Editorial

An attractive British trait is a firm belief in the reality of fictional characters. From Sherlock Holmes to Jemima Puddleduck these creatures have personified all sorts of ideas and attitudes. Winnie-the-Pooh fans will recognise the author of many documents on the organisation of medical services as none other than Rabbit. It is easy to picture how he started to write. 'It was going to be one of Rabbit’s busy days. As soon as he woke up he felt important, as if everything depended on him. It was just the day for Organising Something, or Writing a Notice Signed Rabbit, or for Seeing What Everybody Else Thought About It.'

The remoteness of higher administration from bedside medicine makes it seem an exercise in its own right. The newer documents appear to hint at management for management's sake. In more than one walk of life there seems to be a passive acceptance that the manager must be right. Managerial techniques, with their private jargon, are being exalted to a mystique beyond question. This is an interesting shift from another British trait of distrusting self-styled experts. War has been considered too dangerous an activity for military control and civil direction of the military has been accepted. Mr Enoch Powell considered that doctors were dangerous as controllers of state medicine and that pure politicians, with their undefined expertise, must be the sole arbiters. So far the British love of amateurism has been satisfied by appointing lay members to the higher medical service committees to represent the consumers. Now it is suggested that pure management takes over. The new heroes of society will be these managers. To them the doctor and patient must account. It would appear to be an unequal partnership. In terms of administration the means may be efficient but to what end?

A manager's role, it is said, is to decide what jobs are to be done and to get someone to do them. The people who have been doing these jobs may take exception to this. They are likely to ask whether administration is supporting their direct efforts to combat sickness or is more concerned with servicing the administrative machine. These are probably paranoid views but it is vital for co-operation that high level policy must clearly state its aim. If indeed that aim is to foster the best conditions for treating the sick, suspicion is ended. The point has to be proved. The manager has to show that he has a real knowledge of what he manages. He has to convince those who nurse in geriatric wards or those faced by overcrowded outpatients that he understands their difficulties, and can help. This is a tall order. Even within the
ranks of doctors there is valid criticism that one group does not grasp the problems of another. It is the power given to the manager that makes his burden of understanding so great.

Right or wrong, those concerned with patient care often complain that their problems are not appreciated by the present higher administration. One obvious cause of discontent is a matter of tempo. Sickness demands an immediate response from those who treat it. The higher the level of administration the slower the time of decision. When it comes to hospital planning, yesterday’s hospitals are always being built tomorrow. Such a time scale is, of course, dictated primarily by financial resources. Yet the discarded plans and the temporary expedients in building run away with scant capital. If the management are skilled in deciding what jobs should be done there is little evidence that they will command the financial power necessary to do what is necessary. At best they may be able to set a quicker tempo and decide rather than discuss.

It has been argued before in these pages that the present tripartite health scheme creates artificial barriers to efficient professional work. A unified superstructure of administration does not by itself alter the real work with patients. Design from the top down does not seem so relevant as revision from the bottom upwards. Of course, this must not imply that doctors, nurses and technicians are bursting with agreed ideas for reform. One man’s reasons are still another’s prejudices. Doctors, of all people, often need their heads banging together. The proposed managers inhabiting the higher strata are going to be too remote to aim an effective blow. Better by far to have good management techniques explained and practised at the clinical level, in collaboration if not in amity.

To take one example. The role of the teaching hospital in the community is agreed in principle but by no means settled in practice. Within these hospitals there is still unresolved conflict in determining the staffing structure. Terms like academic and non-academic physicians have little real meaning but generate a lot of emotion. The nice distinctions of an academic hierarchy make the staff structure of the National Health Service appear simplicity itself. Without any high level discussion on Area Boards and the like it would be possible at a local level to integrate the two staffs to the benefit of patients and students. Such problems are already being resolved in some places. It would appear that the University of Otago has found a most satisfactory way of getting the best combination of staff for teaching, research and patient care. It could be that distance stills the rumbles of dissension, but Professor Hunter paints an attractive picture of Otago, well supported by his colleagues. May we do as much in our more populous and complex society.