daily work remains to be seen. Finding resources from these efficiency programmes will not resolve the wider questions of how much the United Kingdom can afford or should afford for health care—it merely postpones the debate.

Two other linked proposals will affect doctors profoundly—"to involve the clinicians more closely in the management process consistent with clinical freedom for clinical practice," and "to ensure that each unit develops management budgets."[1] Again, informed debate on these important issues has been hampered by lack of definition of terms like management budget, clinical budget, and specialty budget, and also by the fact that studies in six hospitals commissioned by the inquiry have not been completed.

General manager

In the view of Griffiths the best way of cutting through the delay and bureaucracy perceived in the NHS is to appoint a general manager at national, regional, district, and unit level, responsible for seeing that decisions are taken and implemented. Day and Klein see a move from consensus to conflict implicit in the Griffiths report in general and in the proposal for a general manager in particular.[2] Dyson goes further and talks of a "long and divisive conflict between the administrative and medical professions that will result from direct or indirect attempts to curb clinical freedom."[4]

These views seem to be based in part on the assumption that managers and clinicians will disagree more often than not. Recurring clashes between autocrats are implied. While it would be idle to pretend that conflict does not occur, it surely does less than justice to the many consultants and general practitioners who contribute to the smooth running of the service inside or outside management teams to place undue emphasis on the conflict view of the NHS, particularly "doctors versus the rest." Moreover, if management is seen as "getting things done through people" the management process rests essentially on the twin pillars of consent and respect, neither of which is the same as consensus. A good manager anywhere deploys facts, logic, and persuasion in search of consent, and only if these fail does the question of overriding opposition arise. A look at industry shows that, while there are some equivalents of King John among the barons, there are not too many Ghengis Khans about.

The question of respect is an important one, too. It is the case—unpalatable perhaps but true—that many doctors view administrators much as an officer corps views its warrant and non-commissioned officers—good chaps whose function is not to think or plan but to take orders and keep things running. This view is, of course, grossly unfair to many able administrators and to some doctors and also conveniently ignores the existence of mediocrities in our own ranks. Nevertheless, the view exists and does have an important bearing on the selection of the general manager at any level, as well as his ability to carry out his tasks.

Despite the fact that Griffiths makes clear that the general manager may be of *any discipline* and could come from within the existing management team *or outside*, much of the debate has been conducted on the assumption that he (or she) will in most cases be an administrator. Will this necessarily be so? And perhaps more important, should it be so? Or should some or most general managers be doctors?

The attitudes of doctors to participation in management vary from a distaste for an activity perceived as unclean through, rather less frequently, interest and helpful cooperation to, occasionally, driving enthusiasm. Yet in the nature of things our profession is arguably the largest reservoir of intellectual ability in the NHS; is trained in problem solving; and is accustomed to making decisions. What is more, a considerable number of clinicians privately admit to a degree of boredom with the clinical life and indulge their managerial talents by variously taking up politics (parish, local, medico, or national), farming, the bench, and so on. Why not, given adequate training, a second career in management? After all, Griffiths himself says "the nearer that the management process gets to the patient, the more important it becomes for the doctors to be looked upon as the natural managers."[1]

If Griffiths does come to pass, the first selection of general managers at district level *is* likely to be mainly administrators with a few community physicians, treasurers, and nurses. At unit level also administrators are likely to predominate. Then, after the expiry of the first round of fixed term contracts in three to five years, the next generation of general managers is likely to contain even fewer doctors. This faces our profession with some choices. One is to acquiesce in a pattern of organisation in the NHS whereby leadership in important areas is ceded to others, with the medical role reduced to providing advice laced with criticism. Another is to take the view that medical training and experience are uniquely important contributions to the practice of management in a health service and that clinicians should be one of the main sources of recruits for general management posts. This in turn will require a rethink about medical training at both undergraduate and postgraduate levels (as suggested by Griffiths), as well as of medico-political attitudes.

We are a conservative profession. This undoubtedly has advantages for our patients and ourselves. It may have disadvantages also—notably a sluggish reaction to change and opportunity. Let us hope Sir John Hoskyns did not have medicine and Griffiths in mind when he said that "the establishment fears change as a decaying aristocracy fears revolution."[8]

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Junior hospital doctors' posts: remaining one in two rotas

SARAH STEWART-BROWN

The Department of Health's circular PM(82)37 asked district health authorities to set up working parties to examine the hours of work of their junior hospital doctors and wherever possible to reduce rota commitments to one in three or better by August 1983.[1] The progress made by districts towards this goal was surveyed by the DHSS in the autumn of 1983, and regional health authorities were asked to summarise the data from their districts before they were presented to the DHSS. The summary statistics for the South Western Regional Health Authority are reproduced here as a basis for wider discussion on the desirability and feasibility of reducing the number of one in two rotas. (The term one in two is used to include the small proportion of rotas that are worse than one in three but not quite as frequent as one in two.)

