DOCTORS AND THE MANAGEMENT OF HEALTH SERVICES: A SOCIOLOGICAL STUDY OF THE MEDICAL ADVISORY STRUCTURE IN TWO SCOTTISH HOSPITALS

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SUMMARY

This research is a sociological examination of the introduction and operation of Medical Advisory Structures in the National Health Service in Scotland. Sociologists, in analysing the differences between bureaucratic and professional forms of work organisation, have pointed to the problems of involvement of independent professionals in large organisations. Medical Advisory Structures have been designed to provide structured involvement of the medical profession in the management of the National Health Service. These structures are intended to encourage the profession to manage itself and to allow the whole profession to advise the administration on management and policy issues. This study is primarily about two levels of that structure - the divisional or specialty level and the Committee of Divisional Chairmen, or hospital level.

In a theoretical examination of the structure two major inputs into the way in which the structure will function are identified. First of all, there is the structure and what it asks consultants to do. Secondly, there is the nature of the profession which has to work within that structure. It is argued that members of divisions and the Committee of Divisional Chairmen face a role conflict between the representation of self or group interests and opinions and making decisions on the basis of broader criteria which are required for the rational management and administration of the service. At the same time a number of professional values and characteristics are identified. At the individual level clinical and professional autonomy is identified as the key value. At the specialty level, lack of inter-specialty knowledge, specialty autonomy and differences in specialty status are identified as the key professional values and characteristics. It is argued that these professional features will interact with the role conflict to encourage solutions to it which do not damage professional values and relationships. It is suggested that if this is the case such decisions will deviate from the aims of the structure.

The way in which Medical Advisory Structures work was studied for two years by observation in two hospitals. This covered the year before and the year after reorganisation. At the end of the period of observation interviews were conducted with consultants in the two hospitals. The establishment of the two Medical Advisory Structures in the two hospitals and their respective Districts and Areas is described and analysed with particular attention to the dominant concerns of the profession. Following this the operation of the structure is described and analysed using descriptive material on three categories of decision. First of all, decisions internal to the profession at the level of the specialty are analysed. These include decisions about increased staffing, requests for additional equipment and the evaluation of patient care. In the second category of decision similar issues are examined at the hospital level. Medical Advisory Structures were also designed to play a part in the management of the hospital and decisions which required this are dealt with in the third category.

The findings of the research indicate that the operation of Medical Advisory Structures is deeply influenced by the nature and values of the profession. At the divisional or specialty level it appears that individual autonomy influences the solution of the role conflict in favour of the ratification of individual requests or in ways that do not conflict with individual autonomy. At the hospital level a concern with specialty autonomy and lack of inter-specialty knowledge have a similar effect in that specialty requests and interests tend to be agreed to on a piecemeal basis. However, in decisions which require choices to be made between specialties differential specialty status appears to have some influence with the higher status specialties tending to be more successful. Suggestions are made about ways in which the operation of the structure might be improved and conclusions are drawn about the medical profession and its involvement in the management of the National Health Service.

INTRODUCTION

Over the last century an increasing number of occupations have achieved professional status and recognition and at the same time traditional patterns and locations of professional work have changed. While in the past, the majority of professional people worked as individual practitioners they now tend to work within larger organisations which are often bureaucratic in character. It has long been recognised by sociologists that there are sharp contrasts between professional and bureaucratic ways of organising work. The theory of professional/bureaucratic conflict suggests that when professionals work in large bureaucratic organisations there are likely to be conflicts which affect the work of both the profession concerned and the larger organisation (1). One key feature is the comparison between the independence and autonomy which professions claim they need in order to undertake their work effectively and the rules, procedural regulations and hierarchies which bureaucracies traditionally use to shape and control the work of employees. Hospitals, with their reliance upon large numbers of professional employees are often seen as a prime location for such conflicts (2,3,4). In particular doctors, with their insistence upon clinical freedom and autonomy represent a fiercely independent group within the organisation. They also claim the necessity of playing a strong part in shaping the development of health services and yet in the past they have not been strictly accountable for such influence.

Most organisations with professional employees have developed strategies which are designed to achieve some structured liaison between the perceived needs of management and co-ordination and professional independence. Professional participation in decisions and the employment of supervisors or administrators with professional qualifications are two such strategies. In recent years, the National Health Service in Britain has made a more systematic attempt to achieve influence over the conduct of professional work and improve the relationship between management and the medical profession. This study is about the introduction of this system in Scotland and the way in which

it has operated in its early stages. It is therefore an assessment of one major strategy for integrating professionals into a broader organisation.

The National Health Service has been in existence for thirty years and in 1974 it underwent its first major reorganisation. An important part of this reorganisation was an attempt to change the way in which the medical profession relates to and is involved in the management and administration of the service. This began in the mid-1960's with the formation of a Joint Working Party between the Scottish Home and Health Department and the medical profession under the chairmanship of Sir John Brotherston, the Chief Medical Officer for Scotland. The Working Party was to consider potential changes in the way in which medical work was organised in hospitals and it is significant that the profession should have been intimately involved in identifying the problem and finding possible solutions right from the start. Prior to this consultants had been grouped into 'firms' consisting of two or more consultants (5). One consultant was designated 'consultant in-administrative-charge' and each firm had its own beds and junior medical staff. In some specialties there might only be one firm in a hospital while in the larger specialties there was often more than one firm.

The Joint Working Party produced its first report in 1967 and recommended that the old 'firms' should be replaced by clinical divisions (6). This was seen as a more rational way of organising doctors in the large and complex organisations which hospitals have undoubtedly become. They seemed to be arguing that the days were over when an organisation based upon small, independent clinical units was feasible. They recommended a shift, for some purposes, from the firm to a group of doctors within a single specialty or group of related specialties. There were two main aims behind this. First of all, to make the profession more accountable for the resources it was using, partly by broadening the context within which clinicians made decisions. Secondly, to make spokesmen of the profession more accountable to their colleagues and thereby improve the quality of medical advice to management.

The Joint Working Party recommended that a division should consist of consultants in the same or related specialties and that they should be concerned with policy about the co-ordination and management of medical care within the specialty. It proposed that each division should elect a chairman and that, in order to create a similar management and co-ordinating body at the hospital level, the chairmen of all the divisions should sit on a Committee of Divisional Chairmen. At that time in Scotland there were five Regional Hospital Boards and within the regions hospitals were administered, in groups of one or more, by Boards of Management and it was proposed that the Committee of Divisional Chairmen should relate to the Board of Management.

By this time plans for reorganising the National Health Service were at a fairly advanced stage. As the new structure, uniting hospital, general practitioner and local authority services under Health Boards, became known, the Joint Working Party directed its attention towards the position of the profession, as a whole, within the reorganised service. Subsequent reports of the Working Party, or sub-groups of it, examined the position of the whole profession within the service. As part of this the ideas of the first report were carried further forward to provide structured medical advice at all levels of the service and a professional Medical Advisory Structure which brought general practitioners and hospital doctors together (7,8). Divisions and the Committee of Divisional Chairmen formed the hospital basis of this structure and these were to provide members for the District and Area Medical Committees above them and on up to the national level.

This represented a considerable change in the way in which the profession was involved in the management structure of the National Health Service. It represented the philosophy that the profession should play a substantial part in the management of the service at all levels. Prior to these recommendations there had been medical membership of Regional Hospital Boards and Boards of Management but these mechanisms did not provide for the co-ordinated views of the medical profession to be vocalised. The divisional system and the subsequent Medical Advisory Structures were therefore intended to

provide better organised clinical services by encouraging doctors to manage themselves and the resources they used in a more co-ordinated way and by improving the way in which medical advice to management was arrived at and transmitted.

The divisional system and the Medical Advisory Structure represent a new strategy for involving the profession in broader organisational concerns. The primary aim of this study is to develop a sociological critique of the structure and thereby to assess the success of the Joint Working Party proposals. The study is focussed upon the hospital side of the Medical Advisory Structure, mainly at the hospital level and below.

To put the new Medical Advisory Structure and the divisional system in their context they, and the old methods of medical involvement in management, need to be considered along with the structure of the National Health Service, both in its original and reorganised forms. This is done in Chapter 1. A second requirement is a sociological examination of what is implied for consultants in the functions which specialty divisions and the Committee of Divisional Chairmen are supposed to fulfil. The introduction of these committees creates new organisational roles for consultants and as a starting point we want to examine the nature of these roles. It will be argued that for both members of divisions and of the Committee of Divisional Chairmen there is an inherent role conflict between the representation of self or specialty interests and the consideration of issues within a broader organisational context. At the same time doctors do not take on these new roles without bringing with them existing professional relationships and values, such as a mutual concern with clinical autonomy. There therefore needs to be an examination of the potential interaction between the role conflict and the professional values and characteristics which are brought into divisions and the Committee of Divisional Chairmen. These theoretical issues are covered in Chapters 2 and 3. Chapter 2 examines the specialty division and Chapter 3 looks at the Committee of Divisional Chairmen.

In any research important decisions have to be made as to the most effective means of collecting data about the object of study. In this case an attempt was being made to find out how the Medical Advisory Structure was working. It was therefore desirable to follow the decision-making process as closely as possible and because of this there was little option but to collect case material on issues from their inception to their resolution. The most effective way of approaching this was to observe the committee meetings within the Medical Advisory Structure and this was done for a period of two years in the two hospitals studied. At the same time the views and opinions of consultants were thought to be an important source of data and towards the end of the observation period interviews were conducted with a sample of doctors in both hospitals. The precise details of the methodology and fieldwork are outlined in Chapter 4.

