# Twenty-four Talks

A collection of reports on the twenty-four Centre Lunch Talks
given at the King's Fund Hospital Centre between
December 1968 and December 1971

March 1972

Price 25p

King's Fund Hospital Centre
24 Nutford Place
London W1H 6AN

Tel : 01-262 2641

# Twenty-four Talks

The first Centre Lunch Talk was given in December 1968 by John Garnett, Director of the Industrial Society. The choice of speaker was deliberate and appropriate, for the idea of holding these talks stemmed directly from the New Thinking Lunches, now called New Action Lunches, that The Industrial Society has been arranging for some years.

The Centre Lunch Talks have been given about once every 6 to 8 weeks. The purpose of each has been to invite some distinguished person to speak for half an hour on a topic related to the health and welfare services with the aim of stimulating new thought or action. As often as not, the speaker has come from outside the immediate world of the National Health Service. Again, this choice of speakers has been deliberate : the purpose has been to broaden our horizons and to prompt thoughts about ways in which we can change things for the better. Often, too, the talks have given us a chance to see ourselves as others see us—' us ' in this context being those working in statutory and voluntary organisations directly concerned with the health services. At times these insights may not have been too flattering, but that is all to the good if it has helped to prevent any self-satisfaction or complacency in the welfare state.

A report of every talk has been published in the *British Hospital Journal and Social Service Review,* and nearly every report has been written by Leslie Paine. The Hospital Centre is very grateful for this co-operation, which has enabled this more permanent record of the talks to be produced. There is much in the National Health Service of which we can be proud; there is much that can be done to make it still better. Perhaps these twenty-four talks have provided some useful signposts for the way ahead.

Miles Hardie,
Director, The Hospital Centre.

March 1972.

CONTENTS


| *Date* | *Speaker* | *Talk* | *Page* |
|---|---|---|---|
| 18 December, 1968 | Mr. John Garnett, Director, The Industrial Society. | Achieving high performance in large-scale organisation. | 9 |
| 22 January, 1969 | Dr. Bernard Benjamin, Director, GLC Research and Intelligence Unit. | The Greater London Council's Research and Intelligence Unit. | 11 |
| 22 March, 1969 | Mr. Harold Young, Director, J. Lyons and Co. Ltd. | Achieving high performance in large-scale catering. | 13 |
| 5 May, 1969 | Dr. Michael Young, Director, Institute of Community Studies. | What ? and the National Health Service. | 15 |
| 25 June, 1969 | Mr. Anthony Steen, Director, Young Volunteer Force Foundation. | The Young Volunteer. | 17 |
| 31 July, 1969 | Mr. George Teeling-Smith, Director, Office of Health Economics. | Targets for Tomorrow. | 19 |
| 21 October, 1969 | Professor W. J. H. Butterfield, Guy's Hospital Medical School. | Priorities in Health Care. | 21 |
| 18 December, 1969 | Mr. Jimmy Savile, Disc-jockey and volunteer porter at Leeds General Infirmary. | A porter's picture of the hospital. | 23 |
| 15 January, 1970 | Miss Rosemary Stewart, Fellow, Oxford Centre for Management Studies. | The inquiring mind. | 25 |
| 3 March, 1970 | Miss Geraldine M. Aves, Chairman of the Committee on the Voluntary Worker in the Social Services and formerly Chief Welfare Officer at the Ministry of Health. | The future of voluntary help in the health and social services. | 27 |
| 28 April, 1970 | Mr. John Wren Lewis, ICI Research and Development Organisation. | The old order changeth. | 29 |
| 9 June, 1970 | Sir Bruce Fraser, Comptroller and Auditor-General and a former Permanent Secretary of the Ministry of Health. | Hospitals and their money. | 31 |
| 14 July, 1970 | Mr. Lewis Waddilove, Member, Social Science Research Council. | Social science research and the health service. | 33 |
| 15 September, 1970 | Mr. Caspar Brook, Director, The Family Planning Association. | The future of family planning in Britain. | 35 |
| 27 October, 1970 | Mr. Paul de Berker, Principal Psychologist, Civil Service Department and Associate Fellow of Oxford Centre for Management Studies. | Motivation of managers. | 37 |
| 25 November, 1970 | Professor Stafford Beer, President, Operational Research Society. | Operational research and the health service. | 39 |

CONTENTS—Continued


| *Date* | *Speaker* | *Talk* | *Page* |
|---|---|---|---|
| 16 December, 1970 | Mr. Mickey Stewart, Captain, Surrey County Cricket Club. | SPARKS | 41 |
| 27 January, 1971 | Mr. Frank Field, Director, Child Poverty Action Group. | Poverty in the welfare state. | 43 |
| 9 March, 1971 | Dr. John Rogers Ellis, Dean, The London Hospital Medical College. | Medical education and the future of primary medical care. | 45 |
| 29 April, 1971 | Mr. Glyn Picton, Vice-Chairman, National Staff Committee. | Manpower policy in the health service. | 47 |
| 10 June, 1971 | Mr. Christopher Mayhew, MP for Woolwich East and Chairman, National Association for Mental Health. | An MP looks at mental health. | 49 |
| 6 July, 1971 | Professor Thomas McKeown, Department of Social Medicine, University of Birmingham. | Priorities in health care. | 51 |
| 5 October, 1971 | Miss Ann Shearer, Free-lance journalist. | The press and the professional. | 53 |
| 16 December, 1971 | The Rev. Michael Wilson, MD, Research Fellow, Theology Department, University of Birmingham. | The primary task of the hospital. | 55 |

# Centre Lunch Talk:

## Hospital Leadership

The King's Fund Hospital Centre has introduced a series of midday talks and discussions on subjects of interest to hospitals and those who work in them. The first speaker in the series was Mr. John Garnett, director of the Industrial Society. Some of the points raised by Mr. Garnett in his lively talk are discussed here by **Leslie Paine.**

*Mr. John Garnett*

FOLLOWING the pattern of the " New Thinking " and " Action " lunches held at the Industrial Society, these Centre Lunch Talks as they are to be called, seem to be an excellent example of the Hospital Centre fulfilling its *raison d'être*. Mr. John Garnett who spoke on " achieving high performance in large-scale organisations " is not only the director of the Industrial Society and author of a book on management and communications, but was also a successful manager with I.C.I.

The large number of administrators of varying sorts who made up the audience much appreciated Mr. Garnett's virtuoso performance. It may be (at least in theory) that he was preaching to the converted, but that in no way lessened either the good sense or the interest of what he so expertly and amusingly had to say.

As befits an expert in communication, Mr. Garnett made certain that his message went home. He even issued specially printed sheets for us to write down the action we intended taking as a result of the meeting. And the message? Well I suppose in a nutshell, it was that high performance by staff depends on the quality of leadership shown by their managers. Leadership is not the most fashionable of words in management circles these days—and understandably so. Old ideas die hard, and in the national mind leadership has for too long been too closely connected with fantasies about the playing fields of Eton and the parade grounds of Sandhurst to be readily acceptable in this modern age of equality and the common man. When Billy Liar and Lucky Jim are in, Harry Wharton and Tom Brown at Oxford *must* be out. Nevertheless Mr. Garnett left us in no doubt that the ability to motivate; sapiential authority; charismatic administration—leadership is still the essential ingredient in his recipe for good management.

Everyone, he suggested, needs a boss. Everyone wants to be part of a team with a readily identifiable captain. Only by linking the whole of an organisation together in this way can those " dying of stress at the top " hope to convey some of their sense of driving commitment to " those dying of boredom at the bottom." Only by such means can managers bring their staff within sight of the Holy Grail of productivity, the elusive and variable 100 which represents an individual's maximum performance.

The size of the management team is, naturally, of great importance—if only to make it physically and mentally impossible for its captain to do his assistant's work as well as his own. Invited at this stage to give their opinions on the number of people one manager should directly control, audience reactions fluctuated widely from 3 to 30. Mr. Garnett trod the *via media* with a muscular Christian choice of an apostolic twelve, or at most a rugby fifteen.

As he knows, and we know, there is nothing magic or immutable about these numbers. They are at best a good rule of thumb. They may be lucky for some, unlucky for others—with " span of control " as with so many other things in this life, situations alter cases. It depends in the hospital world, for example, whether you are dealing with cleaners or consultants, sisters or stokers. Few, however, would disagree with Mr. Garnett's contention that the team which scores goals usually has a good captain who can infuse it with team spirit.

What exactly the necessary qualities are, has never to my knowledge been satisfactorily defined. What subtle blend of personality and character makes one man or woman a leader and another a follower has never been adequately explained. That there is more than one blend is indisputable. There are certainly many different types of leader about, and few who are acceptable to all people in all situations. Perhaps like courage or cabbagedom, it is all a matter of how your ductless glands work. Who can say? Not Mr. Garnett; for as he was at pains to point out, he is not interested in the qualities of leadership, but only in what an effective leader *does*. Like Charles II he believes that a man's best ministers are his actions. Indeed he sees the leader's job as a holy trinity of action—maintaining the task; maintaining the team; and paying attention to its individual members. At the end of every day, he said, managers should catechise themselves to ensure that they have done these three things.

The other two bright shiners in Mr. Garnett's Christmas message, were consultation and communication, and here his beliefs seem to follow not only King Charles but Charles Kingsley. Consultation in his book is very much Mrs. Doasyouwouldbedoneby. Serve those who serve you is clearly Mr. Garnett's philosophy. Co-operation and discipline, as he pointed out, are very different things from obedience and punishment. Staff have a right to know and management a duty to explain the reasons behind orders —the *why* as well as the *what* of instructions.

Although a consulter, he is not a compromiser. Management, he insisted, must retain the right of decision, the right to make up its own mind, but *after* consulting with staff. This demands good reciprocal communication. He who communicates—leads, said Mr. Garnett, so make sure that management controls communications. But certainly not through the grapevine, that dangerous and destructive purveyor of indiscriminate mixtures of fact, fancy, rumour and half-truth. Certainly not by means solely of written instructions which are always open to misinterpretation. Face to face briefing is his answer to the problem of downward communication, as long as management decides who briefs whom and when.

As for feed-back from staff, the only safe way to obtain reliable and vivid information about the thinking of those at the bottom is, in his opinion, through elected staff representatives. Managers, he demanded, must have a positive attitude to staff organisations and should beseech their staff to join unions so as to bring the company's point of view into their councils.

This probably seemed rather far from home to an audience not yet plagued by union troubles. Indeed since the whole of Mr. Garnett's remarks had an obvious industrial flavour some listeners may have been tempted to comment " c'est magnifique, mais ce n'est pas la guerre." They would have been the undiscerning; the points he made might need a different emphasis when applied to hospitals but their relevance is unquestionable.

One point he did not make however—and most present must have been surprised by its absence—was the motivating force of money. His early remarks on the cleverness and good sense of hospitals in exploiting the value of vocation would have sounded better had he added that you can obviously flog that particular horse too hard. It was remarkable that none of the nurses present reminded him of this. The moral for managers in Mr. Garnett's Christmas story as I heard it, was that if you want to maximise human resources in any organisation, big or small, you must pay attention to the realistic needs of the people who are your staff. A fair day's pay for a fair day's work is surely one such need. Perhaps it was too obvious to mention, or perhaps the speaker didn't realise that as yet it is far from a *sine qua non* in the hospital world.

# Centre Lunch Talk

## Research and Intelligence

The second in the King's Fund Hospital Centre series of midday talks and discussions of subjects of interest to hospitals and those who work in them was given recently. The speaker was Dr. Bernard Benjamin, director of research and intelligence for the Greater London Council. Some points raised by Dr. Benjamin in his talk are discussed here by **Leslie Paine.**

*Dr. Bernard Benjamin*

IF those of us who are concerned with the administration of the health services of this country are honest we must admit that even after twenty years of nationalisation we have no exact measure of the health requirements of the nation. We don't know because we lack information, and on January 22 some of us went to the King's Fund Hospital Centre, London, to listen to a man who for years has been trying to rectify the omission.

Dr. Bernard Benjamin, giving the second in the series of Centre Lunch Talks, was billed to speak on the Greater London Council's Research and Intelligence Unit. He is the unit's director but during a distinguished career has also been statistician at the L.C.C. Health Department, chief statistician at the General Register Office, and Director of Statistics at the Ministry of Health. Basically therefore he is, and has been for most of his working life, a man who gathers and processes facts. In practice, however, he is much more than that, for his art lies in extracting from the mine of information at his disposal the gold of useful knowledge it contains.

The function of the department which he has directed since its inception in 1966 is to collect and co-ordinate social, statistical and demographic data and use it for research purposes to the benefit not only of the G.L.C., but also of the government, the London boroughs and the general public. It is a scientific department proud of its professionalism. "We can be told to shut up," said Dr. Benjamin, "but we can't be told to say something untrue." It is also something of an infant prodigy. In February 1967 the first staff were appointed to it. In December 1968 the number of studies it had in progress was about 60.

### Empire Building

Of these the most interesting to the audience were clearly those undertaken for the London boroughs. Inevitably so perhaps since the G.L.C.'s health powers are restricted to the provision of an ambulance service and a staff medical room at County Hall. But useful as it was to know of such surveys as those on the needs of old people, the work of health visitors, or accidents in the home, these were I suspect no more than *hors d'oeuvres* to most of those present. The *pièce de résistance* of the discourse which we all awaited with pleasurable anticipation was the speaker's comments on future changes in the health and social services.

Synopsis had told some of us in advance that in the second half of his talk Dr. Benjamin intended to give his views on "the irrelevance of the Green Paper and the inadequacy of the Seebohm Report." But if his obvious disapproval of these documents brought a light to the eyes of the reactionaries among us, his suggestions for their improvement must have lit a candle of cheer in the hearts of the reformers.

The Green Paper he suggested was irrelevant not because the administrative structure it proposed for the N.H.S. was necessarily wrong, but because it had examined administration without first examining what it was that had to be administered.

Administration he pointed out should follow function not precede it. No one present took issue on the matter, presumably on the grounds that while all know in general terms what the function of the health service was, none were prepared to expatiate on how its resources might best be deployed.

As for the Seebohm Report, Dr. Benjamin saw this as "a blatant piece of empire building for the social services." Like the Green Paper it had failed to base its recommendations on a solid foundation of research into the needs it was supposedly going to satisfy. It was, therefore, as far as he was concerned, unacceptable as a sensible plan for the future. If Seebohm had its way local health and social services would be split apart to the detriment of the public and the denigration of preventive medicine. The medical officer of health's already waning status would be even further reduced and we would all suffer. Everyone before him, Dr. Benjamin suggested, who was over 30, owed his or her survival to the achievements of preventive medicine. Like the well-known dog food advertised so much on television, he seemed to be saying, preventive medicine really does prolong active life. It was important therefore to staunch the flow of good doctors from the preventive service, and this would not be achieved merely by altering its form of management. Neither would such alteration help to define the true role of the general practitioner. Such problems could only be solved by studying them in depth, by taking a long, hard look at the needs of the people, by assessing priorities and deciding how best to deploy our resources to meet them.

