Medical advice to the NHS: a simpler structure

MAURICE BURROWS

Like Gaul, the National Health Service is not one but three entities. While essentially similar, each part has quite different demands and offers varied services. The rural service has scattered populations with stretched lines of communications, the conurbation service has concentrated resources stretched to cope with inner city deprivations, while London, as all agree, has unique difficulties. Thus it is probably beyond the wit of men or women sitting around a table to devise a rigid medical advisory machinery that is ideal for all the NHS's varied circumstances. So the Chief Medical Officer's Joint Working Group, of which I am a member, set its sights on a simple, flexible structure for providing medical advice in the NHS, tackling first advice at district level (p 239).

I see any medical advisory machinery having three essential features:

(a) It must be readily available to health authorities and to clinical members of district management teams as well as being able to offer advice on its own initiative.

(b) the practical arrangements must contain some flexibility while maintaining a balance between the representational and expert elements;

(c) the machinery must have the confidence of the profession at large so that health authorities can be confident that the views expressed represent the general views of the profession locally.

Furthermore, any machinery must be as simple as possible and use doctors' time efficiently—the present structure has proved too cumbersome and wasteful of doctors' time to work effectively.

The 1974 reorganisation of the NHS has been widely criticised—though some of its failings may have been caused as much by worsening economic circumstances and changed industrial attitudes in the NHS during the last six years as by the structure itself. The praiseworthy intention of widening participation in decision making has been lost in less than clear lines of command and obscure channels of communications. Many hospital doctors have found the relations between the hospital staff committee (with or without specialist divisions), its medical executive committee, and the district medical committee (DMC) with the medical members of the district management team (DMT) difficult to elucidate. Further confusion has occurred when a multi-district area also had its area medical committee (AMC) and area team of officers (ATOs) above the district structures. In general practice it has not always been clear how the local medical committees have related to these various groups. There have been demands for changes from all sides. Clinicians do not want to waste time in sterile discussions around committee tables but they do want to participate in giving expert advice with the expectation that the advice reaches the proper quarter and without delay.

The medical profession face a particular difficulty in organising representative machinery for providing advice to employing authorities. As members of a profession of high ideals and strong independence, doctors do not readily hand over decision making to any one person or group of persons. It is important that authorities recognise that unanimity in the medical profession is rare—and thus especially important when it does

occur—but even so a considered balanced view will usually be obtainable. Where an important minority exists it should be recognised and an authority must be told so that appropriate weight is given to it when decisions are being made.

The CMO's Working Group has acknowledged these problems and accordingly emphasised that the machinery should be flexible so as to allow for variations between health districts. It looked closely at the part played by the DMC under reorganisation mark I and found, on balance, that its usefulness had not lived up to the original expectations. Many DMCs had rarely, if ever, met, and some had simply endorsed the views of LMCs or district hospital medical committees (DHMCs).

Before proposing abolition of the DMC the working group closely examined the role and authority of the clinical members of the DMT and their relationship to their colleagues. Adequate cross-representation between single discipline committees and between the three medical members of the management team should facilitate the integration of differing views. Should a matter arise in which hospital doctors and general practitioners appear unlikely to share a common view an ad hoc meeting (or meetings) may be needed to determine whether agreement might be reached. If the differences cannot be resolved informally the way is open for the DMT or the health authority, or both, to make their decision in the light of all the evidence presented.

The elected members—the consultant and the general practitioner—of the new district have two major responsibilities:

(a) Clearly they are responsible to those who elect them, and should represent their "constituents'" views with clarity when possible and with understanding when the "medical view" is not clear cut. Furthermore, the DMT doctors will have to interpret the team's recommendations to their professional colleagues, for it is essential that the clinical representatives should retain the confidence of their colleagues. Without this confidence they cannot provide effective medical advice to the team or participate effectively in management.

(b) The medical members of the team are also collectively responsible with their non-medical colleagues to the health authority. The DMT's clinical members—like the officer members—will have the right to attend meetings of the health authority. They would support the team's collective decisions but at the same time they must be alert to those occasions when the authority should be advised of any reservations held by a substantial minority (or indeed a majority) of their colleagues.

The general practitioner member of the DMT will have been elected by his LMC and it is to that committee that he will turn for advice and consultation. It will greatly facilitate the exchange of views between hospital doctors and GPs and improve the chances of achieving a common professional policy if senior hospital medical staff are adequately represented on the LMC. The DMT's consultant will be elected by a process acceptable to the senior hospital medical staff of the district. They may decide that the election should embrace the whole medical staff committee (the district hospital medical committee) or just the medical executive committee (MEC). The latter committees usually arise from the cogwheel system (divisional chairmen forming the MEC); by election from the DHMC; or by a combination of these two. So present arrangements should be continued if they have been proved satisfactory, though it will now be necessary to ensure that GP's are also adequately represented for the same reasons that consultants should be on LMCs. The consultant DMT member will be responsible to

St Catherine's Hospital, Birkenhead, Merseyside L42 0LQ

MAURICE BURROWS, MB, FFARCS, consultant anaesthetist; chairman, General Purposes Subcommittee of CCHMS

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might be saved before a final decision was taken on the issue of redundancies.