Position at 1 August 1983

Table I shows the proportion of all junior posts that still carried an on call commitment worse than one in three at 1 August 1983: about one quarter. This proportion was remarkably constant across different grades, but considerable variation was evident between different districts (range 14-45%). Two possible causes for district variability were examined, but neither yielded an explanation.

Firstly, it seemed reasonable that districts with small junior staff establishments might have experienced more difficulty in arranging cover than districts with more staff, but there was no relation between the two (figure). Secondly, rota reductions might have been more difficult to achieve in districts where more than one major hospital site accepted acute medical and surgical patients or both. The proportion of one in two rotas among districts where there was only one major hospital site, however, did not differ from the proportion in the other districts (table II).

Rota changes achieved between March and August 1983

In March 1983, when the preliminary reports of the district working parties were submitted, 25·6% of the region's posts carried

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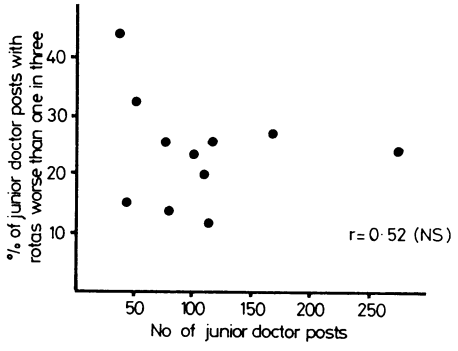
rotas more onerous than one in three: these rotas were common in almost all specialties (table III).

By August 1983, 8·1% of the region's one in two rotas had been changed and less onerous on call duties introduced. In a further 7·7% of posts rota improvements had been agreed by all concerned but districts were awaiting new appointments in order to implement the changes. The means by which changes were achieved and the principal hindrances to further improvements were clearly shown in working party reports to be "specialty specific." For this reason the regional data are presented in table IV for each individual specialty. The posts have been categorised according to the likelihood of improvements being achieved, and the number of one in two rotas at March 1983 has been used as the denominator.



Relation between number of junior staff in each district and proportion of posts with rotas worse than one in three, August 1983.

Reasons for failing to achieve changes

For 49·7% of the region's one in two rotas districts stated that changes were quite impractical. The specialties with the highest proportion of these posts were the small non-acute surgical specialties—for example, ear, nose, and throat surgery, ophthalmology, and dental surgery. For these specialties on call duties are light and hours of work are not excessive. The Royal College of Surgeons has stated that cross cover of ear, nose, and throat patients by those not trained in the specialty is unsafe practice, and therefore the only means of reducing on call commitments in this specialty would be to increase the proportion of first line on call carried by consultants. This would inevitably reduce the experience that could be gained by juniors in managing acute problems. One in two rotas in this specialty should probably remain.

At the other end of the scale the proportion of one in two posts in anaesthetics is small. The two remaining posts identified in the South Western Regional Health Authority are considered acceptable because the post holders are not expected to work for most of the day after their night on call. This practice may be becoming more widespread in specialties where on call work rarely permits more than an hour or so's sleep a night—for example, intensive care for adults and infants, and obstetrics in large maternity units. An analysis of on call commitments does not allow for this type of arrangement to be taken into account, but it is clearly important both in judging whether hours of work are too onerous and in setting fair levels of remuneration.

Two other points emerged from district working party reports.

On call commitments in the acute specialties, in particular general medicine and general surgery, do not equate with being "on take." During on take nights resident junior staff are likely to be working hard for much of the night admitting and treating new cases. In contrast, when they are on call for patients who are already in the hospital duties may be relatively light. In small hospitals it is practical for a single junior doctor to cover emergency admissions and inpatient care; in these hospitals one in three rotas should be easy to achieve for the principal specialties, but every night on call would be likely to be busy. In larger hospitals such a system is deemed to be unsafe practice because of the admitting workload and the large number of inpatients. In these hospitals one team of junior staff will be on take and working for much of the night and another team will be on call for inpatients only and be relatively quiet. Junior doctors in this situation may be on call every other night but on take only once a week.

