Unfortunately, too few consultants can find the time for such prolonged decision-making and many who do may not be able to do it effectively. An appropriate example of medical non-management has been the way extra duty has been organised in our own two hospitals. Hours worked, even within the same division, have varied enormously from unit to unit and in one particular division has differed by 100% between the two hospitals, despite similar staff complements and on-call commitments. There needs to be a fair distribution of work and fair payment for it: this requires effective management. With luck our new contract will remedy many such situations.

Better managers and an area service

What we need are well-qualified medical administrators, with extensive management experience at home and abroad before they take charge of area management teams on a whole-time basis. The area chief must be medically qualified because medicine is about curing people, a fact that many of us forget too easily. I would also argue that all new consultants should have a diploma in management.

Finally, we should break away from our obsession with the National Health Service and concentrate instead on the area

health service and its many problems, particularly during the present economic crisis. How can we do this?

"We must await the Royal Commission," state the managers. "We shall have emigrated if you wait that long," retort the juniors.

"What about a local commission of inquiry?" I suggest to a background of ironic laughter from the managerial ranks.

"A local independent inquiry is what we need," I insist, "a think tank to improve our very own area health service. Let's improve ourselves; mobilise local resources and ingenuity; improve decision-making; start to audit the doctors; replace middle management; and start a hospital jobshop. Finally, let's carpet the VD ward and buy soft toilet paper. . . ."

"We can't agree to that without asking the area health authority," reply the team—to background sounds of expostulation from clinicians.

And what did the AHA say? "No." I wonder why?

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Reorganising the reorganised

A K THOULD

Reorganisation of the Health Service has produced a top-heavy administration. Rapid decisions are impossible and those at the sharp end who serve the patients feel that their voice does not count sufficiently. The reorganisation was proposed for a laudable reason which doctors could not justifiably refute, since they had often argued for it themselves—namely, integration of the three branches. Political considerations had already divorced medical social services from the rest and placed them with local government. Few approved of this illogical step, particularly those in the hospitals. Furthermore, part III accommodation remained part of local government responsibility, though lack of such provision can, and does, have profound effects on the hospital services. Surely a cogent argument for unified administration? And why should the funds for drugs prescribed by general practitioners be administered separately from those in the rest of the integrated organisation? The complexities of the proposed reorganisation were not properly discussed. But now is the time to review the new system before we become used to compromising with the mistakes. The present scheme may or may not suit the administrators but I have heard few doctors welcoming it.

One way advice

The besetting sin is the lack of communication. At present a hospital doctor produces advice with his colleagues in his division. This advice goes to the medical executive, then to the district team of officers and area team of officers, and finally to the area health authority. It may well then be referred back and have to be resubmitted. This authority is now much more remote than were the old management committees. A weakness is that the advice proceeds one way. For once the advice is given the lower echelons have no means of monitoring what happens higher up because they never hear what goes on, or how or even whether the advice is passed on. Ultimately the topmost layer of the administrative pyramid inscribes the holy writ—sometimes, I am sad to say, via local newspaper columns.

The area medical advisory committee sits uneasily somewhere in this structure, not sure to whom it should listen, and confused about what subjects it should legitimately advise on. Committees spawn subcommittees and working parties; health care planning teams—

laudable ideas for integration—further add to the administrative load of the doctor. Doctors want to be consulted but they want the time they spend on management limited so that they can attend to their prime concern—dealing with the sick.

Continuous dialogue

Doctors need to improve their contacts with nurses, administrators, colleagues in community medicine, and general practice. We need a continuous dialogue with the social services, the region, the nearest university department, our representatives on our central advisory structure—even with the DHSS itself. Perhaps when problems are shared in this way, even if only in outline, colleagues will understand our limitations and our strengths and weaknesses. Decisions should be taken openly in an informed way with the reasons behind them and the final outcome widely known.

No one in the NHS should fear argument and discussion in an open forum. But how can we achieve this objective? The device of circulating each committee's minutes to every other committee results in an avalanche of paper, unlikely to be read. Cross-representation fails also as too many people sit wearily on too many other people's committees. The number of committees should be reduced but their importance increased. They should be given all the relevant information in an easily digestible form. Monthly news sheets could be issued at district, area, and even regional level. If we must keep the regions, then regional medical officers must be less remote. Why could they not hold annual talking shops in each of their district general hospitals? The universities should identify themselves with their areas much more than they have done. Why not have a series of regional lectures in all the main towns, and invite others to share in the teaching of the university?