How do we know, asked Dr. Benjamin in a series of fine rhetorical questions, that what is being done in the service at present is what the people who use it need most? Are too many workers in the N.H.S. doing the wrong things? Are some things being done which shouldn't be done at all; and are those providing essential services necessarily using their special skills to the best advantage of the public? The health service, he argued, could not significantly be improved, nor could greater efficiency be achieved unless we attempted to answer such questions with some degree of certainty.

If the whole of the health and social services were to be integrated on an area basis, we must be certain that all the resources we had to offer could best be organised that way. We must also have accurate demographic information available to us. We needed to know not only how many people we would have to cope with in the future, but what sorts of people and what their demands might be. This was too important and too fundamental to be guessed. One could all too easily be wrong if one relied on guesswork. Times changed and with them situations. In 1939, as he pointed out in answer to a question, the L.C.C. was concerned to keep the population of Greater London down to 8m. Today the G.L.C. was worried about keeping it up to 7m. Population movements, even if you couldn't control them were of vital importance to those who had to draw the blueprints of change.

This was why, for example, the current studies of population being undertaken for new towns like Thamesmead attempted to predict not only numbers and age ranges of people inhabiting them, but also the likely composition and life cycles of their various households.

In the discussion which followed his talk Dr. Benjamin made it clear that no amount of statistical study and research would be likely to lead to a situation where the nation's health needs could be exactly matched by the services available to meet them. Nevertheless he can have left few of those fortunate enough to hear his remarks in any doubt that we would draw nearest to this position if we took fullest advantage of the sort of management science that he and his colleagues have to offer. On the old principle of look before you leap, I'm sure that everyone present agreed with him.

I would like to think that the authors of the Green Paper, now that they have had time to reflect on their suggestions and hear the comments of others, would agree also and instigate limited experiment and research rather than wholesale change. Slow but sure was always better than fast and loose.

# Large Scale Catering

Achieving high performance in large scale catering was the theme of a recent lunch talk at the King's Fund Hospital Centre. Mr. H. Young of J. Lyons showed himself a realist, not an alchemist, writes **Leslie Paine.**

A HOSPITAL CENTRE lunch talk brought together Mr. H. Young, director of J. Lyons & Co. Ltd. and some 85 hospital caterers and administrators. The theme was "achieving high performance in large scale catering." With Mr. Young representing one of the most successful British bulk catering firms, and his audience an organisation which serves more meals to more people than any other in the country, the meeting was particularly apt.

It was also, like its predecessors, successful—except for any who may have come along hoping to be given some magic formula for profitable commercial catering. They were inevitably disappointed for Mr. Young quickly showed that he was a realist, not an alchemist. How to succeed in business as far as he is concerned is not a matter of turning lead into gold in a flash, but of hard work and the use of acumen, knowledge, and experience in pursuit of a clear goal. You could say that he is a man who knows what he wants and gets it; but that would be too simple. In addition to dedication and a comprehensive understanding of the food business, he has a full grasp of management theory.

The tricks of Lyons' trade as Mr. Young explained them are the sort that every good manager should know. Listed as he made them, his points would provide excellent chapter headings for a textbook of good management practice, with the accent on practice. One suspects that the secret of his success is that he *does* those things to which many of us pay only lip service. When he talks of undertaking market research, practising delegation, or instituting a good system of communications, he quotes not from Drucker or Mary Parker Follitt, but from the book of his own everyday working life.

### Success and Order

On the menu which he has designed for the aspirant to high catering performance most dishes contain a tablespoonful of practical advice for every pinch of theory. It's no good, he said, on the subject of customers' needs, "offering a Chinese roast beef when he wants chop suey, especially when chop suey's cheaper to produce anyway. Find out his requirements by using three things—market research, operational research, and your loaf." Similarly on financial control. "If you haven't got a system of budgeting, for God's sake get one quickly, and make sure your staff understand it right down the line. It is no good my producing the best budget ever; *they* must help to produce it and then operate it to make a profit they promised." Or on that vexed question of future planning: "Build modularly so that you can whip out the decor in one restaurant (say a London Steak House) and exchange it over the weekend with another (say in Brighton). Never forget that just because the marble halls of the Corner House are still as good as new, it doesn't mean they're not out of date."

Like Ulysses in "Troilus and Cressida" he clearly believes that success and order go hand in hand. As with Mrs. Beeton's recipe for jugged hare, his recipe for profitability begins logically with the fundamentals. "First define your area of activity. Don't waste time channelling effort elsewhere. You musn't just stagger along; plan ahead, particularly for the long term. Make sure that every manager understands the structure of the organisation; the various levels of authority; and has a job specification which it is his prerogative to write and his boss's to alter. Look to your communications and see that they flow steadily, not only up and down but sideways as well. Make your controls few but effective, and study waste, pilfering and expenses—especially wages—for drainage of profit margins."

### Local Management

On the question of waste one listener naïvely inquired whether like the Chicago stockyards Lyons could yet boast that they "used everything but the squeal." "We're doing well," replied Mr. Young, "but not that well—otherwise shares would really jump and I'd be in the Bahamas rather than in London on a dirty day like this." He was equally forthright on other current hospital topics. Except for such things as bread, rolls and ice-cream, for example, he announced (in answer to a query) that Lyons after forty years no longer favoured central production kitchens. With convenience foods and simple on-the-spot cooking they save distribution costs and produce cheaper, better meals locally. In company with the Controller and Auditor-General, he questioned the relative costs of contractors and direct labour for some jobs, and *en passant* took a side swipe at planned maintenance. He wondered, he said, whether in some instances a breakdown service could not be just as economic—and if he regarded his audience doubtfully as he said this, he need have had no fear. Many of them were wondering exactly the same thing.

Above all the burden of Mr. Young's song was that any service is only as good as its managers; and in his book the management which counts most is clearly done in the dining rather than the board room. He sees the heart of successful catering as the local operation manager and believes that a progressive company's management systems should be designed to encourage the local manager's initiative and imagination. This is why he insists on central controls being minimal; on merit awards for staff; and on accounting and budgeting information getting quickly to the local man who has to act upon it. In a nutshell you could say that Mr. Young's view is summed up in the phrase "It's the local manager's name that should be over the shop door, because he's the one who makes the profits."

How right he is in all this and how sad that the hospital service which so obviously depends on dynamic local management doesn't seem to take the same view.

# Centre Lunch Talk

Ideas and the National Health Service was the subject of the fourth in the series of lunch-time talks at the King's Fund Hospital Centre, London. The talk by Dr. Michael Young is reviewed here by **Leslie Paine.**

THERE are administrators who like to make a mystery of their jobs on the mistaken assumption that the more they sit on the higher they'll get. Not for them Dr. Michael Young's Centre Lunch Talk (the fourth in the series) on "*What?* and the National Health Service." *What,* the quarterly magazine of the National Suggestions Centre, has a catch-phrase—"Don't sit on your ideas." In racing parlance this new publication is by Michael Young out of the Institute of Community Studies, of which he is Director. It thus comes from the same stable as *Which* (popular journal of the Consumers' Association) and *Where* (lesser known organ of the Advisory Council on Education). All three magazines and the organisations they represent are the brain children of Dr. Young, one-time Director of PEP, Secretary of the Labour Party's Research Department, Cambridge Don, and until recently Chairman of the Social Science Research Council. All, one might say, are Young, but *What* and the National Suggestions Centre are youngest.

### Pressure Groups

Launched only last year with the aid of generous two-year grants from diverse bodies the NSC as Dr. Young pointed out, is the reverse of its two predecessors, CA and ACE. They are essentially middle-class pressure groups; in a middle-man ideas organisation. They exist to give information to consumers of products and users of services. Its *raison d'être* is to receive information from the public—to be "a suggestion box for the nation"

By all accounts the box is already pretty popular. The centre's staff are reported as being pleasantly surprised at the practicality of most suggestions so far received. Only 35 per cent have had to be rejected and 2 per cent to 5 per cent are said to be worth following up with further investigation or small-scale field trials.

To date these include partially subsidised telephones for the housebound elderly and chronically handicapped in Hull; a neighbourhood centre in the London Borough of Camden; the conversion of disused railway stations into accommodation for gypsies; the use of milkmen as welfare authorities' contact men with the aged; and the provision of houseguides on the grounds that houses like cars should have a handbook.

### Individual Problems

Basically, as Dr. Young explained it, the centre's aim is to improve services by getting ideas across to key people in authority—and particularly to those in local authority. Better, he suggested, an idea which one firm or one local body will take up, than something more grandiose which involves a change in the government of the whole country.

Understandably, therefore, when he moved from the general to the particular, his suggestions for improving the NHS were concerned with local studies of individual problems. "We want," he said, "to produce facts and opinions from outside to help staff inside . . . to persuade go-ahead administrators that by using us they can develop a better service for the patients." And we certainly shall, if they solve the two problems they first intend to tackle—those hardy perennials waiting time in out-patient departments and communications throughout the hospital. For notwithstanding the vast public satisfaction with the NHS which emerges from all opinion polls, there is and always will be room for improvement in any of its parts—and not least those which Dr. Young's organisation is to study.

### Out-patient Inquiries

This does not mean the twelve local consumer groups with research experience which will undertake the out-patient inquiry are likely to be welcomed unequivocally by hospitals. Some, as Dr. Young admitted, are just not prepared to let his local researchers loose on their out-patients. Others, as Mr. A. G. Till (Secretary of the Association of HMCs) intimated during question time, are suspicious of the scheme because they know little about it. This may have led some listeners to think that perhaps the first job for Suggestions Centre's John Matthews (consultant on suggestions schemes recently acquired from Ford's) was a study of communications not at the Central Middlesex Hospital as intended, but among the centre staff handling the out-patient project.

Those listeners must have been amused to hear that Mr. Matthews, having found a large hospital group more enthralling than any industrial organisation, had decided that one of the most interesting problems to be tackled in it was that of communications. Hearing that his pilot scheme involved separate lines of communication for doctors, nurses and administrators, they may flippantly have wondered whether he would not come up with the proposal that hospitals needed a tripartite system of administration.

### Wider Problems

The problem of Dr. Young's talk in fact was the inevitability of the mental let down between the two halves of its subject. When he progressed from *What* to the National Health Service, he journeyed as far as most of his audience were concerned from fascinating *terra incognita* to territory only too well known. They may not have known much about Medic-alert (one of the points he mentioned) but collectively they were all too familiar with the wider proposals he discussed They had all heard before about out-patient waiting studies, communications projects, and the appointment of organisers of voluntary hospital workers (which filled much of the discussion period), even though familiarity in many cases had sadly led only to contempt.

For knowing of course is not doing, and if a simple message is beginning to emerge from the Centre Lunch Talk series it is that administrative actions speak louder than words. Like John Garnett who gave the first talk, and Mr. Harold Young who gave the third, Dr. Michael Young obviously measures success by achievement. A good idea in his view is only worth having if it can be translated into action. Since he is an arch ideas-man and his career illustrates only too vividly how well he practises what he preaches, the impact of the NSC on the NHS could (given a year or two) yet be startling.

## Centre Lunch Talk—

# The Young Volunteer

Less lighthearted than they sometimes appear, the Young Volunteer Force is an organisation of under-thirties who use their inter-party political and financial backing to educate other young people in developing their communities. **Leslie Paine** comments on Mr. Steen's ' Talk.'

IF ' The Young Volunteer ' sounds more like a pub than a talk this would not displease Anthony Steen who gave the fifth in the lunch talk series at the Hospital Centre. As director of the newly formed Young Volunteer Force Foundation he tries to foster a faintly Bohemian atmosphere in his organisation to stifle any odour of do-gooding which might deter potential recruits.

This is why YVF don't go in for badges or caps, adopt something of a ' throw-it-away ' attitude to some of their work, and intend having their national gathering in the main waiting-room of Swindon railway station.

Don't run away with the idea, however, that this is a frivolous organisation. It's not. Otherwise the Prime Minister wouldn't have launched it in June of last year, it wouldn't have all-party political backing, and the Government certainly wouldn't have given it £100,000 of public money to spend over the next three years.

Mr. Steen believes that young people know they have a role to play in developing modern society and it is the adults who have to be convinced that the young are not just irresponsible. ' Most communities,' he says, *'like* their young people, but resent them taking an interest in and criticising local affairs.' Anyone over thirty is viewed by the foundation not only as an adult but as a probable antagonist, and adult prejudice is seen as the main bastion to be stormed.

But while Mr. Steen clearly looked upon adults as the enemy and insisted that a fundamental principle of his force was that ' youth must speak to youth,' the ' too old at thirty ' rule cannot be rigidly applied. Finding enough suitable adult helpers is one of the main problems of conventional youth work. It could well be the same for YVF—an army, every member of which must automatically go over to the enemy in due course. At 29, Mr. Steen himself is about to do so. Like the Chinese, therefore, his policy must be to absorb rather than conquer his opponents —and he seems well on the way to doing this.

### Critics Convinced

Denounced on its inception by other organisations in the field which feared a take-over of funds and activities, YVF in action is already convincing some of its critics they were wrong. Pursuing its main aim of youth participation in local affairs, trained salaried teams have been sent by invitation to 11 towns and areas from Newcastle to North Devon. In some such as Newport, Monmouthshire, shops have been opened, ' like the Army Education Centres, but different ' to be focal points of the foundation's activities. These activities, Mr. Steen said, were not aimed at merely filling the gaps in the Welfare State, ' to do what the Council wouldn't do, and get a handshake from the Mayor at the end.'

The job of his teams, he explained, was to educate the young as to their rights and roles in the community and to survey local needs through youthful eyes. In Newport they had helped to provide an adventure playground. In Chesterfield over 1,000 volunteers were working once a week or more to help old people. In Warmley, Gloucestershire, where there was little for anyone to do after eight o'clock in the evening, the team was trying to persuade the council to convert a disused zinc melting factory into an arts laboratory. Here even the local Hell's Angels had parked their motor-bikes to lend enthusiastic support to a sensible scheme to provide people of all ages with a practical means of self-expression.

### Withdrawal Difficult

If getting into local areas had been difficult, however, getting out again was likely to be more so. Yet strategically timed withdrawals were vital if the foundation were to remain solvent. Some local expenses were met by councils or the DHSS, the rest came from headquarters. Only a dozen assault teams could be financed simultaneously, and some of the existing ones must, therefore, soon move on. But how, one questioner asked. Through development of the foundation's other two aims, Mr. Steen replied—ie by provision of adequate training and advice.

An advisory information centre, he said, was about to be opened in London ' to give not bumph but practical help.' A selection and training scheme was proposed for other organisations and authorities as well as their own.

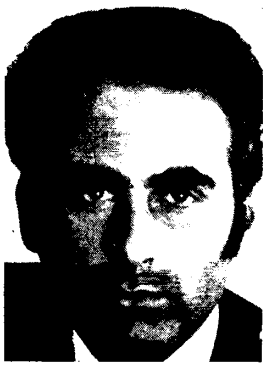
Coming to the hospital service, the audience were supplied with a hand-out giving an impressive list of voluntary work which could be, and already was being, undertaken all over the country. Some questioners, however, doubted whether hospital matrons had the time to deal with the young volunteers and suggested that the immature couldn't undertake tasks requiring mature judgement.

