MEDICAL PRACTICE

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Contemporary Themes

Reorganization: The First Year

I. Plans

On 30-31 May the B.M.J. held a conference in Chichester of 14 invited speakers to consider "Reorganization: The First Year". Seven of the participants prepared a working paper, which was circulated before the conference, and the three used for the first session, on "Plans," are printed below, together with an edited version of the discussion.

Those attending the conference were Dr. R. G. B. Brown, Director, Institute for Health Studies, University of Hull: Dr. G. Coleman, General Practitioner, Birmingham: Dr. J. M. Forsythe, Area Medical Officer, Kent: Dr. A. M. B. Golding, District Community Physician, London: Dr. J. C. Hasler, General Practitioner, Sonning Common, Oxfordshire: Dr. S. Horsley, Medical Registrar, Truro: Mr. Rudolf Klein, Senior Fellow, Centre for Studies in Social Policy, London: Miss Janet Lewis, Fellow, Centre for Studies in Social Policy, London: Dr. J. H. Marks, General Practitioner, Boreham Wood, Hertfordshire: Dr. A. Paton, Consultant Physician, Birmingham: Mr. P. F. Plumley, Consultant Surgeon, Bexhill-on-Sea, Sussex: Miss Zena Oxlade, District Nursing Officer, Bury St. Edmonds, Suffolk: Mr. David M. Robson, District Administrator, Worcester: Dr. M. Ware, Editor, B.M.J.: and Dr. W. F. Whimster, Senior Lecturer in Pathology, King's College Hospital Medical School, London. The first session was chaired by Dr. S. P. Lock, Deputy Editor, B.M.J.

Reports of the other two sessions, on "Practice." chaired by Dr. A. J. Smith, Assistant Editor, B.M.J., and "The Future," chaired by Dr. G. Macpherson, Assistant Editor, B.M.J., will appear in subsequent issues of the B.M.J. A leading article appears at p. 705 and a glossary of N.H.S. terms at p. 738.

Working Papers

How It Strikes A Contemporary

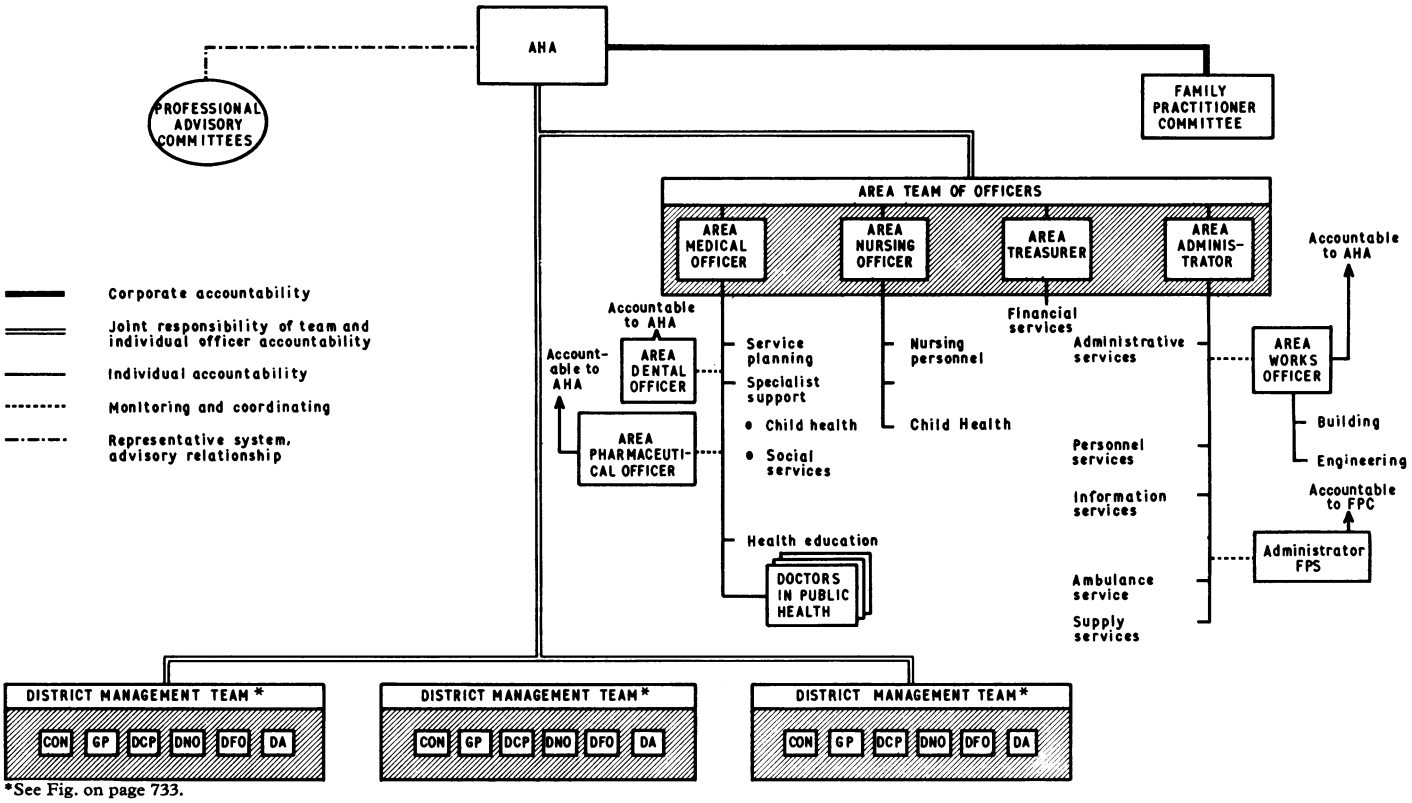
A. PATON

Low morale in present-day institutions—be they factories, the civil service, or hospitals—may be attributed to at least four causes, which are inter-related: (1) incomprehensible communications; (2) ineffective committees; (3) improper management; and (4) inability of those on the shop floor to make themselves heard.

