structure, exhort, persuade, lay down guidelines and hold back money but the effect of all this is marginal and does not radically alter the size and shape and growth of the service. It is what the doctor says and decides that counts. This would be fine if the medical profession was trained and skilled in health economics. The tragedy is alas that with some notable exceptions they are usually too ignorant of health economics even to understand the significance of their own ignorance.

The problem of the NHS has become almost a truism, namely that the demand for health care and the increasingly high cost of investigation and treatment is outstripping the country's ability to pay for it. This can only mean that someone somewhere has to ration it, and decide how the money is to be spent in the interests of all. Until the doctors identify themselves with this problem and take much more responsibility for the totality of the service there will be millions of pounds wasted and much inefficiency and frustration.

Let me try and illustrate what I mean by one glaring example, the planning of new capital projects. Few doctors put forward their requirements with any sense of what they cost. It is the accepted practice to go for the maximum bid. I have examples of doctors touring the continent and the States in search of the latest and the best and ordering without trial and on the vaguest of hearsay; often scouring catalogues to see that every conceivable item is ordered; often resisting change until bought off with the promise of things new. Many incorporate into such plans their own idiosyncratic methods so that the plan is obsolete when they leave. Who, I keep asking, says 'no'? Only when the money runs out are backs really against the wall and economies made but often too late to get real savings.

The administrator attempts the management of resources. Some doctors try to get involved by attending committees. But without the basic understanding of health economics their contribution is limited and many feel their time is not well spent. Others treat the administration as an enemy or even a disease that must be speedily treated and eradicated. Instead of working with the administration they isolate themselves from it and try to bring pressure through what has come to be known as decibel power or shroud waving. The medical profession naturally fears and hates the administration because of its increasing attempt to influence resource management. And what can, in fact, the administrator do? He can't control the volume of activity except by draconian methods like closing whole wards and hospitals, and even that he can only do with the co-operation of the profession. He can't really control the type of treatment, and if he tries to limit the number of cases, that ceiling will be quickly exhausted, thus exposing him to the pressure of a huge unsatisfied demand. He is in no position to evaluate the effectiveness of various treatments or to

allocate resources to the more effective treatment. In the end when money is limited he is forced to come back again and again to his building maintenance budget as the only area where he has real control. Hence the abysmal state of so many of our buildings. The administration reckon that they only control 20 per cent of NHS expenditure. In practice I think it is much less.

I know of no other activity where the responsibility for decision-making has become separated from the management of resources. It is an absolute basic rule for management that responsibility and authority should correspond. We seem to have the worst of all worlds where the administrator tries to exercise responsibility for resource management without power and the profession has the power over resource usage without the responsibility. I find the present isolation of the profession from the management quite frightening even allowing for the hard work done by various committees. The machinery is hopelessly cumbersome. It excludes the basic need which is for real management as it is understood in every other public service or business enterprise.

Conclusion

I think that the only hope for the health service is for us to train up a profession who will be equipped to take a massive responsibility for the totality of the service, to evaluate the use of resources and to manage and to allocate.

Nothing would give me greater satisfaction than to see large chunks of the administration in all health authorities, whether district, area or region made redundant because the doctors themselves exercised responsibility for the resources they controlled.

We can no longer afford a profession that consists of individuals answering only to themselves and their patients. If we are to retain and develop the NHS as a truly public service available to all, no doctor can – to misquote Donne – be an island entire of itself. Everyone must be a piece of the Continent, a part of the main.

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Commentary

Bruce MacGillivray *The Royal Free Hospital School of Medicine*

Alison Munro writes with characteristically trenchant verve: she has clearly suffered badly at the hands of the intractable doctors the system fails to

control. Stern headmistress though she seems to be, there is perhaps a soft spot for her errant charges. I suspect the 'heart' leads other than where the head appears to go. At least I hope so.

Mrs Munro was perhaps a little ill-served by the title she was forced to follow – her main theme after all is management. What she has to say and the position from which she says it, are important. But let us follow the argument.

What about selection? We lose 5 to 8 per cent of the entry, mainly in the first few years of the five year course. A few have serious illnesses, the rest are academic failures which most likely reflect poor motivation, personality problems and an inappropriate choice of study, rather than academic weakness. The figure is probably irreducible. We spend about 600 man-hours selecting 100 students from 2,400 applicants. Despite a lot of thought, we can't come up with anything better.

It is a common error to suppose that medical schools actually select our future doctors. The main element is self selection, biased as it is by hearsay, background, self-esteem and so on, but to no small extent by the school teachers. The headmistress knew whom she felt we ought to have or would take. Perhaps she was right: Consultant parents are a two-edged item, good background, bad bias (did the youngster make up his or her own mind?); a pretty face, disaster, couldn't possibly be serious, and with all those women on the interviewing committee . . . ? In truth, the schools select, but mainly reject, from what is offered and not from the spectrum of available talent. From time to time we try to make our intentions a little clearer, but when no one knows, least of all ourselves, precisely what we ought to want (there is no such thing as a *doctor* – the range of abilities required is protean) we can but fall back on generalities: reasonable academic ability, a robust personality, independence, leadership, responsibility and ability to make decisions, the capacity to cope with, and have, multiple interests (the A-level swot is not on), some sensitivity to the human condition and a view on ethical issues. We always interview. Headteachers' ideas are not always our own and some write up and some write down. Interviewing is not entirely satisfactory but we at least get what we like. Present students are better than ever and we could take half as many again.