Replacement for RHA

The DHSS must also become less remote. Members of the Chief Medical Officer's staff could be responsible for a given number of AHAs and discuss problems regularly with doctors, nurses, and administrators. Perhaps much of the present unrest might not have happened if such a system had existed. I always believed that the RHA provided a necessary safeguard against too much control by the DHSS. But the RHA has become so emasculated that it should be

replaced by a regional committee of AHA chairmen to agree on those services which need to be organised on a regional basis—for example, neurosurgery, and blood transfusion services. There should be a regional medical advisory committee—three from each area—one community physician, one general practitioner, and one consultant. Each specialty could form its own ad hoc regional committee and proffer advice as necessary.

We must look carefully at the cumbersome medical advisory structure. Why cannot divisions report to a hospital medical staff committee with executive and advisory powers and with direct access to the AHA? Community physicians should have a similar hierarchy,

and general practitioners should give advice to the local medical committee with similar direct access to the AHA. The advisory committees could be disbanded and the area team of officers should concern itself only with day-to-day details of administration. The AHA could then make up its mind where advice conflicts or ask the ATO to look at the matter and refer back to constituent bodies for further consideration as necessary.

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Hospital Junior Staffs Committee

Joint evidence agrees with DHSS on EDAs

The junior doctors of the BMA met on 13 January under the chairmanship of Dr D F H Wardle to consider primarily recommendations from the Executive Subcommittee on the distribution of additional money available as a result of the independent audit on extra duty payments.

The auditors' report, summarised in the *BMJ* of 17 January (p 172) had showed, Dr Wardle said, that the total EDA figure should have been £14.25m: £2.3m above the figure given in evidence to the Review Body earlier this year by the DHSS.

The chairman pointed out that there was a dispute whether the DHSS had used a figure of £11.9m or £10.2m. If it was the latter, which covered only England and Wales, then it could mean that there was an extra £4m available and not £2.3m.

The Executive Subcommittee had deduced from the report that the normal working hours per week of junior doctors was 76 and not 84; the Review Body had used the latter figure in preparing its supplementary report (27 September, p 779). That figure, however, had been based on 1974 manpower figures, Dr Wardle explained, and figures up to 30 September 1975 would be available shortly and given to the Review Body.

Recommendations of HJSC

HJS contract

"The committee supports the view of the Executive Subcommittee that a formal no detriment clause should not be sought because of the long-term disadvantages for the reasons outlined in HJS 51 [see next page] which was supported by the regions." (Carried: 34 for, three against, 12 abstentions.)

"That in any repricing of A and B units the existing differential, namely a ratio of 3:1, on this occasion be retained." (Carried: 31 for, nine against, eight abstentions.)

Private practice

"That no member of junior staff should work with any consultant or person appointed to replace a consultant following official BMA policy. No junior should act up in these circumstances or apply for that consultant post." (Carried with one dissentient vote and one abstention.)

London weighting

"That all doctors who maintain a residence outside the hospital should be paid London weighting at the full rate for the area regardless of whether or not the hospital specifies residence." (Carried.)

No detriment

The Executive Subcommittee, the chairman reported, had discussed the complicated subject of no detriment, and the subcommittee's arguments for and against a formal no detriment clause are set out on this page. The chairman had asked the regional representatives for their constituents' views. There had been general support at most meetings for abandoning a formal no detriment clause, though the Northern Ireland representative, Dr R J McBride, said that unless it was clear that the A rate UMT was to be properly priced then the objective of no detriment should not be given up. Dr M Moloney asked the committee to think carefully before abandoning no detriment. And Dr D Bell pointed out that the amounts needed to fund no detriment and the free qualifying unit (11th UMT) were less than the money available from the audit. The Review Body should be asked to fund no detriment, fund the free qualifying unit, and then add the extra money to A and B units. But there was a large majority in the committee for the motion proposed by Dr R Coombe that: "The committee supports the view of the Executive Subcommittee that a formal no detriment clause should not be sought because of the long-term disadvantages for the reasons outlined in HJS 51 [see next page] which was supported by the regions."

Views of the regions

The Executive Subcommittee had thought that the free qualifying unit should be funded—at a cost of about £1.6m. One speaker said that one of the arguments for not funding the FQU was that on balance it would lead to greater detriment. Almost all junior doctors would now be eligible to claim payment for extra duties and extra money should therefore go on A and B units after 44 hours. And Mr I Kidson said that if the FQU was funded there might not be any money available for a change in A and B rates and these must remain flexible.