Several Council members spoke favourably about the loyalty of the staff and criticised the fact that they had not been consulted. Dr W J Appleyard is a member of the Finance and General Purposes Committee but he was not at the meeting that had made the recommendation. He proposed the referral back to the motion though he agreed that the sense had been changed by the reference to natural wastage and early retirement. The BMA should act as a good employer and if there had been proper consultations the savings might have been made. Dr John Ball pointed out that the Council had appointed the Finance and General Purposes Committee and sometimes it had to make unpleasant decisions. The Council would have to say what the alternative savings should be.

It was wrong, Mr A P J Ross said, for the BMA to insist on no medical redundancies in the NHS and then to talk about making its staff redundant. There could be savings in committee costs. If the Secretary reviewed the staffing structure and said that there was no surplus fat the Council would have to consider increasing the subscription.

Whatever the Treasurer suggested was unpopular, Dr R A Keable-Elliott said. The BMA had been living on its capital. The

Finance and General Purposes Committee had decided that the number of staff employed was too high; it was rubbish to say that everyone on the staff was sacrosanct. The Council had to be realistic, Dr W G A Riddle said. There might not be a need for redundancies but the recommendation must be passed on the understanding that Dr Havard would do everything he could to protect the staff. Dr Brian Lewis agreed: a computer had been installed, he said, and word processors bought to save staff but there had been no reductions. Comparable organisations were run with a smaller staff.

To try to meet the conflicting views that had been put forward Mr Grabham proposed to amend the recommendation to read: "That in order to achieve a saving of £79 000 in 1981 the staff of the Association be reduced either by redundancies, natural wastage, early retirement (voluntary or compulsory) at the discretion of the Secretary in consultation with the committee unless after further discussions with the staff alternative savings can be identified which are found acceptable to the Finance and General Purposes Committee."

One or two speakers wanted to remove any reference to redundancies but the Treasurer pointed out that when someone was made redundant the Government paid 41% of the bill. Dr Havard said that he thought the money

could be saved in other ways; meanwhile the staff would have the threat of redundancies hanging over them. Dr Appleyard's motion to refer the recommendation back was lost and Mr Grabham's amended motion was carried by a substantial majority.

Future BMA meetings

- 1981 ARM, Brighton, 29 June to 2 July
Clinical Meeting, San Diego, California, 19 to 22 October
- 1982 ARM, London, 5 to 9 July
Annual Scientific Meeting, Worcester, 9 to 11 September
- 1983 ARM, Dundee, 27 June to 1 July
Annual Scientific Meeting, Cambridge, 1 to 3 September
- 1984 ARM, Manchester, July

Is the DHSS signing off?—continued

framework of health care in each locality. The danger is that these decisions may be taken speedily and without regard for the DHSS's advice that DHAs should "avoid full-time posts at district level or below in any discipline or function unless they are sure that there is work to warrant them."³

"High risk" policy?

The 1974 reorganisation reflected Whitehall's concern to prescribe standardised health care across the country. Central administrators treated health care as a commodity to be packaged and allotted in equal proportions like social security and unemployment benefit. And they relied on a watertight framework of standardised hierarchies and job descriptions to achieve this.

A senior civil servant has described the policy of delegation and autonomy as "high risk" because it means more local responsibility and initiative than has ever been expected or shown before and requires considerable local management talent to carry it through successfully.

From the medical profession's point of view a heavy new responsibility will be placed on the new medical advisory machinery (p 239) and on the local organisation of the BMA. The prospect of 200 autonomous new health authorities, each evolving its own package of policies, means that there will be a wide range of issues that transcend particular crafts on which the whole profession will need to take a view. I suggested in a previous article⁴ that the BMA division is the obvious machinery for formulating and presenting the profession's view. [This article was prepared before the report on medical advisory machinery by the Chief Medical Officer's working group (p 239) had been published.—ED]

The craft committees will undoubtedly continue to service their various branches of the profession at the local level in the newly developed service, fulfilling functions analogous to those of the central craft committees. But it is on these other, wider issues, most of which will arise from a DHA's freedom to spend its own

budget, that the medical profession will need to be united, active and vigilant.

References

- ¹ Department of Health and Social Security. *Patients first*. London: HMSO, 1979.
- ² Department of Health and Social Security. *Management arrangements for the reorganised National Health Service*. London: HMSO, 1972.
- ³ Department of Health and Social Security. *Health Service development: structure and management*. HC(80)8. London: DHSS, 1980.
- ⁴ Anonymous. Slimming down RHAs. *Br Med J* 1981;**282**:247.
- ⁵ Department of Health and Social Security. *Delegation of routine departmental variations and directions*. PM(80)35. London: DHSS, 1980.
- ⁶ Ellis N. Is the BMA division really necessary? *Br Med J* 1980;**280**:1151-2.

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whichever body elected him and should keep it informed and consult with it as occasion demands.

Doctors should remember that the medical members of health authorities do not represent doctors working in the district and are not sitting on the authority to give formal medical advice. They are members of the health authority for their own personal qualities and to see that the appropriate medical advice is obtained through the channels described in the working party's report—namely, the clinical DMT members elected by and responsible to their colleagues.

NHS reorganisation mark II has given us another opportunity to look at how medical advice should be given to health authorities. In my view the working group's report outlines a simplified adaptable way for the profession to give advice at district level with a minimum of delay and little extra commitment for the practising doctor. The Department of Health has asked for views on the proposals by the end of March. The profession should discuss them thoroughly so as to ensure that in 1982 the NHS has a medical advisory structure in which doctors have confidence and which health authorities respect.