Before the operation of the structure can be examined the precise local details have to be provided and these are covered in Chapters 5 and 6. In addition, initial reactions to suggested change and solutions to it invariably indicate the basic concerns of the people involved. The examination of the introduction of the divisional system in the two hospitals therefore provides an indication of the profession's approach to it and the professional concerns which they wished to protect. However, the main aim of this study is to examine the way in which doctors made decisions on the context of the Medical Advisory Structure. One aim of the Joint Working Party was to persuade doctors to manage their own work more effectively and it is precisely at such points that we might expect professional concerns and values to deter doctors from making such decisions. Issues which require doctors to manage themselves and which are internal to the profession are therefore real tests of the structure and the way in which such basic issues were dealt with in the two hospitals is described and analysed in Chapters 7 and 8. Chapter 7 deals with the divisional or specialty level and the ways in which decisions about requests for additional medical staff and equipment and the evaluation of patient care were made. In Chapter 8 similar decisions are analysed at the hospital level. The divisional system was also expected to make a broader management contribution and in Chapter 9

a number of management decisions which required joint professional action are examined. These include the allocation and use of beds, requests for and the allocation of non-medical staff and the implementation of two policies. Finally in Chapter 10 conclusions are drawn about the way in which the hospital side of the Medical Advisory Structure was operating and the implications are assessed for the future role of the medical profession in the management of the health service and more generally the position of professions within organisations.

By its nature this research required intensive study of a number of committees in two hospitals. The doctors and administrators involved allowed me free access to their meetings and to documents which were of relevance to the Medical Advisory Structures and decisions made within them. Without their active help and co-operation this study would not have been possible. Inevitably some of the issues and discussions involved personalities in arguments about very sensitive areas and for this reason I have changed the names of the people and the hospitals in which they worked.

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PART 1. STRUCTURAL AND THEORETICAL BACKGROUND

Chapter 1. Medical Involvement in the National Health Service in Scotland.

Chapter 2. Role Conflict and Individual Autonomy in Specialty Divisions.

Chapter 3. The Committee of Divisional Chairmen: Role Conflict and the Impact of Specialisation.

Chapter 4. Theory, Fieldwork and Methodology.

Chapter 1. Medical Involvement in the Management of the National Health Service in Scotland

Introduction

The main purpose of this chapter is to examine the changing face of medical involvement in the management of the hospital service. Recent proposals have increased medical participation and responsibility in the making of decisions and it will be helpful to look at these in the light of past methods of involvement. The old structure under the 1947 Act and the associated medical contribution to management will be considered briefly (1). The first report of the Joint Working Party on the organisation of medical work will be examined in relation to the faults of the old strategies for medical involvement (2). This will be followed by an examination of the new structure under the 1972 Act (3) and a consideration of the Medical Advisory Structure which has been designed to align with it. From this the main areas of interest for this research will be identified.

The Structure of the Hospital Service 1948-1974

The organisation of the National Health Service in Scotland was detailed in the Act of 1947 (1). The service was administered in three separate parts; the hospital and specialist services, the general practitioner services, and the local authority services.

The hospital service was organised in three tiers. At the top was the Scottish Home and Health Department with the Secretary of State at its head. The second level involved the Regional Hospital Boards of which there were five in Scotland. Below the Regional Hospital Boards were the Boards of Management of which there were eighty-four at the inception of the service. The Regional Boards and the Boards of Management were composed of medical and lay members and in each case the level above vetted the nominations for membership made under the Act. The division of responsibility between the Regional Boards and the Boards of Management was left largely to the local level within broad functional guidelines set out by the Act.

At both levels the Boards had large administrative staffs of which the head was the secretary of the Board. At the Regional level there was also a large medical administrative staff of which the head was the Senior Administrative Medical Officer. Since the 1947 Act there have been various small developments based mainly upon the reports of specially constituted committees. These reports have performed three functions; they have elaborated upon the structure, they have described its functioning and they have made recommendations as to future practice. The main reports which had an impact on the service were the Guillebaud Report in 1956 concerned with the cost of the service (4), the Henderson Report of 1957, with the following remit:

> 'To consider how medical participation in the control and management of hospitals can best be secured in Scottish conditions with special reference to (a) the employment of Medical Superintendents ... ; and (b) medical staff committees, their contribution and functions;' ((5), para. 1).

and the Farquharson-Lang Report which considered the administrative practice of hospital boards (6). The main concern here is with what these reports had to say about medical participation in hospital management.

Medical Involvement in Hospital Service Management

There were three principle ways in which the medical profession was involved in management under the old structure. First of all there was medical membership of Regional Hospital Boards and Boards of Management. Secondly, there were medical advisory committees, both as formal parts of the structure and as ad hoc additions. Finally, medical administrators were employed throughout the service. Each of these methods has been considered by official reports and it will be worthwhile examining the nature and quality of their contribution. The major forms of medical involvement are shown in Figure 1.1.

Medical Membership of the Boards.

The terms for this were set out in the Fourth Schedule of the 1947 Act (1). It was stated that of the members 'at least one half shall

Figure 1.1 The Structure of the Hospital and Specialist Services 1948-1974:
Major Methods of Medical Involvement in Management

Basic Structure	Medical Involvement in Management
SCOTTISH HOME AND HEALTH DEPARTMENT	a. National Professional Consultative Committees. b. Specially Constituted Professional Committees to examine particular problems. c. Medical Administrators.
REGIONAL HOSPITAL BOARDS	a. Medical Membership of the Regional Board and the Board's Medical Sub-committee. b. Specialty Advisory Committees. c. Medical Administrators.
BOARDS OF MANAGEMENT	a. Medical Membership of the Board of Management and the Board's Medical Sub-committee. b. Medical Staff Associations. c. The Medical Superintendent.

be persons other than medical practitioners' and that for the Regional Boards members should come from '... any university with which the provision of hospital and specialist services in the Area of the Board is associated', and '... such organisations as the Secretary of State may recognise as representative of the medical profession ...'. For the Boards of Management medical members were appointed from the Executive Councils in the area and senior hospital medical staff of hospitals in the group, in the case of Boards associated with a university members from that source were not to exceed one-fifth of the total membership.

Medical membership was discussed by both Guillebaud (4) and Farquharson-Lang (6). Guillebaud looked at the arguments for and against medical inclusion:

> 'Those who favour the inclusion of medical members have pointed out that the hospital service is basically a medical service and that the managing bodies should therefore include among their membership some who represent the medical profession. So long as medical members are in a minority, their votes by themselves cannot sway the decisions of the managing bodies, but their advice and experience can be invaluable to their lay colleagues who, after all, have the last word through their majority vote'. ((4), para. 257).

> 'Those who have opposed the appointment of medical members have argued that the proper role of the doctor in the administration of the hospital service is to advise the managing bodies, but not to exercise a vote in any of their decisions'. ((4), para. 258).

In its conclusion the report came down in favour of their inclusion:

> 'Their inclusion gives invaluable advice to the lay members on medical aspects of hospital management, and in return it helps the doctor to understand more fully the broader administrative problems in the hospital service'. ((4), para. 261).

> '... we doubt if the total number of medical members should exceed 25 per cent and we recommend that this figure should

not be exceeded save in quite exceptional circumstances'. ((4), para. 262).

Guillebaud suggests that in some Boards which had medical membership in excess of 35 per cent medical influence could be substantial, indeed his recommendation of 25 per cent is a considerable reduction upon the less than half of the 1947 Act. Farquharson-Lang reached similar conclusions and, while admitting that medical members can give invaluable advice, warned against the usurpation, by these members, of the expert medical advisers appointed to assist the Boards and the committees of professional associations who should be consulted. Medical membership of Boards therefore continued with the qualified approval of the reports which looked at the subject.

Medical Advisory Committees

The second main area of medical involvement has been through membership of committees relating to the Department, the Regional Hospital Boards and the Boards of Management. At the national level there were some committees which are part of the structure, for example, the Standing Medical Advisory Committee of the Scottish Health Services Council. Other forms of involvement arose when committees were set up to look at specific problems for example the Henderson Committee (5). At the Regional and Board of Management level the Boards generally had their own medical sub-committee on which most of the medical members sat. At the Regional level there were also special sub-committees which looked at specific areas and onto which members were co-opted, for example, in mental health and geriatrics.

At the Board of Management level the other main source of medical advice was through the Medical Staff Committees. The Henderson Report looked at their contribution and found wide variation in practice (5). The committee considered that:

'... in general the position is unsatisfactory (a) in relation to the staff organisation itself, and (b) in the extent to which it is consulted by the Board'. ((5), para. 54).

In view of this the report put forward certain principles for the standarisation of membership, the election of an executive and the attendance of the Medical Superintendent. It also made suggestions as to their functions:

> 'The first, to be available for consultation by the Board, second, to advise and make recommendations to the Board on the various aspects of the work of the hospital; third, to protect and foster the interests of the staff.' ((5), para. 60).

The report recommended that the committees have direct access to the Board of Management. In this way the Medical Staff Committees were given greater legitimation for involvement in the management of the service.

Medical Administrators

The third major means of medical involvement had been through medical administrators. This was true in Scotland at all three levels. At the national level there was the Chief Medical Officer with a staff below him allocated to specific functional tasks. At the Regional level there were the Senior Administrative Medical Officers with their staff. Finally, and most importantly from the viewpoint of this research, there were the Medical Superintendents at the local level. These officers were on the Regional Board staff and were co-opted to serve the Boards of Management. The Henderson report considered their position, endorsed the continuation of the practice and elaborated in some detail upon their functions:

> '1. He ought to be in a position to advise the Board about the most effective use of hospital resources, e.g. the allocation of limited funds to new developments in clinical departments.
>
> 2. General supervision of the junior medical staff, pharmacy and medical auxiliaries.
>
> 3. Supervision and organisation of the outpatient department.
>
> 4. Advice on hospital planning, furnishings and equipment.
>
> 5. Liaison with the administrative officers of the Regional Board, Medical Officers of Health and General Practitioners in the area to ensure integration of hospital services with other health services.

