and in whom postrenal obstruction is suspected and ultrasonography shows no evidence of dilatation further investigation by direct opacification of the urinary tract is necessary. The investigative pathway will be dictated by the patient's clinical condition and the facilities and skill available, but antegrade pyelography guided by ultrasound, followed if necessary by percutaneous nephrostomy, may allow total and rapid recovery of renal function.

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Green College Lectures

The National Health Service: reflections on a changing service

PATRICK NAIRNE

I was a short stay patient at the Department of Health and Social Security, unexpectedly admitted to the Elephant and Castle in autumn 1975 after over 25 years elsewhere in Whitehall. The health service was an entirely new experience for me. My reactions to it were a mixture of admiration and concern—particularly concern at the extent to which our finest public service was in difficulties, some of them of its own making.

Launching of the service

The political architect of the NHS, Aneurin Bevan, could not have foreseen all the difficulties; but he forecast their impact. In March 1948 he warned the Institute of Almoners:

After the new Service is introduced, there will be a cacophony of complaints. The newspapers will be full of them. . . . I am sure that some doctors will make some irate speeches. . . . What the Health Service is actually to do . . . is to put a megaphone in the mouth of every complainant, so that he will be heard all over the country.

In recent months Bevan's "megaphone" has become deafening. And the loudest complaints have come from within the health service, expressing the frustration of professionals convinced that they could do more and better if they had larger resources. It is relevant to recall some more words of Aneurin Bevan, speaking to the National Association of Maternity and Child Welfare Centres on the eve of the birth of the NHS:

The new Health Service has been having a most uneasy gestation and a very turbulent birth, but all prodigies behave like that. . . . This Service must

always be changing, growing, and improving; it must always appear to be inadequate. This is the answer I make to some of the Jeremiahs and defeatists who have said to me: "Why start this Service when we are short of so many things?"

Bevan himself soon learnt the truth of his forecast of "inadequacy"—the initial experience of "infinite demand, finite resources." I am convinced that his assertion that "the Service must always be changing, growing, and improving" represents the challenge and the hope to which the NHS must respond if it is to survive as a public service.

Changing, growing, and improving

But how drastic should change be? There is right wing pressure for a fundamental reassessment of the entire concept of a comprehensive health service free of charge at the point of access. *The Times* has described the health service as "the one great unreformed British institution." The *Sunday Times* insisted last December that ". . . tinkering will not do. Forty years on it is time to create a new health service to meet the needs of the next forty years."

But the radical critics appear to forget that ever since the major reorganisation of 1973-4 the NHS has been subjected to constant changes and to the thorough review of a royal commission. It is doubtful whether it should stand for, or can stand, any further large change of organisational structure. I am also sceptical about the wisdom or practicability of fundamental change where many of the critics are now looking—the health service's tax funded system of financing. As the royal commission on the NHS reported in 1979:

We were not convinced that the claimed advantages of insurance finance, or substantial increases in revenue from charges, would outweigh their undoubted disadvantages in terms of equity and administrative costs.

The increase since then in the numbers of the unemployed and the elderly reinforce that judgment. The experience of the United States and Western Europe shows the high cost of both medical care and administration in an insurance based system.

A related judgment of the royal commission also remains valid:

No method of financing a part of national expenditure as large and as

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An abridged version of a lecture delivered on 25 January 1988 at Green College, Oxford. A fuller and slightly different version of this has been given as a Jephcott Lecture by Sir Patrick at the Royal Society of Medicine on 19 April and it will be published in a subsequent issue of the *Journal of the Royal Society of Medicine*.

Before his appointment as Master of St Catherine's College Sir Patrick was Permanent Secretary to the Department of Health and Social Security from 1971 to 1981.

politically sensitive as the Health Services was likely to remove it from Government influence.

Whatever changes may be made to the NHS we cannot contemplate taking out of politics a service that touches directly on the lives of every constituent in Britain. In short, I am convinced that it will be best for both patients and the health service to continue to live with the basic organisation and financial structure as it is.

So where do we look for honey?

There is a widespread cry for more taxpayers' money. And the government may yet decide to accompany further measures for improvement and change with more generous funding. That may be essential, or at least be politically unavoidable. I do not know. It is difficult for anyone outside the NHS to know the extent to which it is a crisis of resources rather than a crisis of management. I am convinced, however, that more money on its own will not resolve the major problems.

But, recognising its formidable range of problems, how can the health service respond to the Bevan imperative of "changing, growing, and improving" without radical or far reaching change or reform?

My own answers or reflections relate to three aspects: relations with the public and patients; links with private medicine and local authorities; and cooperation within the NHS.

