University of Hard Knocks which is inherent in health work—both free items of distilled wisdom rather than products of management expertise.

As regards this latter, consider an example of the matters with which Mr. Maxwell does not deal. In the new county of Lancashire 150 or more members of hospital management committees are to be replaced by approximately 14 remotely based health directors of an untried variety. What sort of a contribution is this ending of self-regulation to the future efficiency of organization?

I would like Mr. Maxwell to explain why he thinks the great imponderables dealt with by the N.H.S. are manageable at all in his sense. Such a lot depends on the life-pattern of the country outside the N.H.S. and its impact on the service. Perhaps only an excellent esprit de corps and the engendered faith can move the mountains involved and, as regards hospitals, provide a continuance of good hospitalmanship.—I am, etc.,

A. F. ROBINSON

Nelson, Lancashire

SIR,—Mr. R. J. Maxwell (20 January, p. 160) makes a forceful argument that good management is better than bad in the National Health Service. Few would disagree. Less convincingly, he argues that most critics of the N.H.S. reorganization proposals are questioning whether the N.H.S. should have any kind of management at all rather than querying "bad management proposals" in the White Paper and the "grey book." We disagree; the critics are saying quite explicitly, we suggest, that the proposals, formulated on the basis of advice from McKinsey's and the Health Services Organization Unit of Brunel University, are "bad management" for the Health Service. Joe Rogaly in the *Financial Times* (23 January) would like Sir Keith Joseph to say "This reorganization is based on the thinking of a bygone decade. We must scrap it and devise something new to meet the new thinking." John Cunningham in the *Guardian* (22 January) says: ". . . more and more people are realizing that Sir Keith Joseph's managerial revolution—drafted by McKinsey's, the management consultants—will take health care in all its aspects even further away than it now is from public surveillance and interest." And finally Robert Jones in *The Times* (1 January) says: "If the Government proposals were the best that business has to offer to the Civil Service I would say bring back the mandarins."

It may be that these and other critics of the N.H.S. proposals (including ourselves, admittedly!) all share "misconceptions about management," as Mr. Maxwell would have it. But he tells us "I shall not attempt a defence of the report on management arrangements (which is concerned with means), but shall try to clarify the objective we should aim for and some ways this objective can be reached." That is a worthwhile task, but it does not serve to correct the "misconceptions" held by the reorganization's critics. There is in fact a good deal of agreement all round about the aims of the Health Service. Indeed, many of the critical discussions go to some length in discussing N.H.S. objectives in health care terms—the biological and psychological nature of care, the interactions of the social and physical environments with health, the stresses experienced both by the providers and by the recipients of care. We note, though, that Mr. Maxwell's article does not place health care objectives in a primary position; instead, he appears to equate "objective" with certain kinds of organizational functions—planning and directing, organizing and getting things done, evaluating performance, and exercising selective controls. This ordering of priorities also characterizes the reorganization proposals themselves. Much of the disquiet with the McKinsey-Brunel work no doubt comes from what critics see as a cart-before-the-horse approach to the reorganization problem. This reaction is most prevalent among first-line providers of care (doctors, nurses, and associated paramedical groups) and among patients or "consumers." In both instances the care process is perceived as being downgraded in relation to the supporting administrative-managerial process.

While we are in sympathy with those objecting on such grounds, we do not see this as the crucial issue. In the paper which Mr. Maxwell quotes,[1] and in subsequent work,[2] we list organizational aims which Mr. Maxwell appears to agree with: inter alia, responsiveness, adaptability, integrated and participatory approaches to problem definition, decision-making, and especially, care delivery.

The McKinsey-Brunel recommendations cannot be evaluated exclusively on the objectives they want to attain or on the basis of the consultants' intentions. The main basis for judging them must be their likelihood of success in reaching those objectives when they are put into practice. The problem with the proposals is, of course, that they recommend a hierarchical, from-the-top-down command and control structure, with minimal opportunities for organizational participation on the part of first-line providers of care or of care recipients—the public. These are exactly the characteristics that lead to a rigid, non-responsive, fragmented organization. A plethora of studies has documented this relationship over the past 20 years and more; the excerpt we quote from Burns and Stalker's work[3]—which Mr. Maxwell takes particular exception to—was published as long ago as 1961.

Our paper[1] suggested that the objectives of the N.H.S. would be better served by using a different type of approach, which we regard as more in keeping with current knowledge about organizations and the people in them. We argued for the use of an open systems model, on the ground that this is one of the approaches that more accurately portrays the highly complex, organic nature of the N.H.S., of its objectives, and of its interaction with the public it serves. The mechanistic model used by the advisers has led to the rigid, structural "answer" contained in their recommendations.

Our criticism, then, is of the managerial means recommended to the Department of Health and Social Security by McKinsey and Brunel and of the organizational approach which underlies the recommendations. We judge the recommendations to be inappropriate for an effective health service, for reasons documented both from research and from experience. (Georgopoulos[4] provides a review of the past decade's work on this question.) We have suggested some possible directions in which to proceed if more appropriate solutions are to be found.

Mr. Maxwell elects neither to question nor to defend the current reorganization proposals in his article. We hope that he will. And since the N.H.S. is not a "child showing pronounced delinquent tendencies" but a highly complex human and technical system experiencing serious functional problems, we hope that Sir Keith will continue to question those proposals and their effects very sharply indeed. There is still time—just.—We are, etc.,

GARY GRENHOLM
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1 Grenholm, G., and Draper, P., *Community Medicine*, 1972, 127, 27.
2 Draper, P., and Smart, T., *The Future of Our Health Care*. Department of Community Medicine, Guy's Hospital Medical School, 1972.
3 Burns, T. and Stalker, G., *The Management of Innovation*. London, Tavistock Publications, 1961.
4 Georgopoulos, B. *Organization Research on Health Institutions*. Ann Arbor, Michigan, Institute for Social Research, 1972.

Body Temperatures in the Elderly

SIR,—I have read with great interest the paper by Dr. R. H. Fox and others (27 January, p. 200), particularly their recommendations.

As a coroner, I see enough cases of death in which hypothermia plays a part to realize that this is a serious matter and I have wondered whether the use of sleeping bags would not be a simple palliative in some cases. Sleeping bags are used by those who from choice or the exigencies of their avocation sleep out in extreme conditions. The equipment these people use is expensive, but it might be that a simpler bag would benefit the aged.

Of course there are problems; one undoubtedly is that many old people would not take kindly to it and another that mild incontinence would render the equipment useless. However, I should be interested to know whether sleeping bags have ever been considered for the prevention of hypothermia in the elderly.—I am, etc.,

F. G. HAILS
H.M. Coroner

Stoke-on-Trent

Care of the Dying

SIR,—I should like to second the plea of Professor M. R. Alderson (20 January, p. 170) for further studies of terminal-care requirements and also his doubts about allocating to the care of the dying only 12 beds per 500,000 population. The need will vary with the quality of domiciliary support and the pressure on acute beds in the local hospital. Nor must we underrate the untidiness of life, since recent work here indicates that a considerable number of patients dying in hospital spent most of their last month at home.

What is worrying is that such an allocation would be inadequate at the same time as it encouraged the removal of these responsibilities from everyday medicine. We who are associated with special units sometimes forget that our units are not always either necessary or even desirable answers. Most patients would choose the family doc-