6. In teaching hospitals, co-operation with the Dean of the Faculty of Medicine about the provision of teaching facilities.

7. Although there are other departments of the hospital of which he is not in charge or responsible to the Board, he ought to be the co-ordinator of all activities within the hospital.' ((5), para. 33).

From then on Medical Superintendents were appointed to the Regional Boards with dual responsibility for the Boards of Management and any duties which the Senior Administrative Medical Officer might want performed. They were established as an integral part of medical involvement in management.

The next report which crucially affected the future of medical involvement was the Joint Working Party Report of 1967 in which the divisional system was first proposed (2). This report, the new structure and the proposed Medical Advisory Structure all suggest that the old forms of medical participation were unsatisfactory, if not in the light of experience in the early years of the National Health Service, then at least with the benefit of hindsight in the latter half of the 1960's.

The Drawbacks in the Old Strategies of Medical Involvement

The 1967 Brotherston Report is mainly critical of the old firm or 'chief' system of medical organisation, wishing to replace this with the more democratic divisional system. However, it does hint at the inadequacies of the old methods of relating clinicians to management. The report mentions the:

'Great need for better communications between clinicians and the administration as a means of encouraging professional staff to take greater interest in the management of the service.' ((2), para. 11).

What were the main faults of the three systems of medical involvement.

The medical members of Regional Boards and Boards of Management were only supposed to be there as doctors but it would appear to have been difficult for them to distinguish between this and their position and requirements in the hospital. It made empire-building a possibility and such influence was hidden from their colleagues. One consultant who was interviewed said:

> 'Our chief was on the Regional Board and we had it good for a long time and built up a good unit, possibly more than we should have.'

and another said, referring to the same person:

> 'There are wards in this hospital which are a memorial to one man's power and influence, they are of unique design.'

It was probably unreasonable to expect such members to act consistently as an independent medical voice and this led in some cases to an abuse of their position. It also meant that the nature of advice received was biased, if not with deliberate intent then by their position as the only authoritative clinical opinion at the Board level. An ex-member of the Board of Management in one of the hospitals studied mentioned this problem:

> 'When I was on the Board of Management I knew the hospital should come first, but I don't say I always behave like that. I always pushed my own unit but I knew I really shouldn't.'

Medical membership of Boards therefore meant that it was sometimes difficult to get objective advice and that such advice or influence that there was came from the limited spectrum of the medical members.

While the national and regional committees set up to look at specific areas were open to the same kinds of difficulty they probably involved the profession in a resonably structured way in areas of specific interest. However, in the case of the Medical Staff Committees at the local level there is some doubt about their effectiveness. It seems likely that the variation in practice noted in the Henderson report continued after its publication. The only study which has examined their role was conducted by Brown in the early 1960's (7).

He looked at twenty medical staff committees, four of them in Scotland and, in considering their size, composition, business dealt with and chairmanship, concluded that:

> '... medical staff are not yet ready to establish a close collective relationship with the governing body of the hospital in which they work, and ... premature attempts to formalise such a relationship will prove sterile.' ((7), p. 19).

One of the problems with the Medical Staff Committees was that they comprised the whole of the medical staff and because of this they tended to deal only with matters affecting the whole staff. The narrower specialty concerns which are recognised by the divisional system, and the relative isolation of the specialties in any hospital, imply that the advice from these committees tended to be very broad and rarely relating directly to medical matters. While it was legitimate for the committees to deal with non-medical matters it was customary that for medical matters the individual medical units, through their consultant in-administrative-charge, approached the Medical Superintendent individually about requirements. This relatively anarchic system paved the way for a number of undesirable consequences:

a. a lack of unified purpose, provision and procedure both within and between specialties;

b. differential involvement of specialties and units in the management of the hospital; and

c. requirements of specialties being fulfilled according to personality and political contacts rather than more objective criteria.

This leads on to the problems which beset the Medical Superintendent as an intermediary between the medical staff and the administration.

Finally, the position of medical administrators must be considered. In view of the above situation the Medical Superintendent would often be put in the position of having to decide upon medical priorities,

in conditions of scarce financial and spatial resources. In such cases a decision might necessitate knowledge of recent developments in a number of specialties and this was possibly asking too much of the Medical Superintendent. The position of adjudication between specialties probably led to dissatisfaction on the part of those who did not get what they wanted and the placing of blame for this on the Medical Superintendent. The reaction of the Medical Superintendent to this situation was just as important. In one of the hospitals studied the Superintendent would take the list of medical equipment requests from the different units and, as a first step to deciding what to approve, throw out all those without the price or the manufacturer's name. In some ways they also seem to have acted as administrators for the medical staff rather than of medical matters as they allowed consultants a route to the Board of Management and even the Regional level, whereas most of the administrative staff within a hospital are at the hospital level only.

The First Brotherston Report

Whether or not these particular arguments are accepted it is reasonable to suggest that the old methods of medical involvement tended to be haphazard and sporadic and to have represented more the feelings and advice of those actually involved, rather than the opinions and views of the whole medical staff. Advice tended to come mainly from consultants in-administrative-charge and Board members and this opened the way for dissatisfaction among those who were not involved.

The second report of the Joint Working Party concerns itself with the problem of:

> 'How to create an effective partnership between the professions and the administration.' ((8), para. 131).

and suggests that what is required is:

> '... an organisation which allows it to operate in a systematic and integrated fashion and, at the same time, relate to the administrative structure.' ((8), para. 132).

This implies that the committee considered the old methods of involvement to be non-systematic and, if not disintegrated, lacking in integration. This adds some support to the arguments above that (a) the medical members of Boards were either not in a position to, or did not use their position to, tender objective or representative advice to management, (b) that the Medical Staff Committees were too broadly based to develop detailed advice, and (c) that the system of using the Medical Superintendent as a channel was fraught with the problems of differential access and inequalities in lobbying and influence.

To return to the first Joint Working Party report, written largely within the format of the 1947 structure, there was a radical change in thinking with regard to clinical medical advice. The Working Party reported on a number of topics including, medical staffing, alternatives to traditional systems of hospital care, and the place of operational research in the service. However, the main area of interest was its proposal for a divisional system of clinical organisation. As a means to promoting better communication between clinicians and management the report recommended an end to the firm system of clinical organisation (the grouping of consultants in any specialty into twos or threes acting as a clinical unit, with one being senior and in-administrative-charge (9)) and the introduction of the divisional system. This change was recommended because the firm system was:

> '... based upon the tradition of consultant responsibility developed largely in the teaching hospitals' and derived '... from a past when the problems dealt with by the organisation were very much simpler than they are now' and that '... the considerable independence of individual consultants and indeed individual hospitals in the past has been replaced by an increasing degree of interdependence.' ((2), para. 14).

In view of this increasing complexity the report felt that the deficiencies of the firm system were unlikely to be overcome:

'... unless medical staff with like interests participate regularly in properly organised meetings from which a consensus of opinion may be obtained.' ((2), para. 24).

With these factors in mind the Working Party agreed upon:

'... the need for a system of clinical organisation based on larger groups of individuals than are to be found in the present units. These larger groups are seen as a mechanism for the pooling of resources and are, therefore, to be regarded as aggregations of medical staff with like interests who will find it useful to deal with certain aspects of their responsibilities on a group basis rather than as individuals.' ((2), para. 25).

The report recommended that individual specialties or groups of related specialties should form themselves into divisions and elect a chairman as their executive officer. The report also suggested the basis for the next level of a Medical Advisory Structure:

'There are matters which are of common interest to more than one discipline and it is desirable that this should be recognised in the clinical organisation. We recommend that this should be done by forming within each hospital or hospital group a committee composed basically of the chairmen of each of the divisions. This might be known as the "Committee of Divisional Chairmen". The Committee would be the body which would deal with all matters of medical policy which have implications beyond a single division.' ((2), para. 62-3).

In relation to the old structure the report states that because of divisional activities in the development of new services and the deployment of resources:

'... the relationship between divisions themselves, with Boards of Management and with Regional Hospital Boards are seen to be of importance and it is envisaged that

> the divisions would be the appropriate forum for the initial formulation of medical advice in relation to the specialty concerned. In this way individual consultants acting through their divisions could ensure that adequate professional advice is available to the hospital boards.' ((2), para. 31).

Among the recommended functions in the report were: the co-ordination of activities between divisions, between medical activities and nursing services and the development of a systematic and critical evaluation of clinical work. The report also recommended a close relationship between the Medical Superintendent and the divisions.

This was as far as the first report went, the second report and the report of a Sub-group of the Working Party expand upon its full development as a system for medical advice (8, 10). This chapter will return to those after the new structure of the health service has been outlined.

The Reorganisation of the National Health Service

The tripartite structure of the National Health Service into hospital, general practitioner and local authority services had been criticised as far back as 1951 by the Chief Medical Officer for Scotland:

> '... mainly because of the administrative structure which has evolved, many persons express uneasiness about lack of co-operation among the three divisions, although clear instances of failure to co-operate are hard to find.' ((11), p.27).