The second point is that subspecialties in general medicine and general surgery require specialised knowledge at all levels of junior staff. A single houseman, senior house officer,

TABLE I—*Number of junior doctors' posts with rotas more onerous than one in three/total number of junior posts*

District	Senior registrar	Registrar	Senior house officer	House officer	District total (%)
1	0/1	3/12	8/56	0/9	11/78 (14·1)
2	0/0	2/7	14/37	1/7	17/51 (33·0)
3	20/71	14/63	12/104	22/38	68/276 (24·6)
4	5/13	3/19	4/61	2/20	14/113 (12·4)
5	4/10	4/9	5/19	0/12	13/50 (26·0)
6	0/1	4/22	19/67	0/23	23/113 (20·4)
7	0/0	1/4	5/27	0/7	6/38 (15·8)
8	2/18	5/25	12/61	12/12	31/116 (26·7)
9	0/0	3/6	13/21	0/9	16/36 (44·4)
10	0/3	6/37	23/74	9/15	38/139 (27·3)
11	0/5	2/16	17/63	5/25	24/99 (24·2)
Regional total (%)	31/122 (25·4)	47/220 (21·4)	132/590 (22·4)	51/177 (28·8)	261/1109 (23·5)

TABLE II—*Districts with one or more principal hospital sites*

No of principal hospital sites	No of districts	No of one in two rotas	Total junior staff	Proportion of posts with one in two rotas (%)
One	6	87	352	24·7
More than one	5	174	757	23

TABLE III—*Junior doctor posts with rotas worse than one in three at March 1983*

Specialty	No of posts with rotas worse than one in three	Total No of junior staff posts	% of posts with rotas worse than one in three
General medicine and subspecialties	68	198	32·0
Geriatrics	16	41	34·1
Paediatrics	27	73	32·9
General surgery	66	184	33·9
Surgical subspecialties:			
Thoracic, cardiac, plastic, neurosurgery	14	47	27·7
Ear, nose, and throat, ophthalmology, oral	46	103	41·7
Obstetrics and gynaecology	21	93	20·4
Orthopaedics	12	131	8·4
Psychiatry	5	90	4·4
Pathology	7	48	12·5
Anaesthetics	2	101	2·0
Total	284	1109	25·6

TABLE IV—*Changes achieved to rotas worse than one in three between March and August 1983*

Specialty	No of posts with rotas worse than one in three	Improved rotas implemented (%)	Improved rotas to be implemented with next appointment (%)	Improved rotas under discussion (%)	Improved rotas considered to be impractical (%)
General medicine and subspecialties	68	4·8	9·5	69·8	15·9
Geriatrics	16	0	21·4	0	78·6
Paediatrics	27	12·5	12·5	12·5	62·5
General surgery	66	16·1	3·2	32·3	48·4
Surgical subspecialties:					
Thoracic, cardiac, plastic, neurosurgery	14	0	0	38·5	61·5
Ear, nose, and throat, ophthalmology, oral	46	4·7	14·0	0	81·4
Obstetrics and gynaecology	21	15·8	0	42·1	42·1
Orthopaedics	12	18·2	0	63·6	18·2
Psychiatry	5	0	0	0	100·0
Pathology	7	0	33·0	0	67·0
Anaesthetics	2	0	0	0	100·0

or registrar can acquire the basics of a subspecialty rapidly because he is exposed to many cases and a lot of teaching in a short period of time. But if this learning process had to be extended to include other staff covering the subspecialty, who did not have regular daytime contact with the team, the learning period (in which patient care might be less than optimal) would be bound to be increased.

The other argument that has been used to support one in two rotas in the subspecialties of general medicine and general surgery relates to total workload. It is argued that in these specialties the cases are often complex. A junior doctor who has an appreciation of the specific disease process may be able to deal with an acute problem speedily and effectively. A junior doctor without the background information might need to spend a long time unravelling the complexities of each case. The effect of cross cover might therefore be to increase the total workload of junior staff.

Discussion

It is clear from the arguments raised by the districts that the workload of a junior hospital doctor cannot easily be assessed from the rota commitment attached to his post and that generalisations about rotas, even within specialties, are likely to be misleading. It is also clear that many junior staff on one in two rotas are content to work these rotas and do not consider that current levels of remuneration are inadequate for the work that they do.

If changeover to less demanding rotas is to be achieved without deterioration in standards of care some aspects of clinical management may also need to change—for example, record keeping, handover procedures, and teaching of junior staff. The changes may result in increased workload for junior staff.

Two issues emerge in all discussions on the hours of work of junior doctors, and although they overlap it is clearly important that they are not confused. They are optimum patient care, which requires knowledge and alertness among the doctors delivering the care, and conditions of service for junior doctors, which includes workload, training opportunities, and remuneration for work done.

