Hospital Management

Sir,—I have read with much interest the report of the Working Party on the Organization of Medical Work in Hospitals.1 However, I have some misgivings with regard to one or two proposals.

If I understand correctly, the working party propose grouping the consultant staff of a hospital into divisions—of physicians, surgeons, obstetricians, laboratory staff, and so on. Each division will have a chairperson appointed by the regional board. Each division will send a representative to an executive committee, which will itself have a chairperson appointed by the regional board. Divisions will deal with purely divisional matters; the executive committee will concern itself with the over-all running of the hospital.

One's first misgivings are over the key position of the executive committee chairman. The working party declare themselves against the old style medical superintendent. Yet they go on to suggest that the chairperson of the executive committee should be appointed by the regional board, should serve for five years or more, and then might return to wholly clinical practice; he should have executive functions, which, however, are not defined. This seems to be a distinction without much of a difference. The aim of administration should be to release enterprise and initiative, not to shackle it. An important factor in securing this object is for the consultant body of a hospital to have confidence in its chairperson. Appointment by a remote and employing body is hardly likely to command such confidence. Election by the consultant body, though possessing defects inseparable from democracy, does do this. If administration tries to solve its immediate difficulties in regional hospitals by insisting on appointment, they will, in my opinion, ensure long-term deterioration in regional hospital services. When other branches of the civil service are seeking ways to release enterprise and initiative, it would seem undesirable for the Health Service to take an important step in the wrong direction.

One's second misgiving is over the position of the medical advisory committee. The working party see no reason why these committees should not continue to meet as before. The wording suggests that they doubt the necessity. Certainly it is difficult to see many functions remaining for these committees after the executive committee has been set up. Executive committees are proposed because medical advisory committees, as at present constituted, are too cumbersome. One doubts whether these latter committees are quite as cumbersome as it is suggested, and they have one vital purpose. They give every consultant a sense of belonging and contributing to his hospital, thus stimulating his enterprise and initiative. This enterprise and initiative constitute the driving force behind regional hospital services.

Morale in these hospitals has taken some severe knocks in the last few years. Creation of executive committees on which perhaps seven out of eight consultants will have only an indirect say is not going to help at all. It might be better if the medical advisory committee maintained its position, but its activities were to be streamlined by the proposed divisions acting as subcommittees dealing with divisional matters and reporting to the main committee.

The working party emphasize that their report is provisional and intended to promote discussion on what are admittedly very important matters. It is to be hoped that ultimate decisions will be wise ones.—I am, etc.,

David Ferriman.
North Middlesex Hospital,
London N.18.

REFERENCE

Sir,—After reading the first report of the Joint Working Party on the Organization of Medical Work in Hospitals, I found myself in agreement with the purpose of the changes, in doubt as to their practicability, and in strong disagreement with one paragraph.

I have since had the opportunity of questioning one of the members of the working party on this paragraph and his reply was illuminating: my disagreement has turned to despair.

Paragraph 60 uses the phrase "in consultation with" in two places. Has the medical profession not learnt, after nearly 20 years of the National Health Service, that this is a "heads I win, tails you lose" phrase? A head of a division appointed under this paragraph is a regional hospital board appointee, however much the local consultants may dislike it—"to do anything about it. Once this becomes agreed policy, although for the first time the local consultants' wish may be heeded, thereafter they can be ignored. The history of the last 20 years is littered with examples of broken faith with the medical profession, broken by Governments, by Ministers, and by the Ministry of Health. For one example, see my letter to you in your issue of 22 May 1965 (p. 1381).

One never learns that good intentions are not enough, that the only thing that Ministers recognize is an agreement in black and white signed by both parties, and that even then there are unilateral breaches.

If this paragraph comes, heads of divisions must be elected by their colleagues, and this must compel acceptance by the regional hospital board. Only so can we make certain that a head of division enjoys the support of his colleagues.—I am, etc.

Nigel Criddle.
Portsmouth,
Hampshire.

Pay-beds in N.H.S. Hospitals

Sir,—I feel that it will be small comfort to him, Mr. D. J. Neal Smith (20 January, p. 151) who I think speaks for not the only hospital group to have had recent experience of the incompatibility of the Minister's statements in the House of Commons with his actions in the course of the "review" of sector V beds.

This erosion into the private sector of hospital medical practice, though more blatant under the present administration, has in fact been noticeable ever since 1948, whatever the political hue of the Government.

Surely a word of caution should be raised when a report that one of the consultants' meetings at the group hospital to have had recent experience of the incompatibility of the Minister's statements in the House of Commons with his actions in the course of the "review" of sector V beds.

For, paradoxically indeed, we are now confronted with a more than 20% reduction in the private beds for this area—in Hitchin from seven to five beds. The Service needs more financial support, not less; those who can afford to pay for their private accommodation should be encouraged, not deterred.

This reduction in private accommodation without peripheral discussion has gone beyond the limit which we in the periphery will accept. We feel that this reduction should be rescinded and the local problems discussed before such moves are implemented, otherwise we will have to rescind our thoughts regarding our increasing work load in the regional hospitals.—We are, etc.,

G. Bankcroft-Livingston.
J. J. Shipman.
Lister Hospital, Hitchin,
Hertfordshire.

Sir,—Mr. D. J. Neal Smith's admirable letter (20 January, p. 186) is hardly given the prominence it deserves, and, so far as I know, there has been no editorial comment on this issue. Carried to its logical conclusion, the subject of a leading article in the same number (p. 134), are surely affected by ministerial policy in the matter of pay-beds.