However, the first mention of any change in the structure was not made until the Porrit Report of 1961 (12). The report was the work of a committee representing all sections of the medical profession and it proposed Area Health Authorities which would deal with all aspects of the health service. There was much discussion about future change but firm proposals were not made until the Green Paper for Scotland was published in 1968 (13) (the first Green Paper for

England and Wales appeared at about the same time (14)). It made two general criticisms of the old organisation: from the viewpoint of the daily provision of care interlocking services for patients were being catered for largely on the basis of ad hoc arrangements and secondly it was not easy to ensure effective joint action between the authorities for the purposes of long-term planning and policy. It was therefore proposed that the services should be under one body. In addition it was felt that in the hospital service the two levels of authority below the Secretary of State operated against greater integration and a single tier was proposed.

More details appeared in the White Paper of 1971 and the main administrative element in the reorganisation was described as follows:

> 'In each area of Scotland the organisation and management of the health services will be united under a single health board ... A wide range of matters will become the responsibility of health boards, so that day-to-day decisions are so far as possible taken in the locality.' ((15), para. 6).

It was stated that finance would remain the responsibility of central government and that the Secretary of State would still be responsible for services provided. Fourteen Health Boards were proposed (this was later changed to 15) and these were to be his agents. In larger areas it was suggested that district management boards might be formed although such matters would be among the items submitted for the approval of the Secretary of State.

The final structure for the new service was outlined in the 1972 Act (3) with greater detail given in the Blue Band Scottish Home and Health Department circulars which have been distributed throughout the health service in Scotland since the publication of the Act. The new structure has two tiers; the Department and the Health Boards, the latter being given responsibility for all the services which were previously split between the hospital, executive council and local authority bodies.

At the national level three main bodies have been set up to assist the Department. First of all, the Scottish Health Service Planning Council with the duty:

> '... to advise the Secretary of State on the exercise of his functions under the Health Service Acts, whether at his request or on their own initiative.' ((3), Section 17).

Secondly, the Common Services Agency, set up to assist the Health Boards in broad areas of service for which individual Health Boards would not be able to have the staff.

Thirdly, the National Consultative Committees about which the Act has the following to say:

> '(1) Where the Secretary of State is satisfied that a committee has been formed which is representative of any, some or all of the professions engaged in the provision of care or treatment under the Health Service Acts, and that it is in the interests of the health service to recognise the committee for the purposes of those Acts, he shall so recognise it, and any such committee shall be known as a national consultative committee ... . It shall be the general function of a national consultative committee to advise the Scottish Health Service Planning Council on the provision of services under the Health Service Acts with which the committee is concerned, but, except in so far as regulations otherwise provide, such a committee shall not concern itself with the remuneration and conditions of service of practitioners or other persons of whom it is representative.' ((3), Section 18).

It should be noted here that the national medical consultative committee will be drawn from the basic divisional structure at the local level.

Below the national level the Health Boards are the main administrative unit and their membership is outlined by the Act:

> '(2) A Health Board shall consist of a chairman appointed by the Secretary of State and such number of other members so

appointed as the Secretary of State thinks fit.

(3) Appointments under paragraph 2 above shall be made after consultation with the following bodies

(a) county councils and town councils of large burghs ... ;

(b) any university appearing to the Secretary of State to have an interest in the provision of health services in that area;

(c) such organisations as the Secretary of State may recognise as representative in that area of the medical, dental, nursing, pharmaceutical and ophthalmic professions and such other professions as the Secretary of State considers appropriate ... ; and

(d) such other organisations as appear to the Secretary of State to be concerned.'
((3), Schedule 1, Part 1).

After some discussion it was decided that 15 Health Boards would be appointed:

Highland	Borders	Ayrshire and Arran
Grampian	Forth Valley	Dumfries and Galloway
Tayside	Glasgow	Orkney
Fife	Lanarkshire	Shetland
Lothians	Argyll and Clyde	Western Isles (16).

As a general principle it has been stated that the members of Health Boards were to be appointed for their ability rather than their representativeness. To ensure an element of public involvement the Act allows for the formation of Local Health Councils:

'... it shall be the general function of any such council to represent the interests of the public in the health service in the area or district for which they have been established.'
((3), Section 14).

The Act also outlines the formation of local consultative committees:

> 'Where, after consultation with the Health Board concerned, the Secretary of State is satisfied that a committee formed for the area of the Board is representative:-
>
> (a) of the medical practitioners of that area, or
>
> (b) of the dental practitioners of that area, or
>
> (c) of the nurses and midwives of that area, or
>
> (d) of the ophthalmic and dispensing opticians of that area,
>
> and the Secretary of State shall recognise that committee.'
> ((3), Section 16).

and gives a broad idea of their function:

> 'It shall be the general function of a committee recognised under this section to advise the Health Board for its area on the provision of services under the Health Service Acts with which that committee is concerned in that area ...'
> ((3), Section 16).

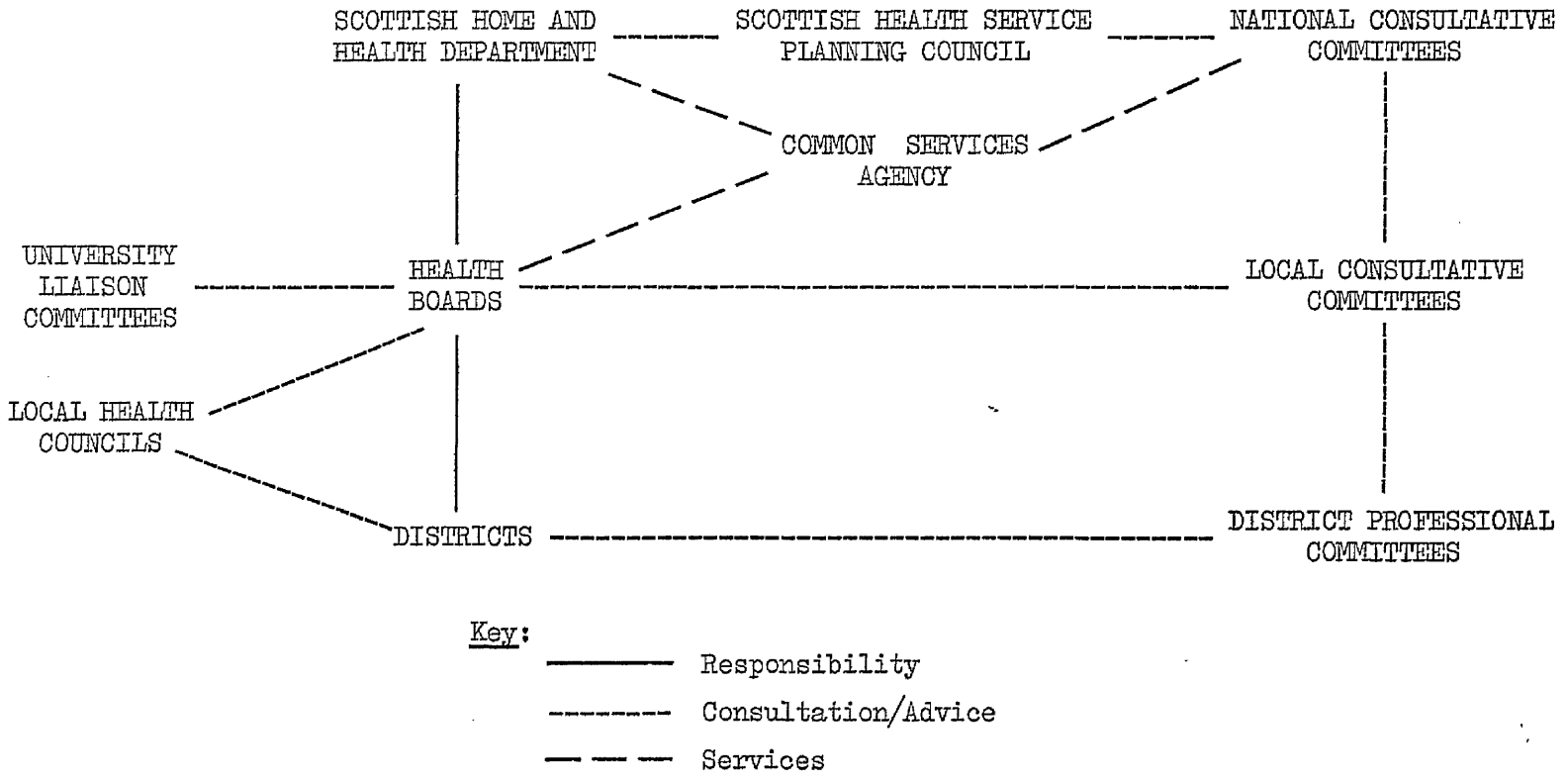
In areas with a university attachment provision is made for the establishment of University Liaison Committees. The overall structure of the reorganised National Health Service in Scotland is illustrated in Figure 1.2.

The main concern of this study is with the Health Board level and below. Greater detail of the organisation of the areas is to be found in the departmental circulars and it is to this aspect of the service that this chapter will now turn.

The Health Board Organisation

The decision was made that the larger areas should be split into two or more districts in order to make the areas of administration more manageable. Within this the department proposed the establishment of Area and District Executive Groups. The Area Executive Groups are seen in the following light:

Figure 1.2 The Reorganised Structure of the National Health Service in Scotland, 1974



'The purpose of an executive group at the area level is to leave the board free to deal with major policy, strategic planning decisions, the broad allocation of resources and matters of substantial interest to the community. Every health board should therefore appoint an executive group of chief officers with formally defined functions, powers, constitution and membership to execute the board's policy and to assist in policy formation.' ((16), para. 4).