From my own point of view, one of the factors that influenced me in the choice of medicine was personal independence. I suspect that this is a significant motivating factor in most of my colleagues. That characteristic leads to a certain amount of intractability, non compliance, about which Mrs Munro complains. It is a common denominator of 'best' doctors (that is, those judged to be so by their peers, which is not the same as the public view). I believe that we cannot have very good medicine without it and it is anathema to bureaucracy. Administration which fails to take it into

account and work with it, rather than tries by force to work across it, will never function well. Have we been selecting the 'wrong' doctors all these years, or the wrong administration?

As to training, we do try. There is as much advice on the curriculum as there are people to whom we are prepared to listen. To teach a little about a lot and a lot about nothing, a course without depth, is a recipe for disaster. We try to expose our students in a positive way to the major disciplines. If we do not produce enough community physicians, bear in mind that we need less than one per cent (35 a year) of our output to satisfy demand. In my view, the reasons for individuals not taking up these various shortage specialties lies not in the training *per se* but in the jobs themselves. I think they are in any case becoming more attractive and one must bear in mind that the posts are of very recent creation. No amount of training will get more doctors or nurses into difficult fields like mental handicap. If we want them there, the solution is to pay more for it.

There is another more serious question over training to which we have all paid scant attention: medicine is growing and growing and as specialties proliferate the postgraduate emphasis must predominate. We probably teach too much, and the continuance of education from undergraduate generality to postgraduate specialism is ignored. The educational process is very inefficient. The problem is not insoluble but it does need a lot of attention.

If we do not teach health economics (some of us do a bit), and it is a far from trivial subject, it is not because there is no time, or that we have never heard of it but rather that it is properly a postgraduate exercise. Most doctors are reasonably numerate – statistics after all is a substantial part of the course – and should be able to handle elementary economics. The full panorama of health economics is another matter. The subject is in its infancy. How does one make decisions on priorities? The complex interaction of economics, medicine and ethics is a task which requires more wisdom than has yet been expended on it. The caution of the medical profession is understandable – they will be holding the bucks at the sharp end not having made the economic decisions in the first place.

In defence to some of Mrs Munro's criticisms, I can say that we do spend a fair amount of time on attitudes and behaviour and we would agree with her that these are fundamental and not so evanescent as are facts. Of the rogues amongst us what can one say? They exist and we all know of them. Any defence is to condone, and I am not prepared to do that. I can only hope that Mrs Munro's view is slightly biased by her position at the apex of the complaints funnel. I do not know a solution and can but offer the counterbalance of the many thousands who do more than their contracts demand. The situation was certainly made worse by the loss of

responsibility and impersonality consequent on reorganisation in 1974, and aggravated by bad salary structure decisions particularly in relation to junior staff.

Some of the arguments about responsibility are not valid although they make attractive polemic. No doctor is accountable only to God (or himself). There is a milieu of practice created by the profession, his peers, and by society itself; he works inevitably with others, junior staff, nurses, and para-medicals, to all of whom he has some accountability. All patients are not stupid, and it is right that personal accountability should matter. In short, I do not believe that there is any deficiency in accountability in medical, moral and ethical matters. Where I think there is a weakness, and I suspect that this is very much what Mrs Munro has in mind, is in disciplinary procedures. These are rather all or nothing, and since the 'all' is draconian, the nothing may sometimes prevail.

In her handling of the resources argument, Mrs Munro is absolutely right, she has put her finger on the nub of the problem in the theme of 'power without responsibility'. The solutions, however, are not all that easy to see. The 'them' and 'us' attitude was very much fostered by the reorganisation of 1974. Responsibility was quite deliberately removed from the profession. 'Medicine is too important to be left to doctors' was the theme, and anti-elitism was the emotional backdrop. The doctors voted with

their feet and by and large opted out. Only now are they belatedly being brought back and it may be that the new reorganisation will return the situation to something like that which existed with the old Boards of Governors and improve matters. Some of the documents emanating from the Department, however, still suggest that our masters have failed to grasp fully the point which Mrs Munro makes so well.

The central problem is economics and forever will be, since resource and demand cannot match. Business parallels are of only partial use. For a start, 'profits' are not easily measured: it is difficult enough even to decide whose money is being considered (the NHS's, the local authority's, the budgeting organisation's or the patients'). Then the costs are often obscure and the 'value' of the outcome difficult to quantify. Further, the management 'structure' on the medical side is not hierarchical except at its junior end - there may be a hundred consultants, all equals amongst equals, in a single hospital, an unthinkable business arrangement. Cogwheel divisional grouping pointed a way to a solution. The organisation needs a lot more thought. It can be done and I believe the profession would accept a reasonable solution, for if nothing else, the problem is clear for everyone to see.

I find Mrs Munro's penultimate paragraph thoroughly encouraging, with one caveat: we would not wish to lose our lay advisors!

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