' Voluntary organisations,' said one ' may be geared to the hospital, but is the hospital geared to the voluntary organisation?'

Mr. Steen's answer was that ' too busy ' can often be an excuse for lack of interest and that people were not like wine—age and maturity did not necessarily go together. More hospitals, he suggested, needed to appoint special organisers of voluntary services, and like the Department of Health in last month's circular on the subject, few of his listeners seemed to disagree with him. It was also important, he added, that voluntary work must be necessary and rewarding, for voluntary workers were becoming more responsible and therefore likely to be more critical if used as mere dogsbodies.

As far as YVF were concerned, he stressed that this was not just another voluntary organisation sent to try us. He saw it as an uprising of young people throughout the land and he envisaged that in the end it would become a powerful national peace corps.

The cynics remained unconvinced, but no one would disagree that if Mr. Steen's particular dream comes true then not only hospitals but the whole country will benefit inestimably.



Mr. Steen is director, Young Volunteer Force Foundation.

# Targets for Tomorrow

**Our apparently healthier working population is judging itself to be less fit to work. Diseases which formerly went unrecognised or caused no concern are now considered to need treatment, and this trend is increasing. The health service is at the beginning of a sequence of changes which will radically affect its organisation. But its standard will always fall short of some theoretical minimum, and medical care must always be rationed in some way.**

**Leslie Paine** comments on Mr. George Teeling-Smith's Hospital Centre Lunch Talk, reported on the opposite page, and referred to in this week's leading article. Mr. Paine finds it full of pertinent questions, but a little too optimistic.

PROPHECY can be sadly disappointing, even in the most learned circles. 'All,' as the Cambridge don C. S. Calverley said, 'is not Bass that is bottled; all is not pork that is pie.' But George Teeling-Smith's lunch-time essay into this particular field at the Hospital Centre was palate-tickling, meaty stuff—Bass No. 1 and pre-war quality Melton Mowbray. The sixth in the Centre Lunch Talk series, it must rate as one of the best—high praise in such company.

Being provocatively prophetic is not of course to everyone's taste. And 'Targets for Tomorrow' is hardly the most encouraging title for a talk to those operating a service which always seems to be trying to make too many bricks with too little straw. Nevertheless Mr. Teeling-Smith played the prophet to a crowded house, and played it well. Where some would have opted for pedestrianism and the obvious, and others for wild fantasy, he (as befits the director of the Office of Health Economics) was radical but reasoned.

Pushing the popular principle of community care farther than most towards its logical conclusion, he emphatically demanded that much of modern medicine should migrate from hospitals into smaller community service centres. Any medical procedures *not* highly technological and *not* requiring sequential examinations over a period should be dealt with in the community. District general hospitals as a result were likely to be a hindrance rather than a help to the future development of our health services. 'I believe,' he said, 'that the district general hospitals which we are planning and building today could in the relatively near future form a barrier to community care—in the same way as the physical inappropriateness of our existing mental hospitals forms a barrier to progress in mental care today.'

The hospital building programme, he argued, stood in urgent need of reappraisal before it was too late. Those who thought we had lived through a therapeutic revolution during the past twenty years were mistaken. Things in the health service had only just begun to change. We were only at the spinning jenny stage in the NHS. The railway, factory, conurbation and internal combustion engine eras were all yet to come.

### Clinical Iceberg

Attempts to melt the clinical iceberg of untreated and often unrecognised disease in the community must increase. Community doctors would have to go out and seek illness rather than wait for it to come to them in the persons of already sick patients. The progressive and degenerative diseases—arthritis, lung cancer and heart trouble—must be conquered by early detection and prompt treatment in a network of automated screening centres. The State should follow the lead of the Institute of Directors and provide regular examinations of the apparently healthy.

All this of course, as he admitted, was likely to be an expensive business. The automated screening centres alone might cost £500m a year to run. And the problem of financing the service would not only continue but worsen as the circle of ill health widened and with it absenteeism of the industrial workers upon whose productivity the whole welfare state depended. Like Ffrangcon Roberts in *The Cost of Health* fifteen years or more ago, he saw scientific medicine as having limitless boundaries and patients as a limitless number. The toothless, the deaf, and the poor-sighted; the fat, the alcoholic and the drug-taker would have been considered in the 1930s as old, unfortunate or degenerate. Today they were accepted as ill. Samuel Butler foresaw in *Erewhon* that those once branded as criminals and social deviants would come to be looked upon as suitable cases for treatment.

### No Accurate Forecasts

Faced by such increasing and insatiable demands what could the NHS do but become an even stricter rationing system of medical care? Things were changing so rapidly that accurate forecasts of medical manpower needs based on current practice were impossible. One doctor in the future, with new drugs, new treatments and more socially skilled ancillary staff might deal with many more patients than today. Nevertheless resources *must* be husbanded by greater use of computers and by ruthless evaluation of every medical practice. Why for example did a recent survey show that 25 per cent of patients in hospital wards were there for administrative, not clinical, reasons? Why did admission periods for hernia repairs vary from one to twelve days? And were 'T and A' operations of any real value at all?

Mr. Teeling-Smith asked some very pertinent questions. There were of course also some he forgot to ask. For example, what about the future role of that vital health worker, the GP? And is there not more to the preventive services than early detection of illness? He also showed a shadow of at best undue optimism and at worst naïvety in some of his comments. Record linkage and computerised medicine is undoubtedly coming, but I see it as much farther away than he does. I would similarly be interested in an eminent psychiatric opinion on his suggestion that 'biochemical causes have already been found for many of the problems of mental illness and this should soon lead to solutions.' High hopes indeed.

But, as the Chinese say, 'Much activity, many mistakes—no activity, no mistakes.' Mr. Teeling-Smith's talk was so obviously the consequence of a vast amount of profound mental activity on health matters that he is due to congratulations not carping. Had it not been so good I would not have wanted to criticise it.

## Centre Lunch Talk—

# Priorities in Health Care

**Leslie Paine** discusses a King's Fund Hospital Centre lunch talk in which Professor W. J. H. Butterfield outlined the present and future resources of the health service. Massive education and better organisation will be needed to cope with the ever-widening spectrum of illness.

NONE of us should be seduced, said Professor W. J. H. Butterfield, by all those succulent girls wearing corsetry they don't need, whose photographs titillate the avid captive audience which uses London Underground's escalators. They are only encouraging us to get varicose veins. The professor was addressing an audience equally avid and willingly captive which had come to the Hospital Centre to hear him speak on 'Priorities in Health Care'—seventh in the series of Hospital Centre lunch talks.

One piece of advice, he went on to tell us, that he always gave to his male students was 'pinch your future wife before you marry her. If you find her natural shape is already confined in elastic and whalebone, start to set aside £250 for the vein-stripping operation she will undoubtedly need twenty years hence.' His point as I understand it, was that the enormous demands made on our health services were random and sprang from many sources: ignorance, foolishness, prejudice, heredity, environment, accidents or acts of God. In addition to corsets and varicose veins, he cited other common causes and effects such as smoking and respiratory ailment, sugar and heart trouble, salt or stress and hypertension. The vast majority of people studied in his Bermondsey health survey, he said, showed some sign of respiratory trouble.

### Wrong Medicine

Most of them, too, went not to the doctor for their treatment but to the chemist. A silly thing to do, he implied, because up to 30 per cent got themselves the wrong medicine—aspirins for tiredness, inner cleanliness powders for skin complaints. Nevertheless by doing so they at least reduced demands on the overworked GP who, the professor suggested, has to make at least one important decision every twelve minutes of his working life. The busiest business men—even bookmakers as he put it—can hardly do more, yet the GP had a poor image both in the public eye and in that of the medical profession.

He should never, the professor thought, have been called a general practitioner at all, but a specialist in community medicine and health education, for these were his fortes. Given the proper assistance (secretaries, labour-saving gadgets, safe drugs, better diagnostic aids) he could play a valuable part along with the medical officer of health and the hospital in the massive educative programme that the health service badly needed. We should begin with our own NHS staff and their families, and then move on to cover schools and chemists. Such propaganda could be of inestimable value as a preventive measure.

And some means of reducing the calls on the service had to be found if it were to be kept within economic bounds. Looked at in terms of annual financial turnover, the NHS of this country was already the tenth biggest industry in the world. This put it in the same class as the Chrysler Corporation, US Steel, Mobil and Unilever. Although as Dr. S. E. T. Cusdin (architect not medico) was quick to point out during question-time, this classification was by the total amount spent annually, not by the amount spent on management—a comparison which he implied would be of considerably greater interest. Industry bought efficiency by paying highly for management skill. This might not be true of the health service. Yet, if this mighty industry in which we were all engaged were to continue to serve its purpose even as well as today, it must as we all know somehow stretch its resources so as to match the ever-widening spectrum of illness.

### Mass Media for Health Service

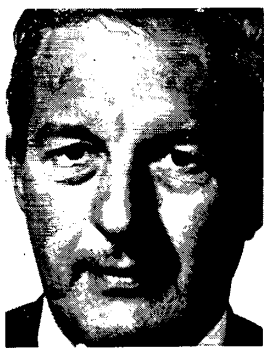
The mass communication media (newspapers, radio, television) and modern technology (computers, monitoring equipment, auto-analysers) should be firmly harnessed to the health service plough. It was vital that better methods of screening for early detection of illness be devised and that obvious abnormalities be treated. By such means some people at least would be prevented from becoming ill in old age. In hospitals we needed to reorganise our out-patient departments, share our beds, improve our communications and be more self-critical. Above all else, we should rid our minds of the idea that the hospital was the inevitable centre of gravity of medical care. It was cheaper, quieter and more comfortable these days for many people to be treated at home. Doctors had to realise this and shape medicine to suit such a situation. The professor didn't say so, but very clearly nurses will have to do the same.

Apart from a concentration on health education, safer drugs and better communications, Professor Butterfield's other suggestions for future action included reducing medical emigration, increasing nursing recruitment, and undertaking more experiments in health service integration. All admirable aims, but unfortunately he forgot to tell us how to achieve them.

On the question of integration he spoke of the Thamesmead experiment as 'a try-out of an area board,' and proffered it as an example of local effort solving local problems by overcoming local separatism. 'After twenty years,' he said, 'people are beginning to discard divisional views and adopt area ones. We may have to build the future integration of the health service on local pride. Health priorities vary in different parts of the country and even from town to town. To meet them we need information not guesses.'

Good sense for the most part but the implication, to me at least, was that area boards could well turn out to be like Thamesmead, allowing full scope for local initiative. But according to Green Paper I they are to have only 16 members, whereas Thamesmead, he told us, has a 140-strong consulting committee. And as for local initiative, this (if the latest rumour is correct) may find itself smothered by a four-layer administrative blanket if Green Paper II becomes reality.

Four or five years hence Professor Butterfield's own hospital, like all the rest, could well be administered by a local committee responsible to a district committee, responsible to an area committee, responsible to a central department, responsible to a Secretary of State, responsible to Parliament. I don't know whether that is efficient integration, but it's certainly bureaucracy. Is it really what Professor Butterfield or anyone of us including the patients really want to see for the future?



*Professor John Butterfield.*

# Centre Lunch Talk

## A Porter's Picture of the Hospital

**Leslie Paine** reports on the guest appearance of a hospital porter and master showman at the Hospital Centre and finds his unpretentious, sincere and sympathetic talk demonstrates that **Jimmy Savile,** like Sam Weller, is someone not only ' perfectly natural and intensely original ' but also profoundly humane. He is not a frustrated doctor but started working as a porter to help the ' Back Britain ' campaign. He also entertains patients in several different hospitals.

THIS was an unlikely talk by the unlikeliest porter of them all. Few such men are welcomed into the consultants' reserved car park; but then few have a Rolls-Royce to put there—especially one with solid gold door handles.

Jimmy Savile's arrival at Leeds General Infirmary two years ago, to do two days' voluntary portering a week, was part of his own private ' I'm Backing Britain ' campaign. It was unusual in that he was welcomed personally by the chairman of the board; and useful because ' it raised the stock of hospital porters tremendously.' He now has a notice on the windscreen of the Rolls reading ' This car is the property of Mr. James Savile, a porter at Leeds General Infirmary.' It matches the ' Made in Japan ' sign on the back. Rolls-Royce like the first and hate the second. Some of the Leeds consultants are said to take the opposite view. Mr. Savile is unlikely to be

worried much either way. A man who earns £50,000 a year for two days' disc-jockeying a week, and raises a similar sum for charity in his spare time, can afford to remain unmoved.

But in spite of his job and income Jimmy Savile is no exhibitionist concerned with a useful publicity stunt. ' If this is a gimmick,' he says, ' then it's the longest-running gimmick in the business.' So, he might have added, is the other hospital work he does including that at Broadmoor. He is now officially listed there as deputy entertainments officer, and proudly recounts a conversation with a couple of patients.

' You a screw now?'

' Don't be silly mate—Jim's one of us.'

For Jimmy Savile, make no mistake about it, may have treated his hospital work lightly at the Hospital Centre but he certainly takes it seriously in Leeds and Crowthorne, Stoke Mandeville and Northampton. ' I'm grateful to be accepted in hospitals and genuinely pleased when my brother porters are *not* surprised to see me at the infirmary, but *are* when they see me on TV. Thank God, that for all my cash I can still be accepted and respected as a human being.'

He stresses that he does not work in hospitals because he is a frustrated doctor, any more than he goes in for lay preaching because he is a frustrated priest. ' I am just not the quality to be either. A doctor has to be strong enough to deal with the tragedy of illness and death knowing that he cannot afford, in the interests of his other patients, to become too involved. I couldn't do that. I'm not strong enough. I may have the ability to earn £1,000 a week, but I haven't the calibre to be a doctor.' He does however (according to Lady Monckton, chairman of the League of Friends of Broadmoor) have the dedication to drive himself to the verge of nervous collapse when he is working for the hospital; and the strength (as he himself disclosed) to run non-stop the 27½ miles from Skipton to Leeds to raise £3,500 for a piece of medical equipment for the infirmary.

He also had the wit to make some pretty shrewd observations on hospitals, the people who use them and the people who work in them. Hospital hooligans—that tribe of drunks and disorderlies who frequent casualty departments late at night —he particularly detests. Hospitals, like churches, shouldn't be disturbed. These people should know better, he argued—and confessed to helping occasionally to teach them to do so with the aid of an old wrestling trick. As the survivor of 96 professional bouts, he should know more than one.

He questioned the way that some casualty patients were treated; pointing the paradox of the drama of the ambulance dash from a road accident perhaps ending in a one- to three-hour trolley queue for X-ray. He suggested the importance of simple smartening-up operations for many accident cases. ' You need to restore their dignity.' And loss of dignity for the patients clearly perturbed him as much as the lack of communication which ignored delays and failed to explain long waits in out-patient, emergency and X-ray departments. Weekly bulletins for staff and voluntary workers, and to help keep patients informed, could be particularly useful. He realised that full-time hospital workers didn't ' dig ' volunteers any more than the police ' dug ' specials. He agreed that ' do-gooders ' could be trying and time-consuming but pointed out there were more than 1m. people in the country ready and anxious to help in hospitals. With proper organisation both parties could benefit—hospitals to improve their staffing and public image; and volunteers to store up some credit in heaven by doing a worth-while job.