The circular states that the executive group should comprise the Chief Administrative Medical Officer, the Chief Administrative Nursing Officer, the Area Finance Officer and the Secretary. The following functions are recommended for the Area Executive Group:

'The executive group should determine the resources required to accomplish the objectives of the board and should present to the Board advice and information which will help it to establish priorities among the objectives to which these resources may be allocated. The executive group should also report on the effectiveness with which the Board's activities are conducted and its plans put into effect ... The task of co-ordinating the Board's business and the work of the executive group and ensuring that the decisions reached are implemented should be undertaken by the Secretary.' ((16), para. 6).

The recommendations at district level have similar implications:

'Where it is agreed that districts should be formed, the scheme should provide for the setting up of a district executive group which would be responsible for the administration of integrated primary care, hospital services and community services within a specified boundary.' ((16), para. 14).

The District Executive Group follows the same pattern as the area with the membership comprising the District Medical Officer, District Nursing Officer, District Finance Officer and District Administrator.

At the sub-district level the circular states:

'The management structure within the district must allow for:

(a) the management of institutions;

(b) the management of particular professional groups such as nurses;

(c) inter-professional co-operation in programmes directed to the care of specific groups of patients or people generally.' ((16), para. 27).

This gives a broad outline of the new structure in terms of basic units of organisation. Where does the Medical Advisory Structure fit into this? The circulars give some idea of the points at which the administrative and medical structure link up. At the area level:

'The chairman or representatives of the professional advisory committees specified in Section 16 (1) of the Act will have access to the board and should where appropriate be invited to attend meetings of the executive group.' ((16), para. 7).

Furthermore one of the Chief Administrative Medical Officer's jobs is to:

'... develop working relationships between the Board and the medical advisory structure;' ((17), Annexe A).

Similarly the District Medical Officer is to provide:

'... support and assistance for the medical advisory committees and divisional organisation.' ((16), para. 23).

This chapter will now turn to the formation, function and place of the Medical Advisory Structure in the reorganised health service.

The Medical Advisory Structure

The recommendations of the first Joint Working Party Report have already been examined and they form the basis of the advisory structure. It is worth noting at this stage that the committees which recommended the structure were jointly constituted by the Scottish Home and Health

Department and the profession and so the profession was to some extent bound by any recommendations made. However, more detailed aspects of the structure have to be considered. These can be viewed under two headings: first of all, its contribution to the service and the functions it is expected to perform and secondly, its formation and its structural position.

The Contribution of the Medical Advisory Structure

The Medical Advisory Structure is incorporated into the service as the main source of clinical medical advice as the Hendry report states:

> 'The Act ... envisages the establishment of professional committees which the Boards will have a duty to consult and from which they will be expected to receive advice. The range of activities of these committees will run from relatively routine matters to advising on major developments in the planning of services and the allocation of resources, and from the purely local responsibilities up to those affecting the whole of Scotland.' ((10), 1.1).

This role is central to the new service:

> 'The new arrangement gives to the profession an opportunity to influence and guide the administration of the service and, in our view, lays upon it a positive duty to do so. The profession will be expected on the basis of its specialised knowledge and of its appraisal of existing services to initiate proposals and to influence policy at all levels.' ((10), 1.3).

Much of the responsibility for the success of the new structure is placed upon the contribution of the Medical Advisory Structure:

> 'The potential improvement in patient care that could result from administrative reorganisation will only be realised if two fundamental principles are observed. One is that professional opinion and advice must be firmly based on the realities of patient care, the other is that this advice must be clearly transmitted to those whose responsibility

it is to make policy.' ((10), 3.1).

The report goes on to state in more specific terms the role of the structure in relation to the formulation of recommendations to the administration:

> 'The effectiveness of the individual MAS committees and of the whole structure will greatly depend on the way in which membership can be made to reflect accurately the wide range of activities involved in medical care. It is in the interests alike of patients, of the community and of the whole profession that advice from every field of practice should be clearly formulated and that claims on resources should be based upon the authoritative views of those actively concerned. It is of greater importance however that the relative merits of competing claims should be assessed within the MAS itself and that the view that is put forward to management should be co-ordinated, responsible and realistic. The MAS will be required to therefore provide a channel of access to management, to express a corporate medical viewpoint, and to provide a general background of accepted medical priorities.' ((10), 3.4).

In broad terms the Medical Advisory Structure is statutorily incorporated into the service to provide medical opinion and advice and to decide on the basis of need where particular resources should be allocated in the medical field. More specifically, Doctors in an Integrated Health Service gives the following run-down:

> '... to assess the medical needs of the population and the extent to which they are met; to identify areas where co-operation between related areas is required; to estimate the value of the service in relation to the resources used; to consider use of resources and their redeployment; to give advice on the proper balance between the immediate demands of day-to-day care and the longer term demands of possible new development. In addition, the medical organisation has

to consider the training needs of junior doctors and provide an effective link with teaching and research interests and the Scottish Council for Postgraduate Medical Education.' ((8), para. 134).

Patient care evaluation is also given high priority:

'We consider that the development of a systematic critical evaluation of clinical work should be one of the most important functions of a division ... While we do not wish to depart from the principle that each consultant is responsible for his own patients, we see great value in the results of clinical work being examined on a group basis. This examination can be most effectively undertaken within a fairly large group which would be able to contribute a sufficient cross-section of experience and opinion and could command the necessary resources to organise and maintain effective evaluation.' ((2), para. 36).

From this it can be seen that the main task of the Medical Advisory Structure is to act as the primary body for the formulation of medical advice, this being done in full cognisance of the facts. It is also clear from the statutory legitimation which the Medical Advisory Structure has that the advice which is forthcoming should be examined very carefully by the administration.

The Formation of the Medical Advisory Structure and Its Location in the Service

In line with the functional areas that have been dealt with above the Hendry report suggests that the following characteristics are required by an Medical Advisory Structure:

'(a) that it should be able to provide considered advice to management;

(b) that there should be clearly defined lines of communication so that every doctor may become involved in the advisory process and participate in it with full knowledge and understanding;

(c) that it should have access to information and the capacity to interpret it so that all doctors can take an active part in the analysis of the effectiveness of the health service and in their contribution to it;

(d) that it should be able to establish close liaison with the nursing profession and all others concerned with the care of patients.' ((10), 3.2).

The structure which has been adopted as containing all these features is the divisional system as outlined in the first Joint Working Party report (2). This report proposes the establishment of committees with the members being bound by 'like interests' and suggests that this can be based upon specialty groupings. From these committees it is anticipated that the particular perspectives, needs and priorities of the specialty groupings will be made known in a structured way. Each division elects its own chairman, the chairmen of the divisions then form the next level of the structure as the Committee of Divisional Chairmen thereby achieving the representation of the different specialty groupings. This Committee of Divisional Chairmen is then in the position of deciding upon priorities, and planning developments based upon the material brought to the committee by the individual chairmen. The reports see this kind of arrangement as the basis of the hospital contribution to the Medical Advisory Structure. In the second Joint Working Party Report (8) and the Hendry Report (10) general practitioners are also brought into the scheme:

'The formal organisational structure for general practice in the new service should be the grouping together of general practitioners with similar or complementary interests. Where health centres exist this will require little encouragement: where they do not exist there are already groups in being which act as electoral districts for the Local Medical Committees ... As the opportunities develop for a full involvement in decision-making ... these groups would then, along with those from health centres, form the basis of a full divisional system in general practice.' (10), 4.8).

The Hendry report recommends that the hospital and general practitioner divisions should come together through their chairmen as the District Medical Committee and this committee is described as:

> '... the point within the district at which medical opinion is co-ordinated and where all corporate advice on the medical aspects of the management of a district is determined. It might consist of the chairman or other representative of each hospital and general practitioner division joined by representatives of junior doctors. The Chairman of the Committee should be elected by the Committee itself and should be its usual spokesman. Neither he nor his Committee should however be the sole point of contact between the Medical Advisory Structure and the executive and he should guide the officers of district management into consulting chairmen of divisions or other accepted representatives where appropriate. His greatest contribution may well arise from his developing a continuing relationship with senior officers in district management and his frequent attendance at their meetings.' ((10), 4.15).

At the Health Board level an Area Medical Advisory Committee is proposed by Hendry and its function:

> '... will be to take a broad view of health planning and it should be assisted in detailed work by sub-committees. The Area Medical Committee may with the approval of the Health Board delegate any function with or without restrictions or conditions, to sub-committees. The details of the sub-committee structure may vary from one area to another and will depend to some extent on the size of the area, but in each area one sub-committee should be a general practitioner sub-committee to which the Area Medical Committee could delegate functions presently carried out by the Local Medical Committee. ((10), 5.4).

Hendry also gives broad guidelines as to the composition of the Area Medical Committees recommending that (a) they should not exceed 15 members except in the largest areas, (b) there should be a reasonable

balance of members in those areas with districts, (c) there should be university membership and junior staff membership, (d) there should be a uniform tenure of office and, (e) there should be some balance between specialties:

> 'Given that the function of the Area Medical Committee is to take a broad view and that specialty considerations will be the responsibility of sub-committees, it may not be necessary to carry the balance between specialties to extremes, but roughly equal numbers will be needed between hospital based practitioners and those concerned with primary care.' ((10), 5.7).

Apart from the General Practitioner Sub-committee the report suggests:

> 'The other sub-committees would principally be those appointed to deal with specialty matters, and its is important that they should enjoy the confidence of practitioners in the specialty concerned.' ((10), 5.12).

For the National Consultative Committee the report suggests that members should be nominated by each of the 15 Area Medical Committees.

One further area should be examined in relation to the Medical Advisory Structure and this is its relationship with community medicine.