Relations with public and patients

My first reflection may appear naive. The NHS must gradually effect a major change in the public perception of the service. It should devote less time to looking upwards to the government that feeds it and more time to looking outward to the public it serves.

The NHS is, for most people, the most important public service; but no public service thinks less about the public than the NHS. The public, as patients, tend to be too subservient to those in the NHS who treat them. The public, as a pressure group, know too little about the health service's priority problems. The public, as individuals, are too careless about their own health. The NHS today needs a public with a much better understanding of what the NHS can do and what it cannot do.

Above all, there is insufficient understanding that the most serious difficulties are in the hospitals, largely reflecting the problems of clinical successes. We are allowed to assume that the limits of the comprehensive service are boundless and that new clinical benefits can quickly be available to all.

As the difficulties have increased the media have increased the opportunities for public discussion. But, fairly or unfairly, the impression remains that the health service "goes public" only when it is on the defensive or has specific information to communicate. Public debate has been predominantly political: there has been no sustained information strategy conducted by health authorities. The media channels should be used more positively. In addition, well organised "open days," posters and leaflets in surgeries and health centres, and video films in public places should be used to educate local people about their own local health service.

But the NHS should go further in taking the public into its confidence. It has become more important to treat people as responsible patients, who are also NHS clients or consumers, but the constructive involvement of the patient in his or her treatment can be seriously neglected. The more rapid turnover of patients, the intensity of hospital and clinical activity, and the consequent pressures on doctors and nurses can contribute to that. I hope that partnership with the patient has an adequate place in medical education today. Hospital authorities should look afresh at patients' handbooks, and they should review through the eyes of patients and visitors the waiting area of casualty departments—the threshold to the NHS, where many people receive their first impressions.

Complementary to all this is the promotion of a healthier lifestyle. The opening clause of the NHS Act places on the Secretary of State the duty to promote in England and Wales "a comprehensive health service designed to secure improvement in the physical and mental health of the people of those countries." It is a duty that cannot be regarded as effectively discharged. During my DHSS years there

was no satisfactory resolution of the political and economic dilemmas presented by the products of the tobacco and drinks industries. The government's recent and controversial white paper, *Promoting Better Health*, and the role of the new special Health Education Authority reflect good intentions. But I believe that much heavier taxation of tobacco and alcohol, and much stronger support from both government and doctors, will be needed if NHS consumers are to think less about what curative medicine must do for them and more about their own responsibility for themselves.

In short, I share the view of Sir Roy Griffiths, in his Redcliffe-Maud Memorial Lecture of 1987, that "the interests of the consumer have to be central to every decision." That is the key to promoting a responsible partnership between the health service and a better informed public.

Links with private medicine and local authorities

A better informed public is likely, however, to be more critical of the service if it fails to make management changes or to introduce new arrangements that may increase the overstretched resources of health care.

Many NHS patients now undergo surgery in private hospitals; many health authorities contract out the long term care of patients; pay bed revenue is keeping open some NHS wards; about a tenth of the population now choose to have private health insurance. In short, a mixed economy of health care now exists. What are needed are a constructive partnership between public and private resources, a fuller public understanding of how they complement each other, and conditions established which will effectively safeguard the interests of those for whom the NHS is the only health service available.

The last point is of great importance. The private sector of medicine, though relatively small, is growing. It must not rob the NHS of essential nursing staff nor detract from the responsibilities of NHS consultants. Patients who wish, and can afford, to see the consultant they want, or to undergo NHS surgery on the date they choose should be able to do so provided only that it does not put at a disadvantage waiting list patients who cannot pay. Health authorities should be encouraged to adopt new arrangements, as some are already doing, which offer a wider choice of private treatment so long as they will increase revenue (and perhaps NHS capital as well) and sustain or enlarge the resources available for the public as a whole. The initiative of a health authority in providing, for example, fertilisation and breast cancer clinics for paying customers should be applauded so long as there is a firm assurance of a net revenue gain and no adverse consequences for the local NHS patients.

It is good that the study by Professor Alain Enthoven of Stanford University, *Reflections on the Management of the NHS*, published in 1985, is being further considered. He argued that the health service should buy acute care services from the private sector when it could get them cheaper than in NHS hospitals. But to apply such competitive criteria as a general practice will require a much fuller and more reliable costing system than exists at present. We must hope for rapid progress with the NHS's six pilot studies in resource management and also a useful report later this year from the Institute of Health Service Management on alternative methods of funding health care.