You should also be prepared to help yourselves he went on, like Lord Rutherford and his between-the-wars staff at the Cavendish Laboratory in Cambridge. When they couldn't get enough money from the university they raised it from other sources. Hospitals must try to do the same. It was no good everyone in all departments dunning the administrators for more cash. Mr. Pearson (the Leeds treasurer who earlier had introduced him) had a financial allocation like a short shirt. If he pulled it down in the front it merely went up at the back. While therefore the speaker firmly suported more pay for people like nurses and porters, it shouldn't, he insisted, be too much more.

Typically he made his most telling points and truest comments in jest. The late Stephen Hodkinson for example, who wrote that fine chapter on ' Patients ' in the *IHA Management Manual,* would have applauded his aside on administrators who flit smartly along corridors and across entrance halls in case they meet a patient. ' Ooh—no thanks—not another; I saw one last Thursday fortnight.'

Mr. Savile impressed his audience with his obvious shrewdness as well as with his lively intelligence, his dynamo drive, and his tender social conscience. He reminded those of us who came to patronise and stayed to cheer, of that old adage ' never judge by appearances.'

Mr. Paine is house governor and secretary, The Bethlem Royal and Maudsley Hospitals.

# Centre Lunch Talk: The Inquiring Mind

**Rosemary Stewart, MSc(Econ), PhD, told an eager audience that ' The true inquiring mind is interested in what is happening and why. Ready-made explanations and prejudices won't do for it.'**

Managers, especially in the hospital service, should strive always and be ready to abandon the familiar, the existing best, in favour of something better. This advice was given by Miss Rosemary Stewart at a King's Fund Hospital Centre Lunch Talk, reported here by **Leslie Paine.**

' IT'S an interesting sign of the times we live in ' said Miles Hardie, director of the Hospital Centre, introducing the ninth speaker in the Centre Lunch Talks, ' that the lady giving this talk has shorter hair than the gentleman who gave the last one.' The gentleman, of course, was Mr. Jimmy Savile. The lady was Mrs. I. M. James, wife of the Savilian professor of geometry at Oxford—better known as the management writer Rosemary Stewart.

Miss Stewart, fellow at the Oxford Centre for Management Studies, was probably best known to most of her audience through her book *The Reality of Management.* I had forgotten her joint authorship of *Continuously under Review,* a paper on management of out-patient departments; and I never knew that she had written a paper—*The Organisation of Chinese Hospitals.*

### Problem of Isolation

Her subject on January 15 was less specific but equally important and interesting to managers, whether British or Chinese, and was called ' The Inquiring Mind,' and Miss Stewart explained why. ' These,' she said, ' are new thinking lunches, and new thinking is only possible if one has an inquiring mind.' Such a mind she added was essential in times like these when hospitals were changing so rapidly. For those with long memories, this has always been the situation. Hospitals, like most things in this world, aren't what they were—probably never were, nor will be.

The frame of reference within which we all have to work to make sense of the world, she suggested, is formed in our early years and tends to imprison us more tightly as we grow older and our arteries and prejudices harden. ' Probably,' was her comment, ' most of us in this room are in danger of that happening if we haven't already succumbed to it. Anyone over 30 (and even some under) and certainly anyone over 40 may well become set in their thinking ways.' The mental activity race, she seemed in no doubt, went to the fittest, and the fittest were the youngest. None of her audience disagreed with her, nor on her point that change must be welcomed.

Success had its hazards as well as age. And from Miss Stewart's point of view it was better to travel hopefully than to arrive; since once having got to the top you became isolated from a free exchange of opinions. Managers, she argued, were particularly vulnerable in this respect because they led episodic working lives dealing with a variety of problems often under pressure. This put an undue importance on the present rather than the future and on tried solutions rather than innovatory ones. Some of us winced a bit as this point went home; and more smiled in relieved agreement with the subsequent suggestion that committees are not remarkable for stimulating people to think. The true inquiring mind she propounded, is interested in *what* is happening and *why.* Ready-made explanations and prejudices won't do for it. On the other hand it is not the sort of mind that suggests change merely for change's sake—a prejudice in itself.

Most of us by this time were wondering not so much whether we had inquiring minds but how to hang on to them if we did, against the ravages of time, change and ambition. Miss Stewart soon told us how.

### Learning Environment

Our presence at her talk was encouraging! Training courses were also useful but must continue throughout one's career and be shared among one's colleagues so as to fertilise the whole working environment. Such opportunities to refresh one's mind and change one's working habits were stimuli to new thinking. But these stimuli must not be over-powerful. Clearly hospital people could not change their jobs too often; clearly they could not all attend T-Groups. Anyway such groups could impose strains too great for some of us to bear. Also, if you wished to change a person's attitudes completely, then like certain religious orders and political ideologists, you had to go in for brain washing.

Miss Stewart made the briefest mention of the value of reading—a subject which someone like myself—reporting for the *Journal*—would have wished she might have had more time to expand.

Her valedictory advice on how to keep your inquiring mind if you have one, was to put yourself regularly in a learning environment; be ever on the lookout for new stimuli in your work; and like American industry strive always, and be ready to abandon the familiar, the existing best, in favour of something better. It was a good point on which to end, although as she herself said earlier ' The stimulus value of events like this talk is low . . . even if one resolves to do things differently or to think differently, the resolution is likely to fade that same afternoon.'

*Miss Rosemary Stewart.*

# Centre Lunch Talk

**Leslie Paine** gives his impression of a King's Fund Hospital Centre lunch talk on 'The Future of Voluntary Help in the Health and Social Services,' by Miss **Geraldine M. Aves.** As chairman of the Committee on the Voluntary Worker in the Social Services, which produced the report 'The Voluntary Worker and the Social Services,' Miss Aves is a leading expert in this field. This was the 10th talk in the series.

VOLUNTARY service in public services is a British tradition. Yet if we who administer the nation's hospitals are honest we have to admit that our interest in volunteers is sporadic and half-hearted. They may have stood us in good stead for longer than we can remember in the committee room and the out-patient canteen, but we are in no hurry to find them jobs elsewhere. 'Do-gooder' in fact is now a term of derogation in the service; and in the eyes of too many hospital people a voluntary worker is synonymous with a middle-class middle-aged woman looking for a means of relieving her boredom, depression, or frustrated mother instinct.

However the times are changing and we must change with them—if, that is, we are to survive.

As Geraldine Aves made abundantly clear in the 10th Centre Lunch Talk (at the King's Fund Hospital Centre on March 3) it is not now the volunteers who need us, it is we who need the volunteers. In a service living on none too high a calorie diet the protein of voluntary service could well be a necessity. When money and manpower are short can we afford to ignore those who are prepared to work for nothing but their personal satisfaction and their bus fares?

### New Race of Helpers

But, of course, as we all know, it is not quite as simple as that. The volunteers of today and tomorrow, Miss Aves pointed out, are no longer a race of people happy to take on any menial task and do as they are told. A broad spectrum of work will have to be made available to a broad spectrum of volunteers. Some might wash up, some might help social workers; all will need to feel happy and satisfied in their jobs.

'There is no typical volunteer today,' she reminded us. 'They are a heterogeneous group. Whoever takes them on must get to know them, their interests and capabilities; and the hospital professionals must be prepared to make them members of the therapeutic team in direct contact with the patient wherever possible and suitable.'

Even those employers who favour the use of voluntary workers, she suggested, do not always define the roles they are to play before appointing them. This is a fatal mistake because how volunteers are used in the organisation often decides the attitude that paid staff will adopt towards them. Such staff must be encouraged to see volunteers not as threats but as helps—and furthermore as colleagues who could bring to old problems fresh eyes unclouded by administrative doctrines or the contents of the pay packet. Wherever permanent workers have swallowed the 'do-gooder' line, hook and sinker, however, this should be faced not ignored. Otherwise misunderstandings will block the development of a comprehensive voluntary service.

For these sorts of reasons Miss Aves made it clear that organisers of volunteers in hospitals and elsewhere are essential—although there is more to their job than merely recruiting and placing voluntary workers. Their *first* task, she stressed, is to get to know the paid staff, to understand them and their problems. By such means the organiser will come to know not only where volunteers can best help, but where they will be most welcome. Given the right volunteer and the right attitude of mind in existing staff, as she pointed out in answer to a questioner later, there are very few jobs which cannot be done on a voluntary basis in hospitals.

Just, however, as paid staff have to be prepared (in the instructional sense) to receive volunteers, so all voluntary workers need preparation and training before they start work. It is quite wrong that on first arrival at their place of work they should still have to ask such questions as: 'What do I have to do? To whom am I responsible? Am I insured and will you pay my travelling expenses?'

### Training Should be More than Lectures

All this should be settled in advance as should arrangements for training. 'And not please just a course of lectures.' These can be helpful but something less formal and more practical usually fills the bill better, and agencies producing volunteers should co-operate to provide this.

Miss Aves sees local volunteer bureaux as useful instruments of recruitment; and as essential, a central volunteer foundation which would act as a focus for all the current enthusiasm and innumerable talking points.

No, she said in answer to Mr. White of the Young Volunteer Force Foundation, she did not see such local and national organisations as rigid and bureaucratic. Nor would they necessarily go on producing the same pattern of voluntary worker as in the past. She thought they would improve recruitment at all levels—young, old, and 'middle-class middle-aged' who must not be denigrated or forgotten. Yes, she said, to his colleague Mr. Howie, there was a need for education and leadership of children in this field, but what volunteers *do* must always be primarily for the benefit of the patient or client and not for the education of the volunteer.

At the end of the talk and its subsequent flurry of questions, I was left with the feeling that in spite of the recommendations of the Seebohm Committee, Green Paper mark 2, and of Miss Aves' own Committee on the Voluntary Worker in the Social Services, there will be a very long row to hoe in the hospital service before voluntary workers are used to capacity. Somehow Miss Aves made it all seem so logical, reasonable and necessary. As the daughter of the man who helped Charles Booth to produce his famous Report on *The Life and Labour of the People of London,* and as the Ministry of Health's first chief welfare officer, she has, of course, both heredity and environment on her side. The sad thing for the country's health and welfare services is that the majority of people working in them lack these advantages.

Centre Lunch Talk

# The Old Order Changeth

**Leslie Paine** reviews a 'more psychological, sociological, theological and philosophical lunch talk than most.' The discourse by Mr. **John Wren Lewis,** an industrial scientific planner attached to ICI, if a little too rich for some digestions was a welcome treat for the gourmet. Creativity, he said, was a basic human need and although men live in groups they must retain the right to criticise and reform. An experimental approach must be accepted.

SIX years ago ICI asked their research and development team to assess the significance of current social trends and to forecast the shape and needs of society in AD 2000. Their interest was commercial; for technology having made possible almost any improvement in human life, given sufficient time, energy and resources, they wanted to know which technological achievements the public would want (and therefore buy) during the next thirty years. Now they have a report which gives them the answers, and John Wren Lewis who wrote it was at the Hospital Centre on April 28 to tell about his work in the 11th Centre Lunch Talk.

its title was a question—'Is Society Getting Sicker?' But some prophets, of course (as the speaker was I am sure only too well aware) have been saying the same thing as a statement for more than a thousand years; usually in support of their own particular religious, political or ideological convictions. Wulfstan, Archbishop of York at the turn of the tenth century for example,

told England that treachery in high places and increased Viking raids were the direct consequence of a slackening of Christian piety. Today Old Moore and the old brigade are likely to quote anything from the Welfare State to equal pay for women as an example of collapsing social standards. With such warnings from such people over such a period, we could all be forgiven for wondering if Armageddon, like the proverbial good time in the song, really is coming, why it still seems ever so far away.

Yet as Mr. Wren Lewis reminded us, it isn't only the zealots and reactionaries who see about them today the portents of increasing mental, moral and spiritual sickness. Progressives, radicals and liberals too are just as likely to quote examples such as the stress of modern living, the rat race, and the tensions of town dwelling, as signs of society's decline. Are they right to do so? No, said the speaker unequivocally, for by failing to put the present into the context of the past, they reach false conclusions. Good diagnosis, he might have reminded his quasi medical audience, depends as much on taking a careful history as on an accurate tabulation of symptoms.

His own recent study had considered the subject from both aspects. As far as he was concerned (and as a scientist in search of the truth. he presumably would be unaffected by commercial pressures) social development over the past two and a half centuries showed that what we were experiencing today was not the malign influences of a new technology, but the dying pains of an old social system. A system based on 'degree, priority and place'; founded on the idea of a grand, cosmic pattern. Challenged by the natural scientists of the seventeenth century, no wonder it was being challenged even more strongly now. Assuming as it did, that man was made for society (instead of the opposite) it denied him, in the name of conformity, the exercise of that one quality which differentiated him from other animals—his creativity.

'Take but degree away' said Ulysses in Shakespeare's *Troilus and Cressida,* 'untune that string, and hark, what discord follows.' But any social system which suppressed personal creativity was playing a nasty and dangerous game. Creativity was an urge as basic and powerful in man as sex or hunger, and Freud had demonstrated what happened when the problems of controlling such appetites were deliberately repressed. The appetite reappeared often in bizarre disguise leaving the original problem unsolved—a situation as applicable to groups as to individuals. Hence the working out of group repressions in the form of war and bloodshed, witch-hunt and persecution; events a thousand times more serious than the worst deviations of individuals.

The sort of unquestioning conformity that Ulysses extolled in fact was both wrong and bogus. God did not expect men to occupy forever the stations to which he was pleased to call them in early life, and the young saw the nonsense in this clearly enough. A man's place in the world was what he made it. Demos, student unrest and trial marriages were manifestations of youth's perception that 'the old order changeth . . . lest one good custom should corrupt the world.' We too must learn to accept a more experimental approach to social life and resist our desires to make the hippies conform. After all it would not be the hippie drop-out who would press the atomic button but the dedicated, fanatical capitalist or communist.

Certainly, said Mr. Wren Lewis (in answer to Mr. J. A. Loring, director, Spastics Society), men needed to live in groups, but not in groups which bind their members hand, foot and mouth with rule, dogma and myth. Individuals must retain the right to criticise and secede. They would make their most important contribution to a healthy social stability not by blind conformation to a group pattern, but by seeking deeper confidence and knowledge in themselves and greater honesty in their relationships with others. Christ, after all, was the great non-conformist of his day.

This undoubtedly was a more psychological, sociological, theological and philosophical lunch talk than most. Not unexpectedly perhaps, bearing in mind that as well as being a scientist the speaker was for several years religious correspondent of *The Guardian.* Indeed he apologised at the end for delivering a sermon rather than a lecture. Some in the audience may have found his argument too theoretical, his statements too general and his assumptions too many for their taste.