Community Medicine and the Medical Advisory Structure

The specialty of community medicine first came to light in the second Joint Working Party report (although this was merely spelling out a concept which had existed for a long period beforehand):

> 'Put in its simplest form, community medicine is concerned with the study of health and disease in populations. The function of the specialist in community medicine is to investigate and assess the needs of the population so that priorities may be established for the promotion of health, the prevention of disease and the provision of medical care. The specialty is also concerned with co-ordinating medical experience so that policies which are in accord with medical needs can be

presented to the department, area health authorities and those responsible for the management of the services below area level.' ((8), para. 100).

Community medicine specialists are seen as having a central co-ordinating role to play in the new service in relation to both the administration and the Medical Advisory Structure and even beyond this in their contact with clinicians:

'The specialist in community medicine working alongside his clinical colleagues would provide for them data about population needs, would assist in the evaluation of each division's activities and the managerial options open to it and would provide a link not only with the area administration but also with the various services providing administrative and other support for divisions. ((8), para. 102).

The Hendry report provides more detail about the role which the specialists are expected to play in relation to the Medical Advisory Structure:

'Community medicine is emerging as a specialty with a wide range of functions. One of these functions will be to facilitate communications between the Medical Advisory Structure and the formal management.' ((10), 3.3).

In terms of involvement with the divisions the report states:

'Each specialist in community medicine would have special responsibility to provide information and professional support to a number of divisions as a contribution both to patient care evaluation and to other divisional functions.' ((10), 4.21).

'In their relationship with divisions concerned with specialist and primary care services, specialists in community medicine should not merely be the source of epidemiological and other advice: they should be in a position to put forward their own interpretation of community needs and to influence divisions

in their decisions about the allocation of resources and the assessment of priorities.' ((10), 7.8).

The role that is anticipated for the Community Medicine Specialists is therefore a very important one in that they are expected to provide both advice to and information for the Medical Advisory Structures. Further details on their role are to be found in the Gilloran report (18).

Developments in England and Wales

While these reports and recommendations were being published in Scotland a similar process was occurring in England and Wales. The principles behind the reorganisation were the same and apart from the publication of two Green Papers in England and Wales (14, 19) the timing was roughly parallel. The English White Paper was published in August 1972 (20) and the Act was passed in November 1972 (21). The only major structural difference between the two services (apart from differences in terminology at the local level, for example, in England and Wales the District Medical Officer is called the District Community Physician) lies in the extra tier at regional level in England and Wales.

The basis of the Medical Advisory Structure is the same in England and Wales as it is in Scotland. Three parallel reports were published in 1967, 1972 and 1974, known as the 'Cogwheel' reports (from the motif on the covers) outlining the systematic organisation and contribution of the profession at all levels (22, 23, 24). The parallel report to Gilloran was the Hunter report (25), published in 1972, this described in detail the specialty of community medicine and its proposed role in the reorganised service.

The Medical Advisory Structure and the Administrative Structure

Most of this chapter has been spent outlining the details of the reorganisation and the principles behind the establishment of the Medical Advisory Structure as a systematic way of channelling professional opinion into management decision-making. What is the overall picture?

This is best illustrated diagrammatically and Figure 1.3 (10) shows the formal proposals for Medical Advisory Structures with a hypothetical divisional system. The only level which is omitted from this diagram which has prominence in the reports is the hospital level of the Committee of Divisional Chairmen, incorporating the chairmen of the hospital divisions. The formal relationship between the Medical Advisory Structure and the administrative structure is shown in Figure 1.4 (10).

The Central Role of the Medical Advisory Structure in the National Health Service

These new recommendations for the involvement of the profession in the management of the service are of particular importance. The Medical Advisory Structure is expected to provide professional advice upon which policy decisions are made, resources are allocated for staff and equipment and the direction of services is changed, and in addition it is expected to evaluate the quality of care provided. There is greater definition of the expected contribution of doctors to management and policy decisions and the points at which this contribution is to be made. This change is important for a number of reasons.

First of all, the Medical Advisory Structures are given structural legitimation in the 1972 Act as the major channel of medical advice. In the past the exact contribution of doctors to management has been nebulous and more dependent upon individual influence than any formal structural process, for example, medical membership of Boards of Management and Regional Hospital Boards. The 1972 Act, on the other hand, says of the Medical Advisory Structure at the area level:

> 'It shall be the general function of a committee recognised under this section to advise the Health Board for its area on the provision of services under the Health Service Acts ...' and 'In exercising their functions under the Health Service Acts, Health Boards shall consult with committees recognised under this section on such occasions and to such extent as may be prescribed.' ((3), Part 2, para. 16).

Figure 1.3. A Hypothetical Medical Advisory Structure

(Divisions and specialties have been named for illustrative purposes only.)

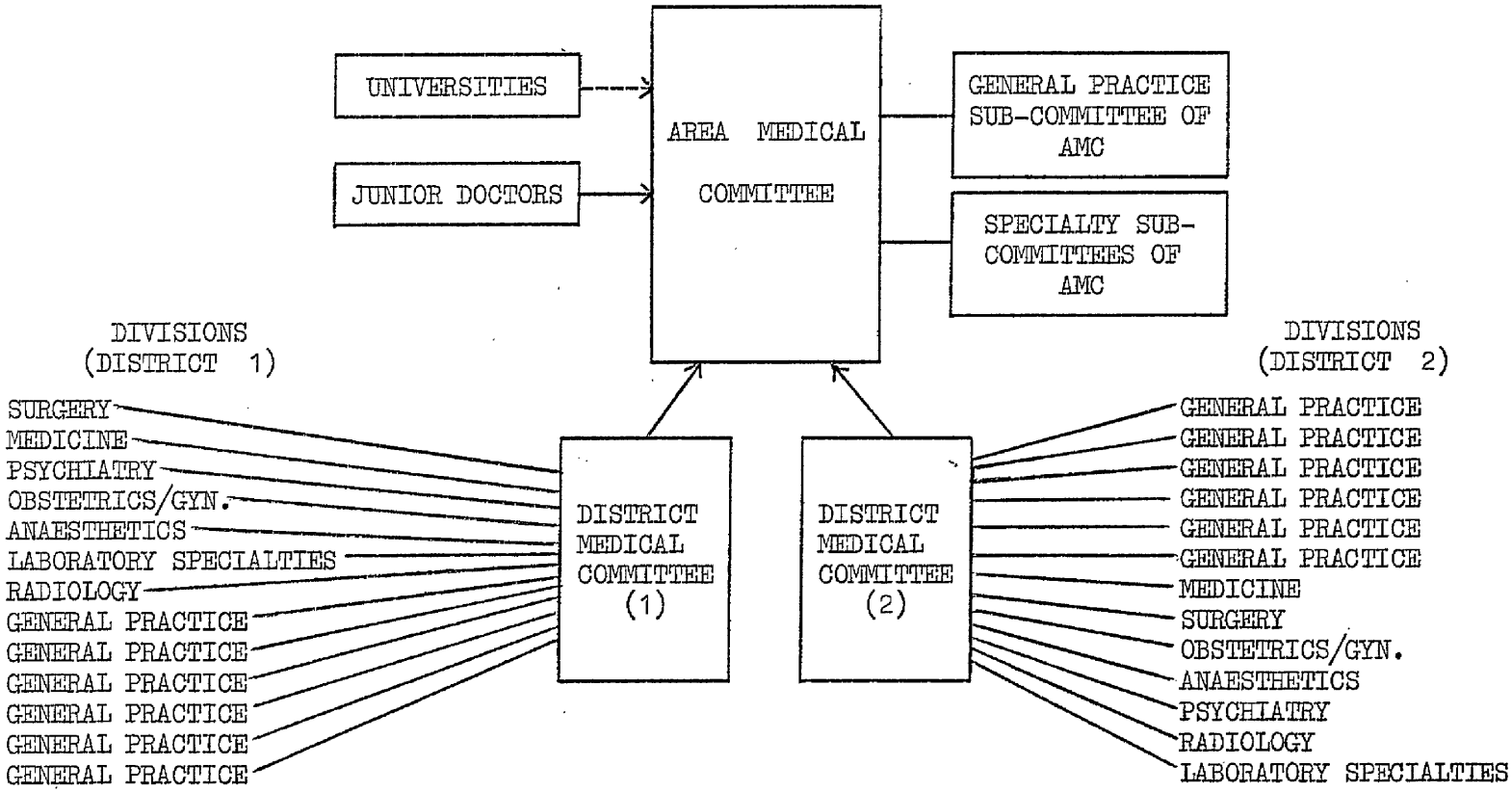
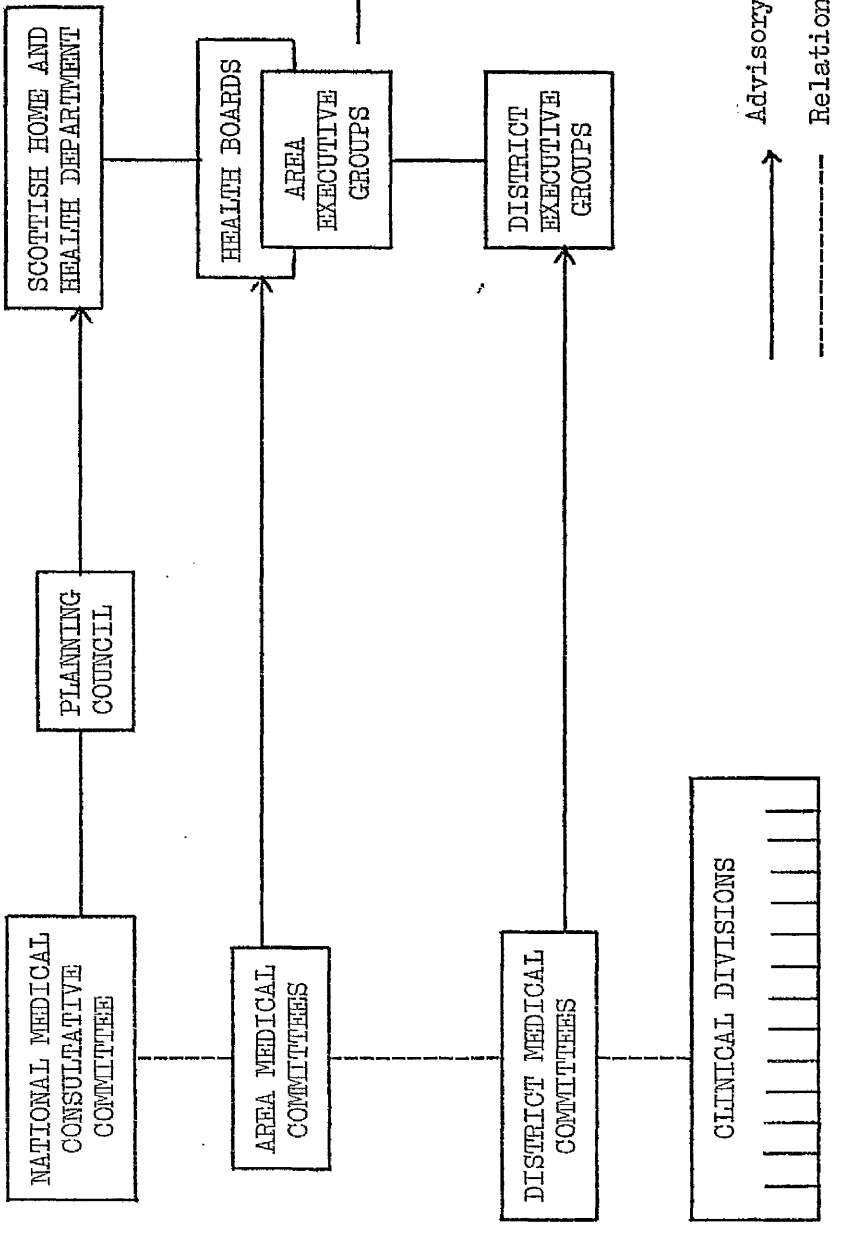


