TALKING POINT

Recent experiences of junior medicopolitics

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Who can be wise, amaz'd, temperate and furious, loyal and neutral, in a moment? No man.

(Shakespeare, *Macbeth*)

The notice was clear: a general meeting of all junior staff would be held on the following evening to elect a chairman for the junior medical staff committee. Since I was at that time the elected chairman and was unaware that the position was vacant, I was somewhat surprised. Looking back now over some contentious months in junior medicopolitics I think that notice signified the start of the dispute in our area and set the tone for the weeks which followed.

My views were well known: I had publicly stated on several occasions that the new contract, as at first envisaged, was a vast improvement on the contract we have all learned to live with, and I still hold that view. But were my opinions, my lack of impartiality, sufficient to deserve the treachery which that notice suggested was imminent? Anyway, why must a chairman be impartial? I now know that many colleagues in other areas were facing a similar problem at that time and subsequently resigned or were voted out of office. Would it always be a change for the better? We have always been dismayed by the small attendances at junior staff meetings but all of a sudden everyone was prepared to attend on numerous occasions. Would they, however, also be prepared to attend the area medical committee, the hospital medical committee, the subcommittees, the emergency committees, the BMA committees, the regional meetings, or even their own divisions?

Division among juniors

The most depressing part of this recent dispute has been the bitter division that has appeared in the juniors' ranks and not knowing which faction to represent has made the job of area chairman exceedingly difficult. I have been lucky in that my own opinion has been reflected by most of my own colleagues and for this reason alone I seem, so far, to have survived the dispute still in the chair. Newcastle may have been an exception, but most of us were, and still are, opposed to industrial action involving the withdrawal of patient care. Furthermore, our consultants have made the same decision regarding their own dispute.

Why should we have felt like this? Why have we in the north-east's only teaching centre refused to be led by the militant minority? There are many possible reasons. Perhaps our consultants have pressurised us and we have been too concerned with preserving our references? Perhaps our conditions of service are outstandingly better than elsewhere? Perhaps our brighter future has coloured our already selfish views? Perhaps we are a haven of Labour Party supporters enamoured of Barbara Castle? Or are we just too passive and really don't care?

I believe we have thought that the action being taken in other hospitals has been both precipitate and unnecessary. To close emergency departments, as happened in North Tyneside, is immoral and I could never be a party to it. I regret that many have thought it their duty to support such behaviour. There are many people in Newcastle who feel we have been strike breakers and have failed to support our friends in what we patronisingly call the "periphery"—who, incidentally, have suffered considerable financial losses during the dispute due to loss of extra duty payments. But surely large teaching centres like ours, by their very definition, carry a high load of patients, who have complex and uncommon problems. To withdraw staff from the outpatient departments in such circumstances must

mean placing these patients at an unacceptable risk and is totally unjustifiable. One wellknown junior medicopolitician has compared medical care to the servicing of a car. I would welcome the name of his garage.

Importance of teaching centre

Just how dependent is a region on its teaching centre(s)? Figures recently made available here have surprised many of us. Over 30% of patients admitted to all departments come from outside the Newcastle area (not including the regional specialties, where of course the figure is much greater). More importantly, the trend has been increasing greatly. For example, there has been a 23% increase in general surgical admissions from outside the area between 1973 and 1974. Does this mean that the peripheral hospitals are feeling more and more unable to deal with all but routine cases? We appear to be carrying an ever-increasing load and whether this trend is good or bad the regional health authority must take this into account when it next assesses our financial needs. With the present organisation I doubt that it will.

We are always shouting for improvements in the organisation of the NHS, but it may be the people who need improving rather than the system—old or new. Incompetence seems to percolate the Service now more than ever before, and in every sphere, not just the administration. Small examples, such as newly fitted x-ray viewing boxes falling off the walls, may be viewed with much amusement, but the disappearance overnight of 10 parking places reserved for junior medical staff (including those in transit between hospitals) leads me to despair. We have recently been told that our nursing complement is 200 above the designated allowance yet I would be ashamed to disclose the number of qualified nurses on duty in our 850-bedded hospital during the night.

There are, of course, always people who can be relied on in any hospital but they seem to be exceedingly rare. Our own hospital secretary has shown tremendous efficiency during the recent difficulties by carefully monitoring all accident room referrals from outside the local area. This was essential at the time because we feared that many accident departments would be closing down. In the event we had a 20% increase in such referrals but managed to keep the total admission rate normal.

Administrative blunders

What are the causes of administrative blunders? The area managers in the north-east blame lack of communication as the largest cause of inefficiency, and at a joint meeting with juniors' representatives in November they agreed to try to improve this. Yet only last week the administrators issued a five-page document on the methods to be used to discipline employees, including junior medical staff. They dutifully sent copies to all consultants, but, by accident I suppose, forgot to send it to the juniors' representatives. Would it be asking too much for the junior staff committee to be consulted about such a circular?

The administrators also blame the recent reorganisation of the Health Service—from which they seem to be forever recovering. It is true that the recent increase in their numbers can be blamed only on the previous Government's blueprint for the reorganisation. The economic restrictions have now halted this increase and may indeed allow the present teams to settle down and improve themselves. It is the middle managers who always receive the wrath of the consultants because it is these poor fellows who are in daily touch with the medical profession. If you ask me, there are faults on the medical side as well. Doctors have to fight for power within the profession's own bureaucracy and have to work for the right decision.

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

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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