

Ad-drefnu'r Gwasanaeth Iechyd Gwladol yng Nghymru

Any Welsh-speaking reader who might have been pondering how McKinsey management jargon would translate into his native tongue will be disappointed. While the White Paper on N.H.S. reorganization in Wales¹ had a Welsh and English text the recently published management document for Wales² sticks to English—but in more readable prose than its sister document for England.^{3,4} Though prepared by a separate steering committee and study group drawn from the Welsh health services the report's proposals are in principle the same as those for England. Wales, however, has dispensed with a regional tier, and the eight area health authorities⁵ will be responsible direct to the Welsh Office.

Calling for integration of services as close to the patient as possible the steering committee lays welcome emphasis on the clinical independence of doctors, observing in an opening paragraph that the report "is not about how clinicians should apply their professional skills and judgement. . . . These will remain untouched by reorganization." Of course clinical decisions are influenced—even restricted—by the circumstances of a particular illness, and the precise boundaries of clinical independence are elusive. But a decision taken in the light of, say, how far a patient is from a particular specialist unit is distinct from restraint imposed prospectively by a management hierarchy decreeing, perhaps, the length of hospital stay for a hernia patient. So it should give some reassurance to a profession exercised by the implications of the management reforms that the steering committee appreciates the importance of giving clinicians an opportunity "both through individuals and through representative machinery" to take part in running the Health Service. "A comprehensive task," the report states, "that includes deciding policies, setting priorities and ensuring the effective use of resources." Given that these changes are coming doctors should seize the opportunity proffered to influence the future course of the N.H.S.

Wales has problems of geography and an uneven population so only five of the area health authorities in Wales will be divided into districts, Dyfed and Mid Glamorgan with four each, and Clywd, Gwent, and West Glamorgan with two. The remaining three authorities—Gwynedd, Powys, and South Glamorgan—will not contain any districts and varying local arrangements reflecting their special needs are planned for these areas. The report gives details about the Welsh Health Technical Services Organization, which will provide certain services that "for reasons of efficiency and economies of scale should be provided on an all Wales basis." Thus it will deal with the design and construction of major capital works, computers, central supply function, and prescription pricing among others. As with England, the new management structure, though allowing more local flexibility in some respects that at present—for example greater financial discretions—nevertheless will keep the reins of power firmly at the top, and the Welsh Office will monitor the way in which plans and policies are implemented by the areas.

"Monitoring" is, of course, one of the management words that has prompted unease in doctors. The report denies that it is a managerial relationship, defining a "monitor" as one who (apart from acquiring information) persuades but who in "the final analysis" cannot order. Similarly, co-ordination

—another ambiguous administrative word—is seen as persuasion and not management. To doctors, accustomed to persuading rather than managing patients, these statements may give some reassurance. But persuasion can be a ticklish task—a persuader needs to be informed, sympathetic, and persistent. Wales, like Scotland, is fortunate that its health services lend themselves to a less formal administrative atmosphere than is possible in England. The bedside is closer to the Welsh Office than to the Elephant and Castle. Ideas can circulate more readily and co-operation is probably more spontaneous; thus monitoring and co-ordination may be less obtrusive and no doubt less necessary.

Even so, the Mid-Glamorgan A.H.A. alone will command an annual budget of £20m. and control 8,500 staff. The success of such a large "health business" will depend not only on the availability of experienced and capable administrators but on whether hard-pressed doctors can find the time to participate in management. Those questions are, of course, pertinent throughout the N.H.S. and the various national discussions on the Government's management proposals will be seeking the answers urgently with conversion day just 18 months away.

¹ *National Health Service Reorganization in Wales*, Cmnd. 5057. Cardiff, H.M.S.O., 1972.

² *Management Arrangements for the Reorganized National Health Service in Wales*. Cardiff, H.M.S.O., 1972.

³ *Management Arrangements for the Reorganized National Health Service*. London, H.M.S.O., 1972.

⁴ *British Medical Journal*, 1972, 3, 601.

⁵ *British Medical Journal Supplement*, 1972, 3, 147.

English as She is Spoke

There is always a sting in the tail of progress. No scientific advance from the discovery of the wheel to the splitting of the atom has failed to return to plague the inventor. In clinical medicine the computer has dangers if applied without considerable caution. The danger lies, as C. M. Boyle showed,¹ in the misinterpretation of common medical terms by patients and, surprisingly enough, by doctors themselves. The computer can assimilate and analyse but not deliberate, and if fed with the wrong data will produce the wrong result, with perhaps serious consequences for patients.

Recently a study has been published on the misunderstanding of plain English by chronic psychiatric patients. J. Cheadle and R. Morgan² devised a deceptively simple battery of questions with multiple choice answers designed to test the patients' understanding of common short expressions, some idiomatic, some metaphorical, some slang or colloquial, such as, "What does 'keep your nose to the grindstone' mean?" or "What does 'break the ice' mean?". Using the same questions, they also compared the results in 90 long-term patients with those from 57 local schoolchildren between the ages of 8 and 11. The investigation showed that the patients understood only 63% of the common English expressions which were proved to be at the level of understanding of children 8 to 9 years old. Poor individual performance was associated with low intelligence quotient and with a long time in hospital but bore little relation to diagnosis.

That understanding of language should so notably decline under the disintegrative process of chronic mental illness deserves thought. But these results have to be seen in the context of the cultural origins and the mother tongue of the patients investigated. With the exception of only two Irish-