The problems of funding have been an obstacle to closer cooperation between health and local authorities in community care. Joint financing complemented a valuable feature of the previous structural organisation—the "co-terminosity" of area health authorities and local authorities. But few district health authorities are coterminous, and local authorities have tended to have conflicting priorities at the very time when community care for the mentally ill, the mentally handicapped, and the elderly was being more widely introduced. If that policy is to be effectively implemented I believe that the division of responsibilities and the machinery of cooperation between health and local authorities must be improved. We must hope that the Griffiths report has pointed a better way forward.

Cooperation within the NHS

My last reflection derives from one of my earliest impressions of the NHS—the extent of the critical distrust that appeared to exist between every level from the DHSS to the hospital.

Twelve years ago there were aggravating factors which differed from those of today. The NHS was convalescing from its first major reorganisation, which was too cumbersome in structure and too expensive in bureaucracy; a change of government had led to a recurrence of scepticism about the role of the regions; and severe inflation had caused a sharp reduction in annual funding after a long period of growth. As another former Minister of Health, Iain MacLeod, used to say, “Money is the root of all progress.” The strains between the health authorities and the DHSS might have been less if larger annual increases in resources had been possible in the second half of the 1970s.

But the difficulties of the NHS have never seemed to me an adequate explanation of its flair for “rubbishing” itself in public. Clinicians openly criticise the numbers of administrators; administrators respond by criticising waste by clinicians. District teams criticise regional teams and vice versa. It sometimes seems as if NHS staffs can join together only in publicly criticising ministers and the DHSS.

The criticisms were often well founded, though that is not the point. And the DHSS had its own difficulties. Ministers of both parties always wished to delegate more to the health authorities, but they were compelled, chiefly by parliamentary pressure, to centralise and intervene. A gradual trend in that direction has been consolidated in the establishment of the Health Service Supervisory Board and the NHS Management Board.

What is still needed is a realistic recognition of things as they are. The reality is interdependence—between the DHSS, on which the NHS depends for its funding, and the health authorities, on which the government depends for the delivery of services. There should now be a general acceptance of an indissoluble marriage between Whitehall and the NHS—exposed like other marriages to occasional conflict—but a marriage which after 40 years should have settled into a relationship of mutual understanding and sympathy.

This philosophy of interdependence needs to be positively promoted between all levels of the health service and between the wide range of professionals and trade unions working within it. It should be the basis of leadership by general managers, supported by the greater managerial involvement of clinicians, by the improved information systems, and by the better communication within the service. The NHS is the largest glasshouse in the world; it risks its own survival if it cannot resist throwing stones.

I remain a firm advocate of further evolution within the present organisational and financial structure of the NHS, where there is much still to be done, and which can be done, to improve the operation and management of the health service if there is a positive vision and firm direction on the part of ministers and health authorities.

One final reflection: the old saying that a man grows his own face. The NHS, after 40 years, has grown its own face. Despite all the problems of policy and finance and of difficulties that seemed as serious as those of today I look back to an impressively caring face—the face of a health service still dominated by a commitment to aspirations and ideals unequalled in the world. This is a unique strength from which the government should take heart.

Medical Education

Reliability of interviewing in medical student selection

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Abstract

Six interviewing panels which had assessed candidates for places at a medical school in 1984 were reconvened in 1987 to assess videotapes of the interviews conducted by themselves and by other panels. Overall recommendations made by panels showed excellent reliability within panels and high reliability between panels.

Introduction

The interview is a central part of student selection in all London University medical schools and in many other British medical schools. Interviews have, however, been criticised as a form of assessment because of poor reliability (consistency between interviewers) and poor validity (the relation between the assessment

and the candidate's true ability and potential).¹⁻⁴ We previously described the interview procedure at our medical school in the University of London⁵ and noted relatively high correlations between the independent judgments of three interviewers who were present at the same interview, implying a reasonable degree of reliability.

The opportunity for this study arose when the BBC began a long term television project in which the selection, training, and eventual practice of a cohort of medical students at St Mary's would be monitored over many years. As a result 56 selection interviews carried out at St Mary's during the autumn of 1984 were filmed in whole or in part by professional cameramen as unobtrusively as possible. After the first programme was screened (*Horizon: Doctors To Be*, 30 June 1986) several of the interviewers expressed the wish not only to discuss in more detail what was taking place in interviews but also to see some of the interviews in their entirety. About 25 interviewers therefore spent an afternoon watching and then discussing four complete interviews. Three of the four cases produced little dissent concerning the final decision that was reached, but in one case most of the interviewers, as well as the chairman of the original panel, thought that the decision had probably been wrong. How stable, therefore, were interviewers' assessments? The present study was carried out to answer that question. Six interviewing panels were reconstituted to reassess not only their own interviews but also those of other panels.

Throughout this paper we report only on the reliability of

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