Some little time before the Health Service reorganization—far too short incidentally to digest its implications—members of our medical executive were asked to read a fat paperback with an anonymous grey cover. The furtive manner in which it was passed round suggested that it might be pornographic—unfortunately it was not. Purporting to explain the impending changes, it has since taken its place in history as the supreme example of mandarin managerial English, known despairingly as gobbledygook. Some time after April Fool's Day and feeling more than usually frustrated, I decided to look into the prospects of becoming a community physician and borrowed an elegant blue H.M.S.O. publication. I should have known better. The only piece I could translate into English with certainty was "accountability upwards and delegation downwards," which meant "never take a decision." Since then I have not attended any committee, have refused to read any minutes, and have asked my secretary to dispatch all official bumpf unread for pulping. I don't think—though how can I prove it?—that my clinical practice has suffered, since my frustrations in the past have been compounded rather than solved by communications and committees.

Twin Cyclones

Some years ago the hospital was struck almost simultaneously by the twin cyclones of Salmon and functional management. In the process many longstanding administrators, both nursing and lay, were swept aside by bright young managers with money in their pockets and a strange, beguiling language. I struggled to understand, and attended managerial courses, until I realized that their words were as empty of meaning as the fat documents which began to roll off the duplicating machines. Meetings and broadsheets were the order of the day; it was impossible to find anyone who would do anything, requests for action being referred to committees. Now, five years later—though Salmon is unfortunately still with us, despite a worsening situation with regard to the nurse on the ward—functional management is an



*See Fig. on page 733.

Framework of the A.H.A. Organization with Districts.

acknowledged failure and we are uneasily back to a sort of administration.

There have been other unfortunate consequences. Senior staff whose length of service had given them some pride and loyalty to the institution either left or became disillusioned. Few of the new managers stayed long either, regarding their jobs as stepping stones to something better. Moreover, they were so busy with paper work and discussions that they were never seen about the place. A few trouble-shooters, who would walk round *their* hospital, inviting complaints and criticisms and pointing out improvements that could be made, might help to restore morale. I am reactionary enough to believe that we might even benefit from an old-style medical administrator.

No one asks people who do the work for their views. Instead, unrealistic committees—in the sense that members know little of the day-to-day work—run mostly by grey men of second-rate ability whose natural reaction is to say "No" have proliferated. In spite of promises of streamlining it now takes longer (by more devious routes) to get a decision than it did before the reorganization. This inhibits self-evident improvements, which would not only lead to a more human hospital but would also save money. The waste of electricity, heating, paper, disposable equipment, etc., is a matter of common knowledge, but it is impossible to do anything about it. On the clinical side we have been talking for years about admission wards; five-day wards for cold surgery and investigation, and specialized units—and yet we still have extra beds in all the wards in spite of a diminishing catchment area. Clinicians spend more rather than less time on committees, most of which are acknowledged round the luncheon table to be useless. If committees were abolished tomorrow none of us would be fully employed: there is overmanning in hospitals as well as in factories. My request for a new endoscope costing a few thousand pounds stays on a waiting list for several years when I know that money saved by a properly run hospital would pay for dozens of new instruments. I look at the decaying fabric of our Victorian pile and think of the thousands of pounds spent on accommodating the A.H.A. in prestige offices in the city centre.

Are We Really Short of Doctors?

No wonder I question the current dogma that the country is short of doctors (at least in the hospital sphere) and that the N.H.S. is short of money. To justify itself in my eyes, reorganization will have to show that it can free doctors, nurses, and other professional staff by efficient administration (not management, which is something different) to look after patients. It should give hospitals their own budget to spend as staff, not managers, think fit. Above all it will have to decide on the proper role of the acute general hospital, since many of the current problems (the front door of the casualty and emergency department; social as opposed to medical geriatrics; unnecessarily prolonged care of acute medical and surgical conditions) are the concern of the community. Not only would such hospitals be smaller and cheaper, but they would be properly staffed, with a high morale born of pride in the institution, and they would take their place once more as an integral part of the community.

Dudley Road Hospital, Birmingham
A. PATON, M.D., F.R.C.P., Consultant Physician

Run-up to Reorganization

J. H. MARKS

Though the Messer (1950)[1] and Guillebaud (1956)[2] Committees rejected the concept of unification in the Health Service, the Porritt Committee (1962)[3] concluded that the tripartite division was harmful to its development and suggested that unified administrative units (area health boards) should be established, with regional planning committees between them and the

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