To me it was Napoleon brandy—vintage stuff, the more stimulating for being distilled into the puny pot of a half-hour lecture from a tun of previous study. And for those who saw little currently apposite in the conflict between individual creativity and group conformity which Mr. Wren Lewis flogged so hard, I would merely say —think again—for example, about the management proposals of Green Paper II and the arguments over the South African cricket tour.

# Centre Lunch Talk

## Hospitals and their Money

The only real way to gain more money for the health service is to influence those who allocate it at the centre, said **Sir Bruce Fraser** at a King's Fund Hospital Centre lunch talk. **Leslie Paine** reports the views of the Comptroller and Auditor-general, who considered that health care workers should be vitally concerned with where the money in the national health service comes from —and goes.

SIMPLIFYING the difficult is no easy task. The number of people who can make complex subjects understandable to the general listener are few. One who can, on the evidence of the twelfth King's Fund Hospital Centre lunch talk, is Sir Bruce Fraser. Not surprising perhaps for a Cambridge double first, especially when he is Comptroller and Auditor-general, and talking about 'Hospitals and their Money.'

Some members of his audience at the Hospital Centre on June 9 probably felt that Sir Bruce had been too simple; that he had over-generalised and told them little that they did not know already. As financial specialists they were undoubtedly hoping for something more detailed and provocative to get their teeth into. You can never, of course, please everyone. But most of those present seemed happy enough to have some of the basic facts of health service expenditure set so clearly and simply into the context of the nation's broad economic policy.

This after all is something the speaker is uniquely qualified to do. Completely at home in the forests

of government finance, the coverts of hospital costing are familiar to him as an ex-Permanent Secretary at the Ministry of Health.

With a self-confessed attachment to the idea of a national health service he is dedicated to its success. Not unexpectedly therefore he took as the theme for his remarks: 'Value for money in health care.' Yet even Sir Bruce with all his lucidity and logic could not explain satisfactorily either how to achieve or to assess it. Clear on the need for efficient management ('My taste in administrators and in chocolates is the same—smooth outside, hard centres'); precise in declaring the impossibility of measuring accurately the economic benefits of the health service; he was vague in defining 'the plus in social terms' upon which he suggested the service's claim for a fair share of national resources depended.

Novel in 1948 and big ever since, such a claim was always likely to intrude into the Chancellor of the Exchequer's thinking on the country's economic policy, because a national health service given its unbridled head would soon gobble up all national resources. Financed almost exclusively from taxation, health care formed part of that dreaded home consumption which modern Chancellors had to regulate if our economic boat was to remain on an even keel. To call therefore for 3d. on the income tax so as to provide more for the health service was completely to misunderstand the way that our modern economy worked. If the Chancellor wished he could provide the £500m. a year, which some said the service needed, from the budget surplus.

How then could one see the service getting more cash? Loans for the hospital building programme, suggested Sir Bruce, were just 'not on'; nor were schemes of direct fund-raising by the service. Increases in charges made to patients might be possible so long as this could be done without hardship, but the hospital boarding charge which many had suggested was likely to put more grit in the wheels than grist in the mill. The only real way in fact to get more money was to influence those who allocated it at the centre.

The Government was committed at present, Sir Bruce reminded us, to a 3 per cent increase in the national health service in real terms, i.e. with inflation already covered. But if inflation becomes too great it could hazard this commitment and even reduce it. This did not mean, he said, that those dedicated people working in the service shouldn't put in reasonable pay claims. To submit unreasonably large ones, however, would only help to increase inflation and decrease the service's 3 per cent.

Although health care workers might not be much interested in where the money for health came from, they should be vitally concerned with where it goes. Greater economy and efficiency, even in minor matters, could add up to something worth while. Collectively throughout the country this improved use of resources gave better value for money and might even allow the 3 per cent to become 4 per cent or more. When the unit costs of hospital departments *all* show up in the annual returns as below the national average, that's the time, proposed Sir Bruce, tongue in cheek, to sit back and be content with a job well done. As for the fear that efficiency in the health service would merely pay for irresponsibility in other spheres of government spending, this was unfounded. The central allocators of money worked on the simple principle of starving the profligates into mending their ways. And by the same token efficiency would be supported by extra cash.

But cheered though his listeners undoubtedly were to hear that administrative virtue would be its own reward, they still remained understandably sceptical of ever being able to prove their efficiency or the social value for money they provided. It all seemed to depend in the end, as Sir Bruce agreed, on how much influence could be exerted on those in the centre, and particularly on the Chancellor of the Exchequer. Political pressures it seems must continue to decide the cost of health.

On the questions of health sweepstakes and private insurance, raised by members of the audience, Sir Bruce was short and not particularly sweet. The first would swell the Exchequer but guarantee no extra cash for the health service. The second merely served to diffuse the available health resources. What Sir Bruce didn't say, of course, was that private treatment reduces demand on the health service as well as using its resources—and anyway how can you stop people investing in their own health?

In dealing with these questions the speaker found himself on pretty shaky ground. Indeed, in trying to assess value for money in the health service he was in rough country from the start. It is to his credit that he kept firmly to the path and didn't allow deviation into the wasteland of fruitless discussion. We may not have got far through the jungle of health service finance, but at least some common misapprehensions and misunderstandings were disposed of *en route*.

# Centre Lunch Talk

In the thirteenth King's Fund Hospital Centre lunch talk, reported here by **Leslie Paine,** Mr. Lewis Waddilove, a member of the Social Science Research Council, underlined the need in the health services to concentrate on the quality and effectiveness of provision in his talk ' Social Science Research and the Health Service.' He also described the work of his council and their concern with the strategy as well as the tactics of research.

ABBREVIATIONS are every man's shorthand; natural short-cuts in the communications paper chase. But how many inhabitants of the hospital world who use them regularly could instantly put a name to the initials SSRC? Those like me who couldn't should have been at the King's Fund Hospital Centre on July 14 to hear the thirteenth lunch talk given by Mr. Lewis Waddilove. For he is a member of SSRC—the Social Science Research Council—and spoke on ' Social Science Research and the Health Service.'

Compared with the medical variety, the SSRC is a stripling in years but not in status or variety of interest. It began functioning in December 1965 and keeps in its research field a flock

of subjects which include economics, political science, psychology, social anthropology, sociology and education. In academic institutions from Aberdeen to Swansea or Sussex some 300 studies go on with its support. Studies of shopkeepers and political leaders; Yugoslav communists and Welsh factory workers; marriage in West Africa and politics in Salford. They mop up well over half its annual budget of £4m.

Like the MRC, explained Mr. Waddilove, the SSRC is concerned with the strategy as well as the tactics of research. Admittedly you couldn't force researchers to undertake studies that didn't interest them, but by showing concern for certain aspects you could nudge them in the right direction. This direction, so far as the health and welfare services were concerned, led to four under-developed areas which needed priority help—the use of resources; the impact of services on users; costs and payments; and public involvement.

On the question of how the health service uses its resources, the speaker made it clear that in his view, resources really meant people. Staff of the right kind and with the necessary skills would become harder and harder to get. Yet demands for more and better quality health and welfare services must increase as the population grew older, better educated and more sophisticated. It was imperative that we learned to discriminate more in the use of skilled people. Work studies and task analyses were desperately required for all staff, including doctors, medical auxiliaries and nurses.

Nursing administrators, he said, could no longer be used as high grade clerks, nor waste their time making ritualistic and completely unnecessary hospital rounds. It was sad in these days of so-called rapid change and new thinking that many highly trained nurses still served food (often not very well) to patients in bed, many of whom were quite capable of eating in a dining or day room. Why also were hospitals apparently loath to share their experience on the organisation of nurses' working time, and on training programmes for students?

Listening to Mr. Waddilove's examples of present malpractices, I couldn't help wondering whether they had been provided from the experience of his wife (who was an assistant matron) and his daughter (who was and perhaps still is a health visitor). It was in fact sad to hear such hoary old criticisms of the hospital nursing service, but even sadder to think that they are still valid.

Research on assessing particular health services, the speaker insisted, must concentrate on the quality and effectiveness of provision, not just on the number of patients treated. But while, according to Mr. Waddilove, we had much more information than we realised which would help us tackle this problem, I still find it impossible to see how we are to measure with any accuracy the ' social effectiveness ' of our efforts, or the ' social value ' they add to society. Although of course it will be a pleasure as well as a surprise if Mr. Waddilove and the SSRC prove me wrong.

On the other hand I would agree firmly with his comments on the cost of the service and the way we pay for it. One of the basic problems of our nationalised health and welfare services is that they are State monopolies. The public have to pay for them whether they want to or not. Yet not only are they denied any real say in the sort of service they get, but may well be criticised for taking more than their fair share of scarce resources, if they choose to pay privately for what they want. The proper roles which private care and the wants (as distinct from the needs) of the people should play in the provision of health care services is something which cries out for dispassionate appraisal.

Certainly in the hospital service as I see it, we have tended to be over-paternalistic in the past, but like the speaker I am not sure exactly how we can involve the public more in what we do. Certainly also I agree with him that pressure groups, no matter how well intentioned, can upset a fair allocation of limited resources. But then what is a fair allocation of resources? Are health care priorities in fact not mainly a matter of opinion? And until we can think of a better way of interpreting public opinion, are the decisions not better left to Parliament?

Undoubtedly, if he did nothing else, Mr. Waddilove in the second part of his talk underlined the importance of the case for serious research into some of the most fundamental of our welfare state services. Bearing in mind the amount that the DHSS now spend on research and development (£5·25m. in 1970-71) he also added point to the view put forward in a *Lancet* leader some weeks before his appearance at the Hospital Centre. If the strategy of health care research is to be wisely produced and the tactics to achieve it properly designed, has the time not come for a new arrival in the research council family? A brother for MRC and SSRC—HSRC, a Health Services Research Council.

# Centre Lunch Talk

Human suffering and misery or an improvement in the quality of life ? Mr. Caspar Brook, director of the Family Planning Association, in the 14th King's Fund Hospital Centre lunch talk, ' The Future of Family Planning in Britain,' reported by **Terry Philpot,** spelt out the choices to a professional audience that took his words and suggestions sometimes with shock, always with interest. Despite short-term difficulties, he looked forward optimistically.

EVEN in an audience of seasoned professionals anyone attempting to bring home fully the implications and facts of the population explosion as it affects Britain can expect a few well-aimed shocks to have their effect.

The Hospital Centre, in inviting Mr. Caspar Brook, director of the Family Planning Association, to give a lunch talk on ' The Future of Family Planning in Britain,' hoped to send ripples of discussion through the indifferent waters surrounding the subject.

Mr. Brook, who believed that his suggestions were controversial, had no illusions about the great difficulties of introducing a national popu-

lation policy, or about how much his own association could achieve.

Mr. Brook told his audience that when he had been asked in May to prepare his talk he had imagined that nearer the date the reorganisation of the health service would be clearer, and that family planning would be moving towards being fully integrated in the health service. Now he was not so hopeful. The plans for reorganisation were in suspense and the present Government had yet to say anything significant about family planning. He did hope, however, that cost effectiveness would appeal to Sir Keith Joseph, the Secretary of State for Health and the Social Services.

Every year there were 200,000 to 300,000 unwanted pregnancies among the 500,000 to 600,000 unplanned pregnancies. The equivalent of three Harlow New Towns needed to be built each year to cope with the growth of population resulting from unwanted pregnancies. This had to be considered in terms of human suffering. The rule, suggested Mr. Brook, needed to be ' no copulation without contraception unless a child is desired by both parties.'

Mr. Brook estimated that it would cost £40m. a year to supply free contraceptives to all wanting them and this would save £400m. a year—the cost of unwanted pregnancies. Of the £40m. at least £1m. needed to be spent on an educational programme that would firmly establish family planning as a part of civilised life. All this investment was worth while : in relief of misery, promotion of happiness, and saving hundreds of millions of pounds of taxpayers' money annually.

Why then, asked Mr. Brook, had not a satisfactory policy come to pass ? There were four main obstacles. First, there was the powerful, if now rapidly dwindling, opposition to widespread birth control. Mr. Brook. could, at least, now look ahead to his grandchildren's time when he believed that family planning would be considered as much a part of civilised life as brushing one's teeth and personal hygiene.

The second obstacle was lack of sex education. This needed to be a part of formal education. The present sex educational system was negligible : the Health Education Council battled on ' valiantly,' but local authorities, with a few honourable exceptions, were not even trying.

Thirdly, present contraceptives were inadequate. Most of them required the intervention of doctors and nurses but of Britain's 70,000 doctors, of whom 23,000 were general practitioners, only 3,000 had any specific training in contraceptive techniques. Under 200 hospitals had family planning clinics and only a small minority of those were available to out-patients. Until recently there had been great emphasis on medical justification for contraception but now Mr. Brook was pleased to note that more and more stress was being placed on social considerations.

Of women at risk, 25 per cent were protected by medical methods, and another 25 per cent by the sheath, while 50 per cent were unprotected.

Fourthly, there were certain difficulties in implementing a national population policy. Despite this the aim had to be free contraception on the health service. Depite his initial remarks, Mr. Brook thought that the present Government would encourage local authorities under the Family Planning Act. Some progress might be made in the next few years.

Mr. Brook urged a seven-point plan for family planning. First, universal education, beginning at nursery school level, in birth control.

Secondly, more research into more acceptable methods. Mr. Brook thought it ironical that while man ' pranced about ' on the moon, he still employed ' Stone Age ' contraceptives.

Thirdly, the training of *all* doctors and nurses in techniques needed to be accelerated.

Fourthly, birth control centres should be established in the 100 towns with a 50,000 or more population. These centres, unlike commercially run ones, would be non-profit-making, and would not exploit the sexually immature, inadequate or stunted. Unlike clinics they would not be authoritarian.

Fifthly, psychosexual difficulty centres needed to be opened in the 100 towns.

Sixthly, the family planning domiciliary services needed to be expanded, and if women were not willing to attend clinics, then clinic staff needed to go to them. The FPA had estimated that there were 1¼m. to 1½m. women at risk living below the poverty line, and the overwhelming majority were unprotected

Seventhly, with more local authorities opening their own clinics, an inspectorate was needed to maintain standards. Already, there were signs that the local authorities did not lavish the care on their clinics that one found lavished by the FPA. Birth control was small beer to local authorities so client-clinic relationships suffered.

Mr. Brook said that there was a tremendous temptation upon politicians to delay, and he hoped that Sir Keith Joseph, despite the fact that the current survey on population was still under way, would not hold back, and that he would create conditions for a reduction in population numbers. This would add immeasurably to human happiness and the quality of life.

# Centre Lunch Talk

**Leslie Paine** has reservations about introducing professional management techniques into the Civil Service, admirable though some changes might be. But reform is certainly needed and would be equally valuable in the health service, where much of the same bureaucracy applies. There are many good managers already in post, and the Fulton principles could sort out the outstanding ones from those who shift their responsibilities on to the shoulders of committees.

IF you believe that a management army marches on its salary cheque; that pay and promotion are the main spurs to ambition, then the 15th Centre Lunch Talk was right up your street. Given by Mr. Paul de Berker, and entitled ' Motivation of Managers,' it dealt with the ideas about motivation which have emerged from the recommendations of the Fulton Committee.