Figure 1.4. The Relationship Between the Administrative Structure and the Medical Advisory Structure



The 'shall consult' connotes a definite compunction to permit the passage of advice and influence. The Medical Advisory Structure is therefore in a position to create the climate within which services develop and because the members of the structure are also the people who provide the service on a day-to-day basis and administration will not be in a strong position to resist professional advice.

A second reason is related to this. The Medical Advisory Structure has been designed so that all doctors are represented, from the individual specialty level up to the national level. At any point in the structure those providing advice to the administration are no longer doing so as individual doctors, but as representatives of a professional constituency. This means that the administration can say that medical opinion has been adequately consulted, but in addition the profession can claim that any advice it tenders has the full support of the majority of doctors below that level. Formally advice is no longer an individual, non-accountable response. It is now the considered professional response.

Thirdly, having designed a structure to perform specific functions, it can be claimed that these functions are being undertaken and it is unlikely that any other branch of the service will question whether or not they are performed or how they are performed. The obvious example is patient care evaluation. Before the divisional system there was no formal provision for the evaluation of the work of doctors and now it has been handed over to the profession through Medical Advisory Structures, it is formally their responsibility.

These factors indicate an influential position for the profession in the management and continuing development of medical services. However, if the administration is likely to accept the majority of the advice from the Medical Advisory Structure, and the structure is going to be responsible for many decisions which it can make unilaterally, then it is crucial to look at the way in which it makes the decisions. The fact that advice comes out of the Medical Advisory Structure and is accepted by the administration is not necessarily an indication of the quality of that advice. The way

in which advice is arrived at needs to be examined before its quality can be judged. This is the purpose of this research, to examine the operation of Medical Advisory Structures and analyse the way in which they make decisions and the extent to which they fulfil the hopes placed in them by the Joint Working Party Reports. The major focus is upon the local or hospital level where the foundations for policy advice to the District Medical Committee and Area Medical Committee are built. However, before doing this there are a number of features of the proposed structure which can be examined on a theoretical level and which will assist in the analysis of decision-making.

Theoretical Implications of the Divisional System

The success or failure of Medical Advisory Structures will be dependent upon many factors and this study cannot hope to examine all of them. The personality of the individuals involved will undoubtedly play some part, but personalities will vary from hospital to hospital and structure to structure and the sociological perspective has tended to focus more upon factors which are common to individuals and the arenas in which they interact, than the differences between them. Also from the perspective of any health service it is hard if not impossible to change personality as a variable in the success or failure of that service. Therefore the main focus of this research is upon the influence of structure as a basis upon which and within which the participants make decisions and channel advice.

Medical Advisory Structures have two major structural influences - the basic design of the divisional system in what it asks participants to do, and the character of the profession which is supposed to work within that system. First of all, the design of the divisional system and the Medical Advisory Structure at any level involves a) the representation by individuals of the interests of the level below and b) the consideration of such interests within the broader perspective which that level implies. For example, members of the Area Medical Committee are drawn from District Medical Committees and are expected to represent district interests and opinions but the committee as a

whole is supposed to subjugate these to area interests and opinions. At each level the very nature of the structure implies a basic role conflict which those operating it have to resolve in some way. Secondly, the members of the structure are doctors and they bring to the structure their own professional values and characteristics. These will undoubtedly affect the approach of the profession to the structure and may also influence the way in which members solve the role conflict outlined above.

In the next two chapters the potential importance and influence of the structure chosen and the profession involved will be examined in some depth. Chapter 2 will look at the level of the division and the way in which its purpose and the values of the profession and the individual consultant may interact to influence the process of decision-making. Chapter 3 will consider the level of the Committee of Divisional Chairmen. At this level specialty is the unit of representation, and the interaction between the purpose of the committee and the characteristics of professional specialisation will be described and assessed.

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Chapter 2. Role Conflict and Individual Autonomy in Specialty Divisions

Introduction

In Chapter 1 the reorganisation of the National Health Service was described and the changing face of medical advice to management was examined. In terms of the latter, the main drive appears to have been the development of clearer, more comprehensive ways of enabling doctors to influence and make management decisions.

In this and the following chapter the relationship between the divisional system of organisation and the nature of the medical profession will be analysed. The aim is to look at those aspects of the structure and the profession which may influence the process by which decisions are made. This chapter will deal with these factors in the context of individual specialty divisions and Chapter 3 will be concerned with the level of the Committee of Divisional Chairmen.

At the end of Chapter 1 it was intimated that a basic role conflict is inherent in the divisional structure. The initial concern here is to examine the concept of role conflict and the way in which it is built into the structure at the level of the individual division. The impact of this conflict upon decision-making will be examined. Following that, the nature of professionalism will be considered. It will be argued that individual autonomy is one of the key professional values.

The aim of this chapter is not prescriptive but rather, to develop an appreciation of the structural forces which are implicit in the design of the structure and the nature of the profession. This will be undertaken in the latter part of the chapter when the interaction between role conflict and individual autonomy will be looked at in relation to the process of divisional decision-making.

The Theory of Role Conflict

The theory of role conflict is part of the general area of role theory. The concept of role has been defined by Banton as:

'... a set of rights and obligations, that is as an abstraction to which the behaviour of people will conform in varying degree ... People's behaviour is viewed from the standpoint of the relationships within which it takes place, and the relationships are defined by the rights and obligations of the parties. A role is in this sense a pattern of expected behaviour reinforced by a structure of rewards and penalties which induces individuals to conform to the pattern.' ((1), p.21).

Merton has probably contributed more to role theory than any other writer and it is in his development of the notion of 'role set' that the theory of role conflict was formulated (2). His starting point is the work of Linton (3) and his comments on the latter's approach to the relationship between role and status:

'For some time now, at least since the influential writings of Ralph Linton on the subject, it has been recognised that two concepts - social status and social role - are fundamental to the description and to the analysis, of social structure. By status Linton meant a position in a social system occupied by designated individuals; by role, the behavioural enacting of the patterned expectations attributed to that position. Status and role, in these terms, are concepts serving to connect the culturally defined expectations with the patterned behaviour and relationships which comprise social structure. Linton went on to observe that each person in society inevitably occupies multiple statuses and that, for each of these statuses, there is an associated role. This proved to be a useful first approximation, as later social research amply testifies. In this first approximation, however, Linton assumed that each status has its distinctive role.' ((2, p.368).

Merton proceeds to argue that a single social status can involve an array of social roles and in this he outlines the concept of role set:

'This fact of structure can be registered by a distinctive term, role set, by which I mean that complement of role relationships which people have by virtue of occupying a particular social status. As one example: the single status of medical student entails not only the role of a student in relation to his teachers, but also an array of other roles relating the occupant of that status to other students, nurses, physicians, social workers, medical technicians, etc..' ((2), p. 369)

It is in the possibility of disparity among the expectations involved in the role set that the problem of role conflict comes to light. Before looking in more detail at the notion of role conflict it is worth mentioning the main critical attack upon work in this area. Gerhardt has argued, in line with Wrong's critique of oversocialised theories of man (4), that the concept has been developed on a naive basis:

'The present stage of the argument is still represented by Merton's well-known statement (1957) that social action is the realisation of one among possible antagonistic expectations in a role-set condition. Behavioural conflict is conceived as resulting from competition between distinct external and/or internal pressures. Conflict solution is envisaged as a tension-reduction process which minimises the individual's felt strain to a manageable level. As early as 1958, this conception was criticised as a mechanical and unrealistic oversimplification ... Processes constituting social behaviour, it was argued, call for a "model of man" other than that of an oversocialised and overadapted being ...' ((5), p. 225).