The principal conclusion that may be drawn from the data of this region is that the best solution to these two overlapping but competing issues cannot be generalised across different hospitals and different specialties. Each case may need to be considered on its own merits, and in some cases a one in two rota is likely to remain the best buy for doctors, patients, and health service managers alike.

The working parties of the 11 districts in the region expended considerable effort in reviewing and reporting on the hours of work of their junior hospital doctors. Without the detailed reports that they produced in a short period of time this paper could not have been written. I am grateful to Dr R Forbes for his encouragement and advice and to Irene Williams for typing the manuscript.

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(*Accepted 5 January 1984*)

Letter to Prime Minister

HJSC's "alarm and anger" over NHS cuts

The chairman of the Hospital Junior Staff Committee, Mr Stephen Brearley, has written to the Prime Minister about his committee's concern about the effects of the cuts in manpower and finance. Mr Brearley's letter and the accompanying evidence are reproduced here.

"The Hospital Junior Staff Committee viewed with great alarm and anger the cuts in manpower and finance imposed by your government on the hospital service. It seemed inevitable to us that such cuts would damage patient care as well as the morale and fabric of the NHS.

"The consequences of these cuts have not even now become fully apparent but evidence is accumulating to rebut your assertion that patient care could be protected. You will have seen such evidence published in the *Guardian* on Wednesday 18 January. I am enclosing with this letter further evidence collected by my committee.

"I would urge you most strongly, even at this late stage, to restore the cut in finance and remove the manpower restrictions which were so hastily imposed and which have had such a disruptive effect."

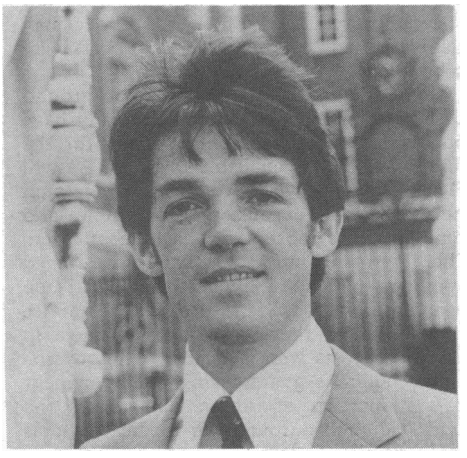
Effect of cuts in manpower and finance on NHS hospitals

Evidence collected by HJSC

The cuts in NHS finance and manpower imposed within a few weeks of each other in the summer drew protests from doctors, nurses, other health workers, the public, and politicians. They were imposed on a health service already struggling to meet its obligations within available resources. For several years funding by the government had been based on unrealistically low assumptions of price and wage inflation in the service, while significant growth was made dependent on authorities' efficiency savings. Although the resources of the health service were claimed to grow in real terms with reference to the retail price index, the high rate of inflation in the service coupled with demographic change meant that growth in practical terms had ceased.

The Hospital Junior Staff Committee expressed its concern over the latest cuts publicly and undertook a lobby of members of parliament when parliament reassembled in October. At that stage few details were available to show how the cuts would be implemented and what would be their effects on patient care and the future of the health service. Since October the HJSC, in conjunction with the British Medical Association as a whole, has been trying to collect hard evidence on the effects that the cuts are having.

The government is fortunate in that the evidence is, by its very nature, hard to collect. There are two reasons for this. The first is that, because of cash shortage and the need to rationalise and redeploy the resources in the light of changing need, many health authorities were already entertaining plans to close beds or whole hospitals.



Mr Stephen Brearley.

It is not easy to discern the effect of the latest cuts against the background of pre-existing difficulties. Secondly, authorities have found it difficult to implement the cuts and as of 1 December many districts had still not reached firm decisions. Even when decisions to cut staff and beds have been reached, it takes time for the effects of these measures on patient services to become apparent.

This paper gives details of some measures that were decided on by district health authorities in England by 1 December 1983. On that date, however, fewer than half of the 192 districts had reached firm decisions and usable information was obtained from only 41. Scrupulous care has been taken in analysing the data to record only measures resulting from the latest round of cuts and to exclude any resulting from pre-existing hardship, however serious these may have been. The measures described can be divided broadly into actual cuts in existing provisions, and postponement or cancellation of imminent new developments.

Medical manpower background

The annual output of British medical schools is now about 3500. There is also an annual net influx of almost 1000 doctors from overseas and, provided these doctors fulfil certain minimum criteria, their numbers cannot be controlled. All these doctors enter the pool of hospital juniors. There are, however, only about 1800 vacancies in general practice and 700 as hospital consultants by which these doctors can leave the pool. Although small numbers of doctors also leave the pool through moves into community health, the armed forces, industry, and early death, and a small proportion of women doctors choose not to continue in practice,