Few hospital administrators may have read the Fulton Report, but most will know of it, if only because it does publicly what they do privately—criticises the organisation and management of the Civil Service. Aiming to cleave the Whitehall rock of ages, its suggestions are designed to dynamise Government departments, modernise the Ministries, and explode a system of administration as immune to change as it is to corruption. And since Mr. de Berker, as a member

of the recently created Civil Service Department, is one of the detonators of this series of management time-bombs, it is hardly surprising that his audience at the Hospital Centre on October 27 contained so many DHSS senior administrators.

Presumably they came to hear whether the word according to Fulton had altered since first utterance in 1968; whether a BCom really had ousted a First in Greats as the senior civil servant's basic qualification, and whether the top dog generalist administrator had finally had his day. Each, according to his individual lights, must have gone away with his worst fears or best hopes realised. For the speaker stuck pretty rigidly to the working party line. Admittedly he didn't actually quote Archbishop Garbett's aphorism about first-class honours graduates who aren't capable of managing a whelk stall, but he made it crystal clear that managerial and not just intellectual ability would govern advancement in the Civil Service, if not of today, then of tomorrow. Motive forces like a sense of duty, a need for order, care and personal security and esteem were, he suggested, as out of tune with the times in the service as Max Weber's concept of the well-oiled bureaucratic machine, cogged by identical and replaceable human components.

Above: *Mr. Paul de Berker.*

Such departments as the Board of Trade, Ministry of Technology and DHSS, demonstrated the necessity for the modern Civil Service to be reactive to public opinion and large organisations outside itself, as well as to the dictates of Parliament. The sort of administrative engine that would haul bureaucracy into the twenty-first century, needed to be scientifically designed and dynamically powered by professional managers ready to shoulder personal responsibility and be judged by results.

What a splendid ideal! But is it attainable?

With a reorganised staff appraisal system and a scientific management approach, Mr. de Berker obviously thought so. And much talk followed on the salutary effects that would flow from greater use of such methods as management by objectives and PPBS (planning, programming and budgeting systems). Perhaps my doubts at this juncture can be attributed to my scepticism of the reliability of all machines and my disbelief in the existence of the well-oiled administrative one. But the speaker himself would agree that scientific management techniques are a part of but not a substitute for good management. They can make it tidy rather than efficient, rigid rather than flexible. And if accurate methods of measuring both personal and general efficiency are as hard to find in the CS as in the NHS, then they will indeed be a long time coming.

Nevertheless, in spite of the obvious difficulties of translating Fulton theory into practice, sensible men will undoubtedly support what is being attempted. The proposals to reduce the number of levels of management function, drastically to cut down the existing 1,400 classes of officer, to create a single salary ladder to span the service, and to produce the sort of parallel hierarchies for specialists and administrators which might encourage the creation of French-style *polytechniciens* are all to be welcomed.

For this sort of reform, plus a less rigid and more sensible approach to recruitment, may at long last lead to the logical situation whereby those who guide and control the development of the NHS have practical experience of working in it. Should the health service from Department to district hospital ever become one however, with managers moving freely from centre to circumference and back, all its staff will be civil servants. Mr. de Berker in fact opened his remarks by suggesting that they were so already.

Judging by the murmurs of disagreement which greeted his suggestion, many present didn't like the idea, but with the sort of transformation he went on to outline, could well change their minds. Some, like the authors of *The Shape of Hospital Management in 1980,* have previously suggested that the health service could do with an injection of real management by men and women ready to take personal responsibility for their actions and be judged on performance. Others believe that efficiency would be improved and managers kept on their toes by the introduction of limited and renewable contracts of service in place of present life-time appointments. Whatever the rights and wrongs of such proposals, the Fulton approach might at least help to sort out the genuine manager from the counterfeit.

The NHS has outstanding administrators. It also has its share of non-managers in management posts—those who do little but service committees, hide behind them, push the paper around, and coast along towards their pensions. They are already bureaucratic chaff, and if by all becoming Fulton civil servants they could be sorted from the administrative wheat, health services and the patients they serve would surely benefit.

# Starting Again with the Health Service

## Centre Lunch Talk

If the National Health Service could be planned again from the outset, no one would think of recreating the present three-part structure. We should therefore stop trying to patch up an unsatisfactory service and create a new one more suited to its purpose. This was the proposition put forward by Professor Stafford Beer at the 16th Hospital Centre Lunch Talk, reviewed here by **Leslie Paine.**

PROFESSOR STAFFORD BEER gave the 16th Centre Lunch Talk on operational research and the NHS. He began by saying that he had no pat answers to our health service problems, and ended by adumbrating as interesting (and to me, as novel and likely) a design for their solution as has been heard for a long time. Certainly for those of us who would wish to see any major management change proved by prior experiment and pilot scheme, some of the things the professor said made not only good sense but music to our ears.

The basis of his proposition was simple, and the argument went something like this. Our present tripartite NHS was organisationally odd and had lost sight of its basic aims and ideals. In producing three separate monolithic service blocks, frozen out of the past, we had institutionalised a set of historical accidents. The notion of a health service as a national system for promoting healthiness was a concept to which many people dedicated their lives—but that was not what we had at present. Instead it seemed that the health service was ' an introverted organisation, preoccupied with its own antecedents, its internal power struggles, its levels of status, its costs and its wages, and which solved its management problems in equations of political factors and psychological stress.'

No one today, given the £2,000m. it cost and the million people who ran it, would think of producing either a similar pattern of organisation or structure of management. Rather therefore than going on tinkering with a poor system which could only be made more efficiently poor, we should take the bull by the horns and go in for change (radical if necessary) but based on and supported by advance operational research studies.

Any health service, he suggested, should aim to do for the people what a thing of beauty did for John Keats. It would be a joy for ever if it brought :

> ' A bower quiet for us, and a sleep
> Full of sweet dreams, and health, and quiet breathing.'

And we were most likely to achieve the health and quiet breathing we all desired if the service concentrated less on collective health and the status and well-being of its institutions, and more on the health of each one of us individually. The best health service was that which produced the most complete individual health package and made best use of it.

When medicine was at an earlier and cruder stage of development, it concentrated, rightly, on cure. Later it moved into the subtler areas of prevention. Today it must be concerned with both but above all should be a regulative service. It should in other words regulate the health of individuals. But to do this it was necessary to have a continuous health profile of every one of them. Otherwise how could those who offered the service know what to offer, to whom and when ? And if a single, regularly updated package of health information was to be produced which could follow each one of us from the cradle to the grave, then presumably it could be done only if we made regular visits to the doctor.

Converted in fact into engineering terms, what the speaker seemed to be pleading for was a planned preventive maintenance system to replace our present breakdown repair service. How was this to be achieved and how could operational research help ?

Operational research, Professor Beer stressed, was not a system aimed simply at reducing cost by the use of mathematical techniques. To look on operational researchers that way was as crazy as ' pointing to a tray of surgical instruments and defining a doctor as someone who used those.' Reduced in fact to its essentials, operational research was just a way of trying to solve management problems by scientific means using a variety of trained professional staff.

Above right : *Professor Stafford Beer.*

Using this approach we should concentrate our attention not on buildings or specific services, but on the ways information was obtained, moved about and used. OR models, conceived in terms of information flow, should be made of hospitals. A large model of the entire health service should be created—and could be within a year. It might have a rough and ready data base, but it could be done and we would learn much from it. There was no excuse for not trying. The fundamental research of R. W. Revans, he reminded us, had exposed the vital links that existed between information flow and efficiency; between good communication, good morale and good treatment. We must improve and extend those studies. Efficiency and economy meant having the right information in the right place at the right time.

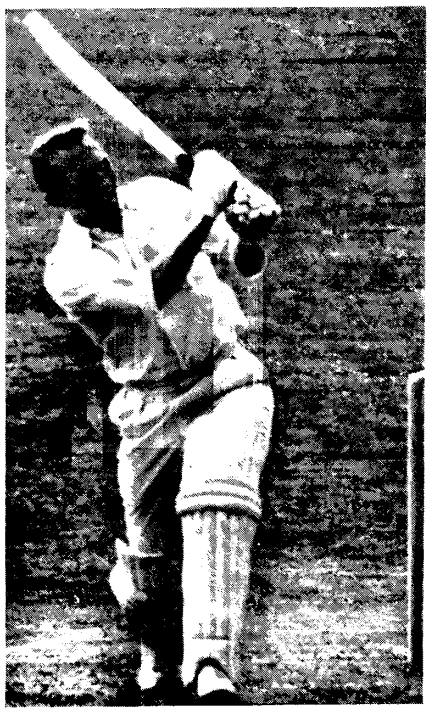
And when we had done such research what sort of NHS would we have in practice ? Comprehensive health centres ' with proper records about the health status of every resident, and containing all medical facilities for out-patient treatment of every kind. Hospitals much like those we have now but which provide every patient with ' an infinitely better aura of information than he has today.' Not all that different perhaps from Lord Dawson of Penn's ideas of fifty years ago. But Professor Beer is certainly right about one thing—good ideas don't always catch on fast.

# Centre Lunch Talk

Famous exponents of all kinds of sport, from motor racing to football, help to raise money for research into the causes and cure of physical handicaps through SPARKS, a rather loose acronym for Sportsmen Pledged to Aid Research into Crippling. **Mickey Stewart,** cricket captain of Surrey, described their work at a Hospital Centre talk and **Leslie Paine** gives us his impressions of the occasion. He also commends SPARKS to the philanthropy of sportsmen and sportswomen who happen to be working in the health and social services.

'THERE but for the grace of God go I,' may be a cry as often of relief as of sympathy, but that is no excuse for not helping your unfortunate brother. Compassion after all, is only *one* of the reasons why we play the Good Samaritan. Although he may not agree with me, those I believe were the morals of Mickey Stewart's Hospital Centre lunch talk—the 17th in the series so far—on SPARKS.

'SPARKS,' as you may have guessed, is yet another example of our present-day predilection for the acronym. It stands for Sportsmen Pledged to Aid Research into Crippling; and Mr. Stewart clearly knows all about it, and those who have



helped it to raise more than £50,000 in less than seven years. He is a member of the society's council of patrons, a roll of something over 20 well-known names in sports as varied as flying (Douglas Bader), lawn tennis (Christine Truman), motor racing (Graham Hill) and real tennis represented by our present Minister of State for Health, Lord Aberdare. Mickey Stewart himself, of course, being currently captain of Surrey is one of the Council's cricketers, and as such is eminently placed to give a view on what makes people like himself give up their time to organisations like SPARKS.

It is mainly in fact from the frank and very honest opinion with which he opened his remarks that I drew the two morals with which I opened mine. 'We aren't do-gooders,' he emphasised. 'Sportsmen inevitably tend to be selfish in the sense that they are eager for personal success or the success of their team.' A viewpoint which anyone will confirm who has listened to a coach or captain trying to instil 'the killer instinct' into his men or women, or watched the tantrums of tennis or soccer players on the base or goal line.

How then did SPARKS get to fly at all, and how did it capture its brighter sparks? The answers, as so often, are simple. The original idea was that of Mr. Duncan Guthrie who decided ten years ago to propound the principle that the active, mobile and fit should help the crippled. This led him logically of course to think of sportsmen; for of whatever age, style or ability they might be, they are certainly among the more active, mobile and fit members of our society. So SPARKS was formed—an organisation for sportsmen, good, bad, and indifferent. And as for getting the stars of the selfish sporting world, that according to Mr. Stewart turned out to be child's play. The organisers of the new charity, he said, made no attempt to change the sporting stars' attitudes of mind; they merely traded upon them and based their money-raising schemes on personal appearances which gave the sportsmen attractive and enjoyable days or nights out.

What sort of fund raising activities had Mr. Stewart himself taken part in? Well he had been a member of a SPARKS Sunday golf team which played local clubs, and had performed in charity cricket and soccer matches. Such occasions might easily bring in £1,000 to £2,000—but mainly he insisted due to the efforts of the local people and not of the sporting celebrities. Then there were sponsored walks with men like David Hemery participating; speaking at sports club dinners, and appearing and helping to run raffles or auctions at balls or gambling clubs. At a recent Stock Exchange Veterans Club dinner for example, two soccer balls autographed by World Cup players and an autographed cricket bat raised £950 by auction in a few minutes. At a similar occasion at a gambling club where £1,600 was given within an hour, Alan Mullery's World Cup soccer boots, and Bobby Moore's jersey fetched £200 apiece, and Colin Milburn's sweater and Merely a Monarch's shoes £100 each.

Then, as the speaker reminded all present, there were occasions such as this when audiences responded generously by giving some donation or by joining the society at £1 a year subscription. For if he had made it sound as though money came easily to SPARKS, it went without question that such money was even more easily spent. Of all they collected, 75 per cent was passed on to the National Fund for Research into Crippling Diseases. The rest had been used for such things as two ten-pin bowling alleys and the seating in the main hall and swimming pool of the new Sports Centre for the Disabled at Stoke Mandeville; and the provision of Sparkle—the first boat in the world capable of being manned almost completely by a crew of wheelchair-bound sailors.

Mr. Stewart and his companion, the secretary of SPARKS, Mr. Arden Camm (also secretary of the Lord's Taverners) were so obviously and so rightly proud of their organisation and its achievements that I (equally rightly) felt ashamed of not having heard of it before. An omission I fear shared by the vast majority of my million colleagues in the NHS. At least, however, I have made atonement for my ignorance, not merely by writing this piece but by commending as I do warmly to all the many thousands of health service sportsmen and women this excellent organisation which has the well-being of the crippled so very much at heart. And when I say 'heart' I mean it. For in spite of his assertions on the selfishness of the top rank sportsman, Mickey Stewart left me, and I am sure the rest of his audience, just as Jimmy Savile did a year ago, convinced that I had been listening not just to a cricketer or a disc jockey, but to a man with a tender social conscience as well.

---

SPARKS,
1 St. James's Street,
London, SW1.

## Centre Lunch Talk—

# Always With Us

**The needs of poverty cannot be met by providing services which the poor will not accept; new methods must be found of conveying help to those who need it and an imaginative attempt made to anticipate their feelings as well as their needs. Why is it that only 51 per cent of those entitled to rate rebates, 20 per cent due for exemption from prescription charges, and a miniscule 4 per cent of those who could claim free welfare foods, have been applying for them ?**

Always with us the poor may be, but many do not recognise this fact until it is forcibly brought to our notice. Standards change and the poor can no longer be seen in 1930s terms, but the stigma of poverty is still felt to exist and causes many people entitled to benefits to be reluctant to apply for them. **Lesle Paine** comments on a Centre Lunch Talk by Mr. Frank Field, director of the Child Poverty Action Group.

I WENT to the Hospital Centre firmly believing that poverty in Britain was declining. I came away equally convinced that I was absolutely wrong. The poor of Britain are indeed getting poorer and more numerous. As befits the director of the Child Poverty Action Group Mr. Frank Field had the facts and figures to prove his contention.

The number of working poor and the number of poor children Mr. Field suggested had both doubled since 1966. In spite of twenty years of welfare statehood, the Britain of 1971 had to face the fact that over a million of its children

Above right : *Mr. Frank Field.*

lived in poverty, and that most of the existing means of remedying this situation did not appear to work.

