



Intravenous antibiotics

In the NZMJ Digest for August 2010, I have read Professor Mike Ardagh's article: *How to achieve New Zealand's shorter stays in emergency departments health target*. [eNZMJ 11 June 2010;123(1316): <http://www.nzma.org.nz/journal/123-1316/4152/content.pdf>]

The wording of this title is clumsy, but if you read on you will see what he means. How do you keep people away from Emergency Departments (EDs), and how do you manage them better if they come regardless? He remarks that "ED overcrowding is causing death and other harms in this country."

Ardagh takes the case of a man with pneumonia who needs IV antibiotics. He reveals a series of delays in the handling of the case within the hospital that are inimical to good patient care, and that take up too much time and too many resources. At the end of a paragraph that consists of questions for which Professor Ardagh seeks answers, he asks why intravenous antibiotics could not be delivered in the community.

If he really wants to know, I can help him with that one by describing the management of such a case as it applies here in Wellington, where private medical care cannot compete with the superior organisation of IV therapy to be obtained in the Short Stay Ward at Wellington Public Hospital.

I have for many years had a damaged limb that is very susceptible to attacks of streptococcal cellulitis. I need penicillin at those times, and I need it fast. Sometimes I can abort an attack with oral floxapen; other times I need it to be given intravenously. Some years ago, when I developed an attack, I got one intravenous shot from a GP plus the \$100 bill for the house call. That helped get me right. Recently, when I fell ill again, my GP directed me to the ED at Wellington Hospital. It was a long wait to be seen, but once I had got through the swing-doors, it was all go. A nurse got a needle into a vein, and the IV floxapen was begun.

I got a total of four spaced injections, each delivered right on time. At GP house-call prices, excluding the concealed subsidies paid to GPs, and adjusting for inflation, I got \$500 worth of IV penicillin therapy, two meals, and a bed for the night. I was back home in 24 hours, pulling a chair up to the table, and preparing a thank-you note to the staff of the Short Stay Ward.

In a lot of medical debate, the accent is on what we ought to be paying doctors, with no discussion at all on the ability of the patients or the taxpayers to pay them. Nobody who gets sick needs to be told where they can get it all for free, and, if I get another bad attack of streptococcal cellulitis, I'll know where to go. My GP is in complete agreement.

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