen in the accident and emergency department and discharged by a doctor or his or her representative without being admitted are not included in our figures for acute medical admissions. The rate of referral from different general practitioners varies, but by a factor of less than 3 (1.66% v 4.85%); there is no significant difference between fundholders and non-fundholders. Finally, our average length of

stay and bed use factor are better than the average for Wales, where most hospitals have parallel systems for admitting acute medical and geriatric emergencies.

The appointment of a bed manager, flexible use of all acute beds in the hospital, and protocols for early discharge and transfer have failed to prevent constant overflows into non-medical wards, waits on trolleys in the accident and emergency department, and temporary closures, even though some general practices have access to community type hospital beds. Brief analysis (to be audited in more detail) suggests that few of the admissions are inappropriate. Major factors include patients' increased demands and expectations and general practitioners' fear of complaints and litigation. Given this, it is difficult to envisage any reduction in beds, let alone the 30% predicted in acute district general hospitals,³ whose surgeons are already practising day case surgery to a maximum.

General practitioners have neither the time nor, probably, the skill needed to treat most of our acute medical admissions, even if they were provided with more facilities. Planning must be modified to take account of these issues.

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- 1 Hobbs R. Rising emergency admissions. *BMJ* 1995;310:207-8. (28 January.)
- 2 Edwards N, Weneke U. In the fast lane. *Health Service Journal* 1994;104(5432):30.
- 3 Audit Commission. *Lying in wait*. London: HMSO, 1992.

Bed crises are occurring almost daily in some hospitals

EDITOR,—Richard Hobbs is correct in stating that emergency admissions are increasing.¹ The figure shows the trend in acute admissions through the accident and emergency department of a large general hospital. After a period of stability between 1984 and 1991 the number has almost doubled. It has taken a great deal of hard work and managerial flexibility from all doctors in the hospital to help the department cope with this throughput.

A medical admissions ward has been opened, bed managers have been introduced, and the hospital allows emergency admissions into any available bed regardless of specialty; a surgical directorate even funded an increase in medical beds during the winter to enable continued elective surgical activity. Despite these measures, however, bed crises occur almost daily and staff find themselves on the seemingly endless treadmill of processing these large numbers of admissions. The reasons for the increase are many, but we think that the following points are important.

Firstly, there are increasing numbers of frail elderly patients living alone at the margins of safety in the community, in whom a minor fall, infection, or other small mishap can seriously impair independence. This often necessitates admission for rehabilitation. When community care fails it is easy to phone the emergency services whatever the time, whereas it is not easy to mobilise social

services to provide support for elderly patients requiring emergency social care.

Secondly, expectations that doctors should not make errors are increasing. To this end, our junior staff are advised to have a low threshold for seeking a further opinion and admission in cases of atypical chest pain; it is better to admit a patient for a day than run the risk of complaint, litigation, or even a charge of manslaughter.

Thirdly, use of the emergency services has increased. Partly, this may be accounted for by policies that encourage patients with chest pain to phone for an ambulance rather than phone their general practitioner.

Finally, early discharge of patients may result in early readmission.

Hospitals can be made more efficient in their handling of acute medical cases, but with every step taken to increase efficiency the size of the problem seems to increase. It is a tribute to the hard work and dedication of staff that hospitals do not grind to a halt because of people requiring emergency care.

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More resources are required to facilitate the discharge of acutely ill elderly people

EDITOR,—Richard Hobbs's editorial on the increase in emergency admissions draws attention to an important trend, which, as he states, should be the subject of urgent research to see exactly what is happening and why.¹ It is surprising that he does not mention demographic changes leading to relative increases in the numbers of very elderly people as these changes are likely to be one important reason for the rising rates of emergency admissions. Unfortunately, in advance of any results from research he suggests solutions that are born of political correctness rather than reasoned appraisal.

