The medicine of misery*

A personal account

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MONDAY

We spent part of this morning's ward round making a priority list; which of the five patients in need of admission was most acute, which could wait. There are two elderly ladies, both living alone, both very depressed. Edith is no longer taking care of herself, picking at her skin to the point where nasty sores have formed, and pulling her eyebrows out in her distress. Jonathan should have been admitted last week, we delayed and he took an overdose of Ativan. Alan is an elderly man who gets recurrent depressions. They seem to resolve of their own accord without medication if only he can be admitted for two or three days. Eleanor is a young mother of 28 who has been depressed for three months. Now she is completely preoccupied with ideas of killing both herself and her children.

I work as a registrar in psychiatry in a small acute admission unit attached to the District General Hospital of a busy market town. In normal times it is a happy and pleasant place to work. A combination of skilled and friendly nursing staff, good relationships with local GPs, a good social worker and psychologist, and hard-working committed consultants means that the trauma and stigma so often associated with admission to a mental hospital scarcely exist. As it is based in the community it serves, large numbers of patients can be managed on an outpatient basis and we could, in the past, if things broke down, intervene quickly.

Now, however, we are in a crisis! Last year the district budget for nursing services had been over spent by £50,000. To make up the deficit new staff posts have been frozen and there is no money for overtime or bank nursing. As a consequence, with two staff on long-term sick leave and one on maternity leave nursing levels have been reduced to two a shift (three or four is the normal level). This is not enough to look after 15 in-patients and 25 day patients. Closing eight beds was the only option, which is why we now sit weighing up our patients' varying levels of distress and try to decide who should get the one vacant bed, who could cope at home as a day patient or be passed on to another hospital.

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One of our current in-patients took an overdose last week when she heard that we planned to admit her to one of the psychiatric hospitals in the city, 30 miles away. Eleanor gets the bed and I go to phone the senior registrar at one of the city hospitals to see about them taking Alan. "No," I tell her "he is not an emergency in that he is eating, drinking and not suicidal, but in the past, when we haven't admitted, he has rapidly gone downhill and ended up mute, withdrawn, refusing to eat and requiring ECT. We would like to prevent that." But the one bed she has should be saved for someone in more acute need, "of course if he deteriorates ...". In this situation preventative medicine goes by the board.

TUESDAY

My study day and a chance to go to lectures at the city hospital and to hear from colleagues how bad things are elsewhere in the district. Four beds are closed at the Young Schizophrenic Rehabilitation Unit, seven out of 20 on the psychogeriatric ward, leaving only two available for acute admissions.

One of the long-stay wards for elderly chronic schizophrenic patients has been completely closed and most of its elderly, quite disturbed patients dispersed back to a unit from which they were originally separated out as being too frail to manage. Agatha Ward was one of the homeliest, with bright pictures and curtains, fresh paint and caring staff. Now there are 29 patients, many elderly and incontinent on a ward with two baths. Of course, it can be managed. As recently as 1970 bathing on these wards was a production line process – one in the bath, one dressing and one undressing with no privacy or dignity. Things had improved.

WEDNESDAY

Our local psychogeriatrician arrived to discuss a referral. He does not have a bed for her but luckily – the horror of it is that one uses that word – she is too ill with a chest infection to be transferred from the medical bed she now occupies. He is clearly upset and angry. Because of the lack of nurses he has lost 12 out of 19 beds available to him. Yesterday he arrived on a ward to find two nurses looking after 25 elderly patients. "And what am I supposed to say to an old man, living alone, covered in his own excrement and

eating out of tins – 'Sorry I have to reduce my workload as we haven't enough beds?' I've been in the Health Service for 20 years. I've never seen it as bad as this. Winter will be the crunch."