To start with, few people really understood the problem. They saw the poor in 1930s terms, and forgot the forty years of affluence which had followed. Hence the TV interviewer who thought an income of £16 a week ' rather a lot ' for a family supposedly on the breadline, but accepted the same sum as perfectly reasonable for his own wage increase in 1970.

There was a general disinclination to accept the simple fact that low wages and lack of cash were the root causes of poverty. The public seemed to want some other explanation such as mental or physical handicap, dishonesty or laziness. Could it be the touch of puritanism in most of us which produced this need ? Or perhaps an atavistic predilection for the sort of Tudor ' poor law ' justice that offered one man charity and another the vagrants' branding iron ?

For if poverty is not seen as a stigma by both the poor and the public at large, how can you (the speaker asked) explain the grudging and ineffective way in which we operate our social security system ? Why, for example, do only 51 per cent of those entitled to rent rebates, 20 per cent due for exemption from prescription, optical or dental charges, and 4 per cent of those who could claim free welfare foods, actually apply for them ?

According to Mr. Field the reason is the refusal of many poor people to parade their misfortunes in public. Means tests, unsympathetic counter clerks, and badly printed forms all helped to deter them, and were, the speaker implied, designed to do so. So was the undue stress placed on the penalties levied against improper claimants. Fraud (real or suspected) involved last year almost £698,000, and more than 13,000 claimants. In 1969 the sum was nearer £800,000 and 4,000 claimants were taken to court. Yet also in 1969 we defrauded the Inland Revenue to the tune of at least £16m. and still only 17 people appeared in court as a result.

The story was the same over housing. Supplementary benefitees did not have their rents paid in full even if they were council house tenants. The poor it seemed must be content with the lowest grade of accommodation. Britain, the speaker argued, was once again becoming two nations; and although most present obviously agreed with him, one from the DHSS logically pointed out that with rising standards of living we were bound to have more poor who were less poor—if you will excuse the paradox.

The audience also took Mr. Field's point that you cannot meet the needs of poverty by providing services which the poor won't accept. If we really wanted to help, he said, we must find new methods of channelling assistance and information to those who needed it. His own organisation had set up market information stalls and found them crude but effective. Similar new thinking was necessary by the Government (higher basic entitlements and the scrapping of means tests), by social agencies, social workers, and by us all.

No one in fact when the talk ended appeared to be out of sympathy with what had been said. Everyone accepted that we owed a duty to the poor. Yet, as Mr. Field would be the first to admit, the poor are people just like the rest of us; and people *do* contain their fair share of fiddlers, feckless, and work-shy. Otherwise why should that very tender-conscienced Socialist Minister, Mr. Richard Crossman, have authorised the addition of 100 social security investigators to his Department in 1970 ? But leaving that aside, Mr. Field is right in most of what he said. The true measure of any society's quality is still the concern it shows for its less fortunate members. If the poor are always to be with us let us at least try to make them as few and as happy as possible.

# Centre Lunch Talk—

# Doctors of Tomorrow

**Dr. John Rogers Ellis,** MBE, physician to the London Hospital and dean of its Medical College, is secretary of the Association for the Study of Medical Education and editor of the 'British Journal of Medical Education.' When he asked for what future medical students of today were being educated, at the 19th King's Fund Hospital Centre lunch talk, **Leslie Paine** was present to hear the answer he suggested and comment on Dr. Ellis' concept of family health advisers as first-line contacts.

THE basic question Dr. John Ellis asked of himself and us when presenting the 19th talk in the Centre Lunch series was—can we expect today's medical students to be tomorrow's general practitioners? And the answer he gave was 'No'—not without altering the general practitioner's role considerably.

Medical students today, he said, just didn't want to be family doctors. The proportion of those who on taking up their training showed an interest in the GP service fell from 21 per cent in 1961 to 16 per cent in 1966.

It may have picked up slightly since, but in a medical world of increasing specialisation, general practice in its present form could expect to have a dwindling attraction. Modern medicine too often by-passed the family doctor as more patients used the specialised services provided by hospitals, occupational and local authority health services, and voluntary organisations.

*Dr. J. R. Ellis.*

It was doubtful whether members of a family today desired the personal service that a family doctor once offered. 'Patients appreciate,' he argued, 'the pressures which could lead a family doctor to reveal the confidences of one member of the family to others'—a doubt which a recent much-publicised decision of the GMC disciplinary committee can have done nothing to dispel. And the task of a doctor who was increasingly acting as an agent for the delivery of medical care by others, rather than delivering such care himself, was obviously one with decreasing 'job appeal' for the majority of hospital trained medical students.

Family doctors had not the experience to be surgeons, the time to be psychiatrists, or the knowledge to be effective general physicians in a specialist world. Even, therefore, if medical educationists could find ways of using their influence to steer students towards general practice, would they be right to do so? The answer as before was obviously 'No'—not without altering the general practitioner's current role.

Could we really afford to give up the cherished idea of the family doctor, the image on which the whole NHS had been founded? The answer this time was 'Yes we could; on the grounds that a large part of the population had never enjoyed the theory in practice anyway.' *Dr. Finlay's Casebook* it seems was never anything but a limited edition available only to a limited public. And if that were more obviously true forty years ago when the poor waited in the out-patient department for what the rich got at home, it still remained so today. There was a world of difference between being on a GPs list and having a family doctor.

When modern medical science demanded the talents not of individuals but of teams of medical experts, plus special equipment, and purpose-built premises, the very idea of a personal physician able to give his patients the benefits of all aspects of doctoring was an anachronism. The best of modern general practitioners certainly could not treat all your illnesses on his own and seldom at home. The time had clearly come therefore to stop using terms like family doctor and general practitioner indiscriminately. The functions of the two were now different and must be split apart. The true general practitioner of the future would have to be a generalist physician specially trained and widely experienced, whose primary function would be 'to solve those problems in which all variables (physical, chemical, psychological and social) are involved, and to which no quick, easy, and complete answer can be found by rule of thumb.'

**Family Health Adviser**

The future 'family doctor' on the other hand would be a family health adviser; someone to sign the certificates, provide the preliminary examination, give the necessary basic reassurance, and act as a genuine first line of medical defence. Someone who would answer the question 'Where shall I go for help?' rather than the direct appeal 'Help me.' Such family health advisers, Dr. Ellis proposed, could well be nurses with a suitable additional course of training.

He did not think, he said in answer to a question put by Dr. T. M. Chalmers (dean of the Cambridge Medical School), that to introduce family health advisers would still further reduce the number of nurses working in hospitals. In fact he considered it might stimulate recruitment to the profession. He agreed with Dr. J. H. H. MacRae (general practitioner, Fulham) that ideally a general practitioner should not have to abandon his patients when they went into hospital; but he felt that it was either that or abandoning the rest of the patients on his list. A first-class general practitioner he thought might be able to change places with a hospital general physician, but no man could do both jobs. His new style of general practitioner would in fact be virtually indistinguishable from the sort of general physicians who worked in hospitals today and he would also work in the health centres of the future.

Dr. Ellis argued his cause so cogently; loaded every rift of his talk with the pure ore of such logical reasoning that I for one was left in no doubt of the inevitability of his proposals. Indeed, I found some comfort in the reflection that tomorrow's world of supermarket medicine would still contain an element of the family firm in the form of the home visiting family health adviser. That this 'little doctor' should be a nurse neither troubles nor surprises me. Nurses, after all, have long been the hospital staff who are carefully trained to see their patients not just as people but as individuals as well.

# Centre Lunch Talk—

# Master NHS Plan

Where is our NHS manpower master plan? **Glyn Picton,** vice-chairman of the National Staff Committee, asked this in the Hospital Centre's 20th Lunch Talk, and did not expect an answer. Instead he expounded an ideal staffing policy for the health service which few could expect ever to see in practice. Neither did the speaker. But he argued that to strive towards the ideal and fail would at least produce better results than not to attempt to formulate a policy. **Leslie Paine** reports.

HEALTH services, in the jargon of modern economics, are high-cost labour-intensive industries. In other words they are expensive and employ a lot of staff. Every administrator working in them knows that. Clichés about bottomless pits and open-ended commitments were fed to us with our management pap. We cut our administrative eye teeth on the fact that 70 per cent of hospital expenditure goes in wages.

But what have we done about it? That was the question Mr. Glyn Picton (vice-chairman, National Staff Committee) posed in the 20th Centre Lunch Talk 'Mapower Policy in the Health Service.' Where, he asked rhetorically, is our manpower master plan? Where indeed? According to Mr. S. I. Smith's brief statement during question time, the Department of Health is 'thinking deeply' about this complex problem. With the service approaching its twenty-fourth year it has had quite a bit of thinking time already, and anyway thinking isn't doing. Without wishing to belittle the cere-

*Mr. Glyn Picton.*

bral powers of Mr. Smith and his colleagues, I cannot see the health service ever having in practice the sort of ideal policy that the speaker propounded—and neither obviously can Mr. Picton himself. Any other view, like Dr. Johnson's opinion of second marriages, must surely after twenty-three years be a triumph of hope over experience.

Not that I blame the Department for trying. Indeed it must, for as Chester Barnard once said: 'to try and fail is at least to learn; to fail to try is to suffer the inestimable loss of what might have been.' The nut to be cracked however is a tough one. How tough the speaker showed in his opening remark. 'In an ideal organisation,' he said, 'the objectives are known and defined.' There is the heart of the matter. When health itself is indefinable how can a health service define its objectives? And if you cannot define your objectives except in general terms or those of existing services, how can you design a detailed manpower policy to attain them?

But the best must not be the enemy of the good. If the ideal is beyond us, as clearly it is, second, tenth or even a hundredth best is better than nothing. That was Mr. Picton's simple plea; and of course he is right. Every organisation—fish shop or factory, hospital or Harrods—has a manpower policy whether it knows it or not. It may be organised or disorganised, *laissez-faire* or natural development, order or chaos, but it's there; for organisations are people. The better the employment policy therefore the better the organisation. Manpower planning, as Mr. Picton rightly insisted, is an integral part of the continuing process of management, aiming to exercise influence at the place where work is done. And in this respect the NHS is well down towards the bottom of the class.

The faint fragments of policy which occasionally emerge from committees like Lycett-Green, Noel Hall, Salmon, Godber, Zuckerman, and now Hunter (on medical administration) are sadly unco-ordinated. Like the devil each committee seems interested only in looking after its own, and certainly every hospital administrator could testify to the speaker's comment that the Department of Health's solutions to local employment problems often appear inconsistent. They would also support his argument that by insisting on uniform national pay scales being rigidly applied to non-uniform jobs, Whitley Councils made some decisions easier but management generally more difficult and less interesting locally.

All of us in the field would welcome, I'm sure, Mr. Picton's proposal that such councils might restrict themselves to producing broad national wage agreements, leaving local administrations to apply local supplements 'which would respond to the realities of operational conditions.' I can see such a policy causing a few headaches, especially in London, but the Fulton Report has already made a similar suggestion for the Civil Service.

### Co-operative System

Speaking for myself, who hadn't previously heard of Norman Ross's book *Constructive Conflict,* I was intrigued by the concept of an industrial firm as a co-operative system for the production of incomes and other staff benefits (job satisfaction, status, power) and as a plural society of conflicting but legitimate interests. Whether this makes comparison drawing between hospitals and industry more meaningful, I'm not sure. Unlike industry for example, hospitals still have no easily definable or measurable product, and so no ready means of assessing productivity—a vital management function.

On the other hand, no one has a better acquaintance with plural societies rife with conflicting interests than hospital administrators, which is why some have for years been asking for the introduction of general managers on industrial lines. Certainly any hospital manager worth his or her salt should snatch greedily at the sort of increased decentralisation and delegation which Mr. Picton implied in his remarks. Nothing is more productive of good management than the giving of increased management responsibility, as long as greater freedom of management manoeuvre accompanies it.

The speaker saw it as an historic tragedy that the NHS is to be reorganised without benefit of a Royal Commission on the basis of 'two Green Papers which together do not amount to a slim volume even by the publication standards of minor poetry.' I would whole-heartedly agree with him, but with the publication of the third and yet slimmer Consultative Document, the opportunity for a depth study on reorganisation is lost. At least, however, the latest paper stresses the importance of efficient management in the service of the future—a subject upon which this Centre Lunch Talk had a fundamental bearing.

## Centre Lunch Talk—

# An MP Looks at Mental Health

Mental illness is not only an urgent problem but, as Mr. Christopher Mayhew, MP, suggested in his Centre Lunch Talk, 'the greatest barrier to human welfare in this country at this time.' An outward understanding can often mask misconceptions and conceal secret beliefs that, like poverty, mental illness is something that only affects the weak, feckless and bad living. In fact an avoidable divine retribution. **Leslie Paine** reports on some of the speaker's radical conclusions.

'THE history of mental health reform is largely the history of changing public attitudes,' wrote a previous Minister of Health, Kenneth Robinson, some years ago. It is a viewpoint with which Mr. Robinson's Labour Party colleague, Christopher Mayhew, MP, would undoubtedly agree. For the urgent need to improve Britain's mental health care by influencing public and political opinion on the subject was the basis of the twenty-first Centre Lunch Talk which Mr. Mayhew gave on June 10.

'Mental disorder in its various forms and degrees,' the speaker proposed, 'is the greatest barrier to human welfare in this country at this time.' In the light of some other of the nation's problems—housing, poverty, the elderly, unemployment—a sweeping statement, yet one in fact with which few in the last resort would disagree. Mental afflictions, as Mr. Mayhew went on to point out, know no barriers. They are sicknesses

of no particular age, class or creed. People do not divide neatly into two separate groups—mentally well and mentally ill. We are all in the same spectrum of sanity and mental disturbance could affect every one of us. It is indeed everybody's problem.

#### Secret Beliefs

Increasing compassion for the mentally sick, however, has not necessarily brought about a general acceptance of it by the commonalty. Too often outward understanding could conceal secret beliefs that, like poverty, mental illness is something affecting only the weak, feckless, or bad living. A divine retribution, in other words, which many could avoid if they were better people.

This kind of outlook almost suggests that tackling mental illness is a job not for doctors, nurses and other health workers, but for the Church; and according to Mr. Mayhew could account for the fact that although so obviously the responsibility of the NHS, the public seldom appears to think of mental health in political or government terms. In this sense, therefore, the public gets what it deserves in the way of mental health services. At political gatherings, he told us, and in such parliamentary Bills as that which produced the present charter for the disabled, references to mental sickness were conspicuous by their absence. The All-Party Mental Health Group was a gallant effort on the part of a minority of MPs, but seemed to be achieving little.

One wonders why. Bearing in mind the speaker's earlier comment on the rising tide of personality problems confronting all MPs among their complaining constituents, how do those who supposedly run the country manage to ignore so plain a national problem? Is it a failure to discern the obvious, or a realisation that mental treatment may heal minds but doesn't necessarily catch votes? To be fair, of course, mental illness is but one of many national problems with which Parliament has to grapple. And many parliamentarians obviously realise that mental ill-health, while a great and urgent problem, is not in fact a growing one. Newspaper headlines may imply the opposite, but mental illness in Britain is not increasing. This anyway is the view of medical colleagues of mine at the Maudsley.