The trends towards shorter stays in surgery seem unlikely to happen quickly enough for the problems on medical wards to be solved simply by the renaming of surgical beds as medical beds. For example, on the basis of retrospective studies a substantially shorter stay was one of the benefits expected from the widespread introduction of laparoscopic cholecystectomy. Prospective studies, however, have shown only marginal advantages over minicholecystectomy.²

More sinister is Hobbs's rediscovery of "low dependency medical crises." He presumably has elderly people in mind since he advocates that general practitioners should be allocated budgets to place patients perceived to have conditions in this category into nursing homes. We believe, however, that this solution signals a return to the days of the workhouse since it was the exposure of the myth of this approach that led to the development of modern geriatric medicine.³ Hobbs's own example of acute myocardial infarction well illustrates the reasons for our concern. As he states, modern treatment of this condition is one of the driving forces behind appropriate increases in acute medical admissions. Like many other acute medical problems in older people, however, myocardial infarction commonly presents with atypical symptoms, and specialised investigations are often required to establish the true diagnosis.⁴ Yet it is these patients, presenting perhaps with a fall or with confusion, whom Hobbs would consign to nursing homes or, in some localities, to low tech

community hospitals. Leaving aside the moral question of the re-creation of an underclass of acutely ill elderly people not thought to be worthy of investigation and treatment in acute hospitals, the denial of timely fibrinolytic treatment to such patients is likely to lengthen their stay in institutions and thus be more expensive; it would also increase dependency after the acute illness, leading to less successful or unsuccessful discharge.

Research is indeed needed, as Hobbs suggests, but it should start in acute hospitals, not in nursing homes. Meanwhile, community resources should be directed at facilitating discharge from hospital rather than at placing hurdles in the way of the appropriate investigation and treatment of acutely ill elderly people.

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- 1 Hobbs R. Rising emergency admissions. *BMJ* 1995;310:207-8. (28 January.)
- 2 Hobbs KEF. Laparoscopic cholecystectomy. *Gut* 1995;36:161-4.
- 3 Warren MW. Care of the chronic aged sick. *Lancet* 1946;i:841-3.
- 4 Northridge D, Hall JRC. Cardiological services for the elderly. *J R Coll Physicians Lond* 1995;29:9-10.

Health promotion in general practice

EDITOR,—We wish to respond to A S Wierzbicki and T M Reynolds's letter¹ regarding our study of health promotion in general practice.² Our objective was to observe the effect of personal health education on the lives of patients with angina; hence this was our obvious criterion for inclusion in the study. It is incorrect that a 50% reduction in the incidence of angina was the criterion chosen to indicate a successful outcome. Rather, in determining our sample size we suggested that effective intervention might reduce the frequency of episodes of angina in those who were categorised as severely affected by about 50%. This criterion was purely arbitrary, but other relevant criteria for determining sample size were unavailable.

The difference in death rate was an incidental finding: further follow up may elucidate the importance of this observation. Our report stated that 38 of the 42 deaths that occurred were attributed to cardiovascular causes.

Our study did not show that personal health education had any additional effect on body mass index, but this may have been because our intervention emphasised the frequency of consumption of various foodstuffs rather than quantities. As a change in frequency of consumption was reported, more detailed dietary intervention might have been of further value. Full validation of reported smoking habit was not completed for all patients, but errors of underrecording would be unlikely to affect our conclusion. While more of the intervention group, as might be expected, reported having stopped smoking, the reported change in smoking habit did not differ significantly between the two groups.

Unfortunately, Wierzbicki and Reynolds seem to have misread our paper. We stated that the intervention group reported a decrease in frequency of attacks of angina and that significantly more of those patients reported taking prophylactic treatment: the possibility of self prophylaxis before exercise was not neglected. Exercise tolerance was not validated independently, but this would not have been appropriate in the study, which was carried out fully within general practice.

The conclusion of our paper supports, rather

Quarterly admissions through accident and emergency department 1984-94