By mid afternoon it's clear we can no longer look after Edith as a day patient, but while she's happy to come in somewhere she knows, she refuses to be sent to a strange hospital 30 miles away. Doctors and social workers agree that a Section 3 (of the Mental Health Act) for up to six months admission and treatment is appropriate. The relative, whose consent is also needed, refuses when she learns how far away her aunt has to go. Edith sits hunched and fretful in a chair in the office, her face and arms covered in scabs, plucking at her almost non-existent eyebrows, saying repeatedly to anyone who will listen, "You wouldn't like it if you pulled your eyebrows out, would you?" Two hours later, at 7 pm, doctors and social workers decide to admit her under Section 2. This is not without some disquiet, because although it is for a month only and does not require a relative's consent, it is for assessment. Edith does not need assessment, she needs treatment. The Mental Health Act was designed to deal with medical, not geographical, need.

Thursday

The day is taken up with out-patients. Normally I have a total load of 60 to 70. It would be less if we had a community psychiatric nurse. My colleague emerges tense from her office at lunchtime after another lengthy discussion with a GP. "This is the fourth time you have told me that ideally you would admit, but you have no beds." Our consultant wrote to all the local doctors explaining our predicament and suggesting that they write to their MPs. They have been very supportive, but patients don't melt into the mist and good community-based care is only an alternative with more, not less, staff.

One good thing about the situation is that staff have not taken it out on each other or the patients. Miraculously, the atmosphere remains friendly and morale high but, as my consultant remarked, "It's draining. On the one hand I have to say "yes the situation is awful and we have to change it", and on the other to say constantly that what we are doing is not worthless, that we can still be therapeutic and empathise. There are times, however, when I feel management forgets that this isn't Sainsburys and patients are not oranges who respond to the law of supply and demand!"

The Unit general manager points out that no staff have actually been cut and that we have coped with low staffing levels in the past. But in the past bank nurses were available for a crisis and there was a large amount of goodwill to cover crises. Goodwill is finite. People will not do long hours for no pay when they realise they are being taken for granted and there is no end in sight. We are only too aware that next year's apparent increase in spending on the National Health is actually a deficit with little chance of closed beds being re-opened. When Health Authorities have raised income through advertising or hospital shops, it has simply been lopped off their allocation. The only reward reaped by making savings seems to be the demand for more.

This is not a healthy way to run a service. There are days when it does not feel like a service at all, and that we are providing containment not therapy. Mentally ill people are not glamorous. More often than not they are the old, the lonely, the frightened and the dispossessed. Crises occur at the worst of times, when they have lost jobs, homes or families, and the family that is around is often in a crisis as well and so are not in a position to stand up and shout on their relatives' behalf.

There is no doubt in my mind that admission units such as ours can be life-saving in the fullest sense of the word. Not just through drugs or ECT, which could at a push be provided on an out-patient basis, but through understanding, support and involvement in that person's life and sometimes quite simply 'asylum'. Moreover, in a community-based unit, that support can extend to friends and family and continue after discharge ... but that requires staff ... which requires money.

As I watch the National Health Service disintegrate around me, I hear friends I respect seriously discuss the option of private medicine, not because they believe in it or want the money, but because they cannot see where else they can obtain space to do their job well. They want to practise clinical medicine, not spend their lives fighting with each other over beds and resources. Others talk of leaving altogether. Neither option appeals to me. I grew up taking socialised medicine for granted, glad to practise in a country where the health care you received was not determined by your income. The buildings that I work in are Victorian, the portraits of philanthropic and charitable founders stare down in the board room. That is enough; I have no desire for a return to their values.

The answer is political, of course, but how do medical and nursing staff exert political pressure? The nurses have a code of conduct from the Health Authority so that they may not discuss internal policy matters with either the Community Health Council or the press. We are not similarly gagged, though I am told my ideas are naive. I think, for example, that spending vast amounts of money on murderous weapons of mass destruction is indicative of a national paranoid psychosis – and that it might be better spent on keeping people alive and well now, rather than killing them later. Apparently it is not so simple and I should stick to my patients. I would like to – if someone would give us some beds.