#### Urgent Problem

Mr. Mayhew quoted two sources to show the present incidence—the mid-town Manhattan survey which indicated only 20 per cent of New Yorkers as mentally fit; and a Maudsley survey, carried out via GPs, which suggested that 14 to 15 per cent of our population was suffering from some form of diagnosable psychiatric disorder. Understandably perhaps, I incline to the latter view. Knowing little of the detail of either study I cannot help thinking that as quoted by the speaker, the New York one overstates its case. Admittedly it all depends on what you mean by mental disorder, but if (as I suspect) to be mentally unfit in Manhattan meant for the purposes of the study to be the taker of an occasional sleeping pill or tranquilliser, or in some way to be unhappy, then we all qualify as mentally sick.

Leaving aside its exact size, however, no one will quarrel with the speaker's view that mental illness in Britain is an urgent problem, widespread and under-resourced. After all, both Mr. Crossman and Sir Keith Joseph have said that they were committed to doing something about it. Mental health care currently accounts for only some 13 per cent of NHS expenditure and an even smaller proportion of the amount spent nationally on health research. There is an obvious moral to Mr. Mayhew's comment that in this scientific world we can play golf on the moon but yet do not know why a baby is born mentally retarded, or how to cure schizophrenia.

What we have to do he felt was to create the sort of climate of public opinion in which the young graduate would proceed as naturally into research in the field of mental illness as into that of physical illness, the pharmaceutical industry, or any other. The young were already deeply interested in the subject and understood the great need for further study.

We shall triumph, concluded Mr. Mayhew the politician, and the Government White Paper on Services for the Mentally Handicapped published since his talk is a most encouraging sign that he may be right. Let us all hope so, although as Mr. Mayhew, chairman of the National Association for Mental Health, will recall, even that association was not prepared a year or two ago to agree to a motto which virtually said baldly 'Mental illness can be cured.'

## Centre Lunch Talk

# Priorities in Health Care

One medical specialty's gain can all too easily be another's loss; one's freedom, another's restriction. Are we right not to question expensive practices like transplants and psychoanalysis when we have yet to explore other and possibly more profitable fields of endeavour like the medicine of the unborn ? **Leslie Paine** comments on the views of **Professor Thomas McKeown,** who argued that environmental changes are most important.

HEALTH depends as much on proper food, housing, education, work and leisure conditions as it does on hospitals and doctors. This was the premise on which the 22nd Centre Lunch Talk 'Priorities in Health Care' was based. Its presenter, Professor Thomas McKeown, took the broad view of his subject one would expect of the professor of social medicine of Birmingham University. Major health improvements during the past two centuries, he postulated, were due primarily to changes in our environment and behaviour patterns. The trick had been done not by doctors but by the achievement of smaller families, advances in agriculture, and sanitary

reform. When we had fewer children, were better fed, and housed in cleaner surroundings, no wonder we lived longer and healthier lives.

Even today the investment in general health likeliest to give a good return was money spent on improving our environment. The same could not be said with confidence of any particular aspect of medical work. Indeed, Professor McKeown argued, modern medicine still placed its emphasis in the wrong places. Its engineering approach—seeing the body as a machine to be kept in good repair—devoted too much of its time to cure and too little to care. The congenitally, mentally, and elderly sick, for example, presented major health problems, yet received only a minority share of treatment facilities and research interest.

### Doctors' Work

A national reappraisal of the work that doctors do was required—both inside and outside hospital. Inside, because the size, organisation and style of our medical institutions affected the way doctors were trained and so their future medical attitudes, prejudices and preferences. Outside, because the proportion of resources to be allocated to health education and other preventive measures needed most careful reconsideration.

The borderline between medical research and practice was also due for close scrutiny. It had become too tenuous and easy to cross and required stricter policing. We should take greater care in the research stakes to try to ensure we backed the favourites; and before the results of such work were accepted into medical practice, the way they were likely to affect other aspects of the health service, including the use of restricted resources, should be closely assessed. Professor McKeown's plea for a more Benthamite approach to the provision of health care produced many answering ripples of sympathy from the pool of his audience—and a few cross-currents as well. Arthur Gray (house governor, Moorfield's Hospital) questioned whether the gamble of research could or should ever be restricted to likely winners only. Was it not in the nature of things that today's outrageous ideas were tomorrow's accepted practices ? Dr. P. Hopkins suggested that the speaker was interested in mass medical care at the expense of the individual.

### Facts of Life

The speaker stuck to the guns of his earlier argument. The facts of health service life—limited resources, increasing needs, and a lack of accurate measures of productivity and comparative efficiency — demanded wise investment in research and as correct an assessment of expenditure priorities as we could achieve. But we must accept that when the service was organised on various levels—central, regional, local—priority decisions would inevitably be taken at each of them.

The individual doctor, for example, treated his individual patients as he saw fit, and it was right that he should continue to do so—so long as he could be made to realise the effects of his decisions on society and the NHS as a whole. Whatever the Department of Health said, LHAS, HMCs and RHBs would make their own policies in some spheres, and no one would stop them. But we couldn't have a plethora of policies for everything. There was a need for central control too, especially over broad medical issues such as the efficacy of screening for early detection of illness, and the future of hospitals for the mentally handicapped. Panels of experts should produce national policies on the classic lines of the poliomyelitis immunisation scheme, and the Department of Health must make such policies obligatory. Doctors could be saved from some of the dilemmas they face only by removing from them the temptation of freedom of choice.

Professor McKeown's subject has, of course, been tackled twice before by previous centre lunch talkers—Professor Butterfield and George Teeling-Smith. Common to all three approaches has been the sensible argument that an ounce of prevention is worth a pound of cure. Common to all three audiences has undoubtedly been the reaction to such a variety of theorising that in this sphere an ounce of practice would be worth a ton of precept. It is the way of the world that there must be much talking to achieve little doing; but at least if the doing when it comes follows the lines suggested in this latest lunch talk, our health priorities will look more sensible than they do today. Until then politicians will decide national priorities as best they can, while locally they will remain the province of pressure groups and the medical profession.

Above : *Professor McKeown.*

## Centre Lunch Talk—

# Living with the Press

The 23rd Centre Lunch Talk given by **Ann Shearer** on October 5 was billed as ' The Press and the Professional.' Since the professional in this case was a collective euphemism for health and welfare workers, the occasion was nothing if not seasonable. For autumn is chestnut time, and the antipathy which exists between hospitals, other health services and newspapers is as old as it is apparently insoluble, reports **Leslie Paine.** The problem is a fundamental difference in outlook.

LIKE Sherlock Holmes and the Duke of Wellington Miss Shearer is not one to be deterred by apparent insolubility. Lady journalist she may be (Cambridge educated, *Guardian* trained) but she still managed to give, to me anyway, an excellent impression of the sort of hard-boiled, scoop-hungry, determined reporter that Eve Arden once typified in half a dozen Hollywood movies. Her approach was cynical, her argument practical; and as I heard it, went something like this. Let's see ourselves as we really are—warts and all. Let's face the fact that we are all motivated by self-interest—one hopes reasonably enlightened. Let's make no bones about using each other

*Miss Ann Shearer*

to our individual advantage. At least this may open the door to greater frankness and understanding and could provide the basis of a working partnership.

I think she is right. It is true, and no amount of prevaricating will alter the fact, that the basic requirements of a good reporter are a brass neck and the readiness to ask questions even at the most inopportune moments. But while that may make him unpopular it does not, as many hospital people would have you believe, automatically make him dishonest as well. In his relationship with us in fact, the newspaper man undoubtedly sees himself as the honest partner seeking the truth; while we endeavour to obscure the facts and cover up our mistakes.

Indeed, the mutual mistrust which exists at present illustrates above all else that viewpoints depend on standpoints; that truth too often lies in the eye of the beholder, and that opinions, like reflections in a mirror, differ according to the angle of your view and the distortion of your prejudice. As Miss Shearer put it: ' You seem to find us troublesome, untrustworthy, prone to misrepresent you, negative, and scandal-mongering. We find you evasive, oblique, and deceitful—or at least less than totally honest.'

The mention of honesty, as Mr. J. Warrington (trustee, Medical Council on Alcoholism) pointed out, raises a major difficulty in itself. When problems are far from straightforward, doctors for example, if they are honest, cannot provide the direct statement, the yes or no answer that reporters like. And reporters, if they are honest, cannot necessarily tell the complex tale simply and succinctly enough to interest and be understood by their readers while still remaining absolutely true to the facts. In such a situation, as audience and speaker finally agreed, the NHS PROs have an important bridging role to play. Remember too, the speaker added, that misreported statements are more often due to technical failures (bad telephone lines, sleepy copy-takers, hasty sub-editors) than to malice or incompetence.

### Different Outlook

But of all the causes of the present discontents none, Miss Shearer was at pains to emphasise, is more important than the fundamental difference between our and her aims and outlooks. Basically health and welfare workers are concerned with the public interest, and journalists with what the public is interested in. Everyone knows that bad news is good news; that ' St. Thomas' devastated by plague ' is a headline to get us gawping, whereas ' No more deaths than usual at St. Thomas' ' is about as arresting as the American cricket results.

And if sometimes the people involved feel hurt or misrepresented by the story of the collapsing casualty department or the latest claim for negligence, surely it is better for publicity to force improvement than for bad news to be kept secret and the conditions that create it to be thus perpetuated. The recent provision of £3m. of government money to improve hospitals for the mentally handicapped sprang, she reminded us, not from our efforts but from the original article on Ely Hospital which appeared in the *News of the World*. That paper's motives in publishing the story may not have been the highest, but the results were spectacular.

Fortunately we were spared a long-winded and unprofitable ' ends and means ' argument during question time, which instead devoted much attention to the shortcomings of newspapers in which juicy but misleading stories made headline news, while corrections and apologies commanded only two obscure lines on an Inside page. This Miss Shearer agreed was valid criticism, although it only illustrated once again the difference between our respective attitudes and outlooks. It was precisely those differences and the tensions they produced that she believed could, with greater effort on both sides, be made more productive and worth while.

How persuasive the audience found her argument it is hard for me to say, but perhaps you can get some idea from the parting shot fired by Mr. R. C. Stead (PRO, Sheffield RHB) just as we broke for lunch. ' Obviously,' he suggested to the speaker, ' You have made as good a case for an Ombudsman for the Press as you have for one for the health service.'

## Centre Lunch Talk—

# Hospitals on the Danger List

If hospitals are to survive as something more than medical centres they must rediscover the personal aspects of healing. They must help society to see that more money must be devoted to large-scale health problems such as mental illness and handicap and the problems of old age. **Leslie Paine** reports on **Dr. Michael Wilson's** analysis of the shortcomings of hospitals today and his proposal for wide spectrum health discussions

THE 24th Centre Lunch Talk, given by Dr. Michael Wilson, was titled ' The Primary Task of the Hospital.'

Michael Wilson, MD, MRCP, DTM&H, is not only an experienced doctor but an academic and an ordained priest in the Church of England as well, who completed in 1971 a three-year investigation into hospital chaplains and chapels for the planners of the new Queen Elizabeth Medical Centre, Birmingham. Published as *The Hospital—A Place of Truth,* those who have read it will know that it ranges much wider than its sub-title

Above : *Dr. Michael Wilson.*

*A Study of the Role of the Hospital Chaplain* might suggest. The same is true of this talk, based on and carrying the same title as the book's opening essay which originally appeared in the October 1970 issue of *The Hospital.*

In Dr. Wilson's eyes a hospital's primary function is neither cure, care, teaching nor research, but ' to enable patients, their families and staff, to learn from the experience of illness and death how to build a healthy society.' This task—this fundamental educative role which influences not only people's views on sickness and dying but many more of society's attitudes, from those which affect the financial priorities of governments, to those that decide individuals in their choice of careers—is what hospitals are failing so lamentably to fulfil today. Or to be more precise, are failing to fulfil *correctly* today.

Instead of trying to show people that health is a mental and spiritual as well as a physical state; is concerned not with self alone but with relationships, with ' love thy neighbour ' and the well-being of mankind; hospitals, and general hospitals in particular, have yoked themselves blindly to the technological plough, with all that that entails. They have, in other words, adopted the motor car servicing approach to medicine; are concerned almost exclusively with the remedying of physical defects; and by so doing give credence and support to the stunted view that health is no more than a freedom from sickness. When health of this sort is impossible to achieve yet the public's demand for it is understandably insatiable, such a road leads inevitably to frustration and financial bankruptcy. It is, Dr. Wilson would add, a pretty sure way to spiritual bankruptcy also.

Hospitals, in fact, to use his version of one of their favourite catch phrases—are ' on the danger list.' If they are to get off it, if they are to survive as something more than medical centres, they must relearn the value of care as well as cure and replace the treatment of disease with the healing of people. As the speaker pointed out in one of many eminently quotable phrases, ' the individual patient, amputated from his family, is a hospital artefact.' Hospitals too must help society to see the paradox of giving the mouse's share of its health resources to elephantine health problems like those of mental illness, handicap and sicknesses of old age; must teach the man in the street that the so-called miracles of modern medicine are in practice severely limited both in scope and achievement.

Not, however, that Dr. Wilson is suggesting that either the miracles should cease or the curing, caring, teaching and research that hospitals do should stop. What he earnestly desires is all this and heaven too—heaven being the general acceptance by hospital staff, and particularly by doctors, of the broader, Christian concept of health he proposes.

He sees signs of a change of heart in such developments as community therapy centres, family psychiatric clinics, and the growth of voluntary organisations particularly concerned with the elderly, lonely, deviant and emotionally disturbed. He also offers the rise of drug and alcohol addiction, suicide and behaviour disorder as an example of ' Western man increasingly expressing his disease in ways which do not fit into the hospital pigeon-hole '; giving ' *a cri de coeur* in ways which demand a personal model of healing.' Whether the psychiatrists would agree with him I don't know; but I find the implication that some people choose subconsciously to go sick deliberately, in ways not treatable in general hospitals, hard to swallow. Drug addicts, alcoholics, would-be suicides and other disturbed people get much of their help from hospitals anyway.

Nevertheless, on the evidence of this talk Dr. Wilson is a good diagnostician; he knows what is wrong with hospitals. But diagnosis does not of itself cure the sickness, and his suggestions for this are several, varied and mostly well known. Improving personal relations in hospitals, listening to the patient's point of view, making health training interdisciplinary and focusing it on community rather than hospital—all these we have heard before. His idea of setting up a teaching hospital chaplaincy unit, we have not. Nor his proposal for wide spectrum health discussions cutting across every professional boundary and using empty hospital chapels as their conference halls. This above all his proposals might do most to achieve the ends he so devoutly desires—but only if the doctors are convinced and join in. Sadly, in spite of Dr. Wilson's passionate protestations, it seems to me a big ' if.'

Printed in England by Law and Local Government Publications Ltd., 27-29 Furnival Street, EC4A 1JR.