Managing the Hospitals

Sir,—In recent months the management structure of hospitals has been the subject of many investigations with the expressed view of improving efficiency at all levels and making the most of available resources. These investigations have given rise to a spate of reports—for example, Farquharson Lang (Scotland),1 Hawat (Northern Ireland),2 and finally, the most recently published King's Fund (London) report.3 It is now quite obvious that these important reports are receiving scant attention from hospital doctors, because they have not been made aware of their content and are thus unable to investigate them fully and assess their eventual effect.

It is suggested that there is now a case for all levels of hospital medical staff to examine and assess their individual roles in the hospital structure of the future, and consider if any benefit is to be derived from the application of recognized managerial principles in their own work. These principles are based on an analysis of business and commercial efficiency and their application, in part or in toto, without critical examination and recognition of the unique structure and function of a hospital could prove disastrous to the efficiency of hospital medical practice. The medical profession can be proud of the standard of efficiency in the majority of our hospitals, and should recognize that if industry, the Civil Service, and other administrators had matched this in their own spheres of operation then our present-day economy would never have occurred. The fact that continued and steady progress has been made in the hospital service where levels of authority are difficult to define, and where all hospital regions are of the same size and region, is an argument in itself for retaining the existing flexibility. The same considerations weigh heavily against the introduction of "super managers," which most of these reports favour.

It is significant that the idea of a "super manager," who in most cases would be a lay administrator, originated from committees and working parties composed almost entirely of hospital secretaries and other laymen, who are completely unqualified to investigate the subjects under review. It would not be uncharitable to suggest that a "Charter for Hospital Secretaries" would be an apt title for their valuable work. In most cases these working parties have decided their own terms of reference and do not appear to have gathered the detailed and impartial evidence on which their opinions should have been based.

The influence of the Institute of Hospital Administrators can be seen clearly in the recommendations contained in these reports. Their views were made clear when asked by the Ministry of Health for their comments4 on the King's Fund Report.5 They firmly held that hospital administration can no longer be viewed in the simple terms of comprising a partnership of medical, nursing, and lay administration. In the complex working of medicine, surgery, and nursing there are only two of a wide range of essential services.6 They declare that the Beaver concept of tripartite administration "has become regarded as wholly outmoded by both hospital administrators and by others concerned with the management of the hospital service."7

It is imperative that the medical profession realize that these reports carry implications as great as did the original introduction of the National Health Service. They should not allow less important preoccupations to detract from the recognition of the magnitude, the scope, and the far-reaching effects of these reports. The lay take-over of hospital administration in the hands of a few all-powerful general managers, most of whom would be "lay," would eventually reduce the status of medical staff to the level of all other groups of hospital workers. These reports infer that the medical profession can play no worthy part in the running of the hospital service. The interference with professional freedom and the doctor–patient relationship which would eventually follow the introduction of such an all-powerful management will unquestionably ruin our hospital service for all time, and would make hospital medical practice an unattractive and unrewarding career.

The present reorganization of the general-practitioner service will eventually locate most general practitioners in group-practice centres owned by local authorities. It does not require a great stretch of the imagination to see this branch of the profession eventually falling under the thumb of lay administrative managers.

All doctors should unite now to face this great challenge to our profession and its freedom. The British Medical Association should ensure that the maximum amount of publicity is given to the implications contained in these reports. The response to your leading article (4 November, p. 252) indicates a lack of interest by the profession, who do not appear to be aware of the gravity of the situation which is now facing them, and unopposed implementation of these reports through lack of interest is very likely to occur. The medical profession and the British Medical Association should ensure that "medical administration" is added to the curriculum of undergraduate and postgraduate medical training as a matter of utmost priority to ensure that a supply of appropriately medically qualified administrators will be available to fill the managerial breaches now being artificially created.—

JAMES BLUNDELL.

North Armagh
Hospital Management Committee.
Langsh, Co. Armagh.

REFERENCES
5. Hospital, 1966, 6, 58.

Clomiphene for Ovulation

Sir,—Your leading article (25 November, p. 434) states that "to determine whether a woman responded at all to clomiphene and when she ovulated requires nearly continuous 24-hour collections of urine for steroid assays over two to three weeks." But surely all the non-ovulating infertile woman wants is to conceive and the only test that interests her is a pregnancy test. How many busy housewives or working women can collect 24-hour specimens daily for three weeks? How many laboratory units in how many hospitals can do the necessary estimations and do them daily for three weeks? It is a curious benefit to a few people while a failure to use them can do harm to a larger number." What harm? Your leading article states that the untoward side-effects of clomiphene are slight, so even if it is given to many women who do not need it, as it undoubtedly will be, or do not respond to it, it will not do them any harm. It is obviously waste of time and clomiphene to give it to women with regular ovulatory cycles, because its only therapeutic function is to induce ovulation. Most of our cases, however, have been patients with long-standing secondary amenorrhoea or oligomenorrhoea with only two or three cycles a year, in whom ovulation obviously does not occur or occurs only very seldom.

It is of course important to select suitable cases so far as possible, and urinary gonadotrophin or oestrone estimations are helpful for this purpose. It is also important to note those cases that do not respond to clomiphene at all, for it is sometimes appropriate to go on treating them for more than three or four courses, though some women who do not respond to the first course may do so to the second or third course. But to
Correspondence

Low Back Pain

Sir,—Although it is now commonly believed that defects in the neural arch (spondylolisthesis) are stress fractures rather than congenital in origin, it is quite misleading to suggest that such stress fractures of the pars interarticularis are common findings in patients with low back pain. ("M. M. Today: Low Back Pain," 11 November, p. 341). Furthermore, it is rare to find a defect in the pars interarticularis which can be shown on serial x-rays to go on to unite. Perhaps this is because the forces acting on the lower lumbar vertebral tend to separate the fracture surfaces.

Defects of the neural arch, with or without an associated forward slip (spondylolisthesis), are more commonly found in association with chronic low back pain, and 7.9% of a total of 4,411 patients from four series quoted by Rowe and Roche had defects demonstrable on x-ray. When symptoms occur they are the result of the mechanical weakness or loosening of bone around the defect, and are the same as those seen in lumbar instability from any other cause, such as degenerative disease of the lumbar spine.

When conservative treatment fails the logical treatment is to stabilize the unstable segment, a form of treatment not mentioned in your article.—I am, etc.,

A. W. F. LETTIN.
Orthopedic Department,
St. Bartholomew’s Hospital,
London B.C.1.

REFERENCES

Congenital Dislocation of the Hip

Sir,—Your leading article (18 November, p. 341) on the admirable study of hip dislocation by Dr. H. V. L. Finlay and his colleagues (same issue, p. 377) raises a point which perhaps needs a brief comment. You state that congenital dislocation of the hip is congenital but not a genetic defect in the same class as the developmental errors like harelip, cleft palate, and absent or supernumerary fingers. In fact none of these conditions are entirely genetically determined, but there is an important degree of genetic predisposition for all of them. The evidence for this in twin and family studies is as good for congenital dislocation of the hip as for cleft lip and palate, and rather better for the most instances of absent or supernumerary fingers. On the other hand, if you are using "genetic" not in the sense of determined by genes but in the older sense of developmental (timing and the class of morphological abnormality involved) your statement is of course valid.

The familial aggregation of congenital dislocation of the hip is of some practical importance. Even where all babies are screened for the condition it is worth, for example, examining a baby girl whose brother or father had congenital dislocation of the hip with special care; just as it is worth examining a little girl who is first-born and breech-born with special care.—I am, etc.

C. O. CARTER.
M.R.C. Clinical Genetics Research Unit,
Institute of Child Health,
London W.C.1.

REFERENCES

Sir,—Dr. H. V. L. Finlay and others are to be congratulated on their study of congenital dislocation of the hip in the newborn infant (18 November, p. 341). It is fortunate that a valuable description of Barlow’s tests and rightly emphasize the importance of direct palpation of the head of the femur. Unfortunately your leading article tends to blur the distinction between the Barlow and Ortolani test.

The distinction between these tests is of vital importance.

In Ortolani’s test the knee is held with the hip flexed and the hip is then slowly abducted. In the dislocated hip reduction of the joint will occur with a palpable "jerk" or "jolt," which is usually visible. ("Click" is not a good translation of the Italian "shalzo" and "scatto"). Ortolani emphasized that his test was practically identical with the Lorenz maneuver involved in the reduction of congenital dislocation of the hip. It is therefore effective only if the hip is actually dislocated. For this reason it will not always detect congenital dislocation of the hip in the early stages when the hip is merely unstable or where the hip slides in and out of the acetabulum without a jerk or jolt. Ortolani did not in fact recommend the test in the first three months of life. In Barlow’s test, on the other hand, is designed specifically for use in the newborn and the first three months of life. The hip is held in a pincer grip between the thumb in front and the middle finger behind. In this way when the flexed hip is abducted pressure

REFERENCES

London W.1.

W. I. D. SCOTT.

RAYMOND GREENE.
A. W. SPENCE.

London W.1.

REFERENCES