How people react to role conflict situations, and what influences their reaction, the main burden of Gerhardt's criticism, is not the concern at this stage. The main aim is to identify the role relationships which are inherent in the design of Medical Advisory Structures, rather than how members of divisions perceive their obligations and how they react to, or accommodate, them. In the

present context the interest is in the basic formulation of role conflict theory.

As may have become clear already there is also some confusion in this area in the way that terms like 'status', 'role' and 'expectation' are utilised. As Banton comments one writer's 'status' is another writer's 'role'. After looking at a number of the definitions of role conflict derived from various studies the terminology to be used in this study will be stated.

The concept of role conflict is applied to situations in which an actor has to perform two or more incompatible roles simultaneously, or, has two or more conflicting expectations placed upon him or her by other social actors while he or she is playing a single role. Gullahorn describes it as follows:

> '"Role conflicts" refers to the situation in which incompatible demands are placed upon an actor (either an individual or a group) because of his role relationship with two or more groups. Generally the person(s) involved feel internally the obligation to meet the competing demands, face the threat of possible sanctions if they fail to fulfil either demand, and yet find it impossible to comply fully with opposing obligations.' ((6), p.299).

Getzels and Guba (7) define the concept in a similar way and spell out the possible alternatives for the person in the role conflict situation:

> 'That is, the situations are so ordered that an actor is required to fill simultaneously two or more roles that present inconsistent, contradictory, or even mutually exclusive expectations. He is then forced to choose one of several alternatives; he may abandon one role and cling to the other, he may attempt some compromise between the roles, or he may withdraw either physically or psychologically from the roles altogether. In any event, over a long term period he cannot fully meet the expectations of all

> the roles, and to the extent that he fails to meet the expectations, he is judged ineffective in the management of one or another of the roles by the defining group.' ((7), p.165)

While Gullahorn highlights the incompatibility of demands, Getzels and Guba concentrate upon the incompatibility of roles. Gross et al, in their study of the school superintendent, clarify the situation by outlining three possible views of role conflict:

> 'The first differentiates those who define role conflict according to incompatible expectations perceived by the actor. The second differentiates those who, in defining role conflict, specify that the actor must occupy two or more social positions simultaneously in order to be exposed to role conflict from those who do not make this specification. The third differentiation is similarly between those who make a specification and those who fail to do so; in this case the specification is that an expectation must be legitimate for it to be involved in role conflict.' ((8), p.244)

In this study the status involved is that of consultant in the National Health Service and one of the roles which occupants of that status are expected to fulfil is that of member of a division.

In the present context the concern is not with the perception of actors but rather with the expectations which derive from the purposes of a division and are inherent in the role of member of a division. The role conflict considered here and in the next chapter involves conflicting expectations within a single role. How doctors react to these expectations will become clearer at a later stage. What are the expectations which the structure creates for the member of a division?

<u>The Medical Advisory Structure:</u>
<u>The Division and Role Conflict</u>

According to the Joint Working Party reports (9, 10, 11) a division

is to act as a forum within which demands, priorities and opinions of consultants in any specialty, or group of specialties, are decided. This is true of both business generated by the division and of business sent to the division from some other part of the structure, for example, the District Administrator, or, the Committee of Divisional Chairmen. The division is seen as the best place to do this because all consultants in the specialty or specialties concerned are members of the division and thereby all the interested parties have the opportunity to:

> '... participate regularly in properly organised meetings from which a consensus of opinion may be obtained.' ((9), para. 24)

The division is supposed to decide what is best for that specialty and to render 'good advice to management'. However, the performance of this function involves two separate processes.

First of all, consultants are expected to put forward their own requests, proposals and ideas. This is the basic working material of a division. This is how a division finds out what it, as a specialty, might want, need, or, think. In addition, it is the only way in which consultants can achieve what they want, it is the only way in which their interests can be validated and be passed on to higher levels if further approval is necessary. Secondly, as intimated above, the consultants as individuals, and as a group, are expected to make decisions about what is best for the specialty as a whole. For example, if there are a number of requests for extra staff or extra equipment from members of a division, it is expected that decisions will be made about the relative priority of such requests. In doing this the members of a division have to be concerned with the interests of the specialty as a whole.

Therefore, the role of member of a division involves two expectations:

a. a consultant is expected to pursue and represent his or her own interests, for that is the only way they can achieve what they want; and

b. a consultant is expected to act as an objective, independent arbiter over his or her own and other requests in deciding what is best for the specialty as a whole.

Again it should be emphasised that these are not necessarily seen as the expectations inherent in the role of member of a division, they are expectations which follow from the design of the structure and the way in which the Joint Working Party reports anticipate that structure will function.

In terms of the representation of individual consultant interests the significance of the change in the structure and the pressure upon the individual to fulfil this expectation must be seen in their historical context. Previously consultants were organised under consultants in-administrative-charge, with one or two consultants under the administrative charge of another consultant. This grouping of two or more consultants and their junior staff was called a 'firm' (12). Under the firm system consultants had to submit requests for equipment or changes in routine to their consultant in-administrative-charge and that was the formal route by which they could obtain what they wanted. The consultants in-administrative-charge were the means of contact with the administration and their opinion of what was requested could be crucial in determining the success of the request, they might even refuse to take such requests any further. For the first time, within divisions, consultants are able to have their requests discussed openly with the chance of convincing all their colleagues that what they want is right. Yet at the same time this forum is not supposed to be a vehicle for the ratification of subjective interest, but rather subjective interest has to be tempered by the objective needs of the specialty.

However, it should be borne in mind that not all decisions will implicate the two expectations identified above. The areas in which role conflict is potential have to be more clearly delineated.

Decisions which Place Consultants in Role Conflict Situations

The potential for role conflict exists in all decisions which involve individual consultant requests or interests. The most obvious examples of this are claims for additional resources by a consultant, for example, additional staff or equipment. Requests of this nature must be seen in the context of the financial parameters of the service. In all areas of expenditure there are more requests for resources than there are resources to meet those requests. It is therefore customary to assign priorities to consultant requests of a similar nature at some level in the system. It is apparent from the Joint Working Party reports (9, 10, 11) that a division is supposed to decide which requests are most valid within its own specialty. Allocations of money to meet requests for additional staff or equipment occur at one or two intervals during a year and because of this a single request made to a division is only part of a broader picture of demand within that specialty. Therefore, it is not only a matter of deciding whether or not a request is valid but also of comparing it with other requests from other consultants.

These situations arise because consultants, through their everyday work, decide that they need something extra, for example, an additional member of staff. Requests have to be presented by consultants to their divisions and they have to convince their colleagues that what they want is necessary and in the interests of the specialty as a whole. They have to present their subjective requests in terms of the overall needs of their specialty. Their colleagues have to decide whether or not each request is valid and how it compares with requests for additional staff from other consultants. This may involve a number of consultants arguing for their own individual needs and attempting to persuade their colleagues that their particular request is more valid than the others. In this example, although the rationale will apply whenever consultants are competing with one another for scarce resources, potential role conflict exists in the following ways:

1. Those consultants with requests will be in a position in which they have to argue for their own requests in terms of the needs of the specialty. They may experience some difficulty in pressing for their sectional interest as if it were a specialty interest because they would be seen as pushing their own interest in a situation where self interest should take second place to group interest.

2. Those with requests have to argue their case in relation to the requests from other consultants. They have to compare what they want with what others want and thereby may have to criticise others in defence of their own proposal. This again could be seen as pushing for their own interest.

3. Those without requests have to make judgements about the relative and overall validity of the various submissions. While they only have to fulfil the objective expectation of determining specialty need, a longer term view of the interaction in the division must be taken. Although they are in the position of judges in this case, they will be the judged in others. They will have requests in future which they want the division to accept and they will be judged by people whom they have judged in the past. If they take the broader expectation when they do not have requests this may have implications for the way in which others respond to requests which they make in the future.

Undoubtedly the two sets of expectations are legitimate in terms of the function of divisions and the three experiences of role conflict outlined above are logical outcomes of these legitimate expectations. What are the possible outcomes of this role conflict? As Gross et al suggest there are four possible ways of dealing with conflicting expectations:

'a) and b) concentration upon one or other of the expectations
c) a compromise between them
d) avoidance of the role conflict altogether.'
((8), p.292-3)

In divisions the following solutions are therefore possible:

a) the representation of individual self interest is seen as the main expectation and the division is used to ratify

individual requests;

b) the interests of the specialty as a whole will be the prime concern, individuals will not press strongly for their proposals and what they want will be considered in the light of specialty needs;

c) there will be a compromise between the two; and

d) situations or decisions which involve role conflict will be avoided altogether.

It should be mentioned that in terms of the aims of the structure the second form of resolution, taking specialty need as the yardstick, is the desired outcome. Undoubtedly there will also be matters for decision which do not involve any conflict of expectations, for example, if the decision calls for individual opinions or if there are no diverse individual interests in deciding what the specialty wants or thinks.

Up until now the members of divisions have been considered solely as occupants of that particular role. However, they are also members of the medical profession and there needs to be an examination of the elements involved in being a consultant which are brought into the division and the role conflict situation.

The Medical Profession and Individual Autonomy

The theory of professions has developed in rather a haphazard way. Millerson (13) and Moore (14) have been highly critical of the kinds of uncertainty which have been created and which they lay at the door of semantic confusion, a concentration upon specific occupations in the development of defining characteristics of professions and insufficient attention to changes in the nature of professions and the ways in which occupations attain professional status and recognition.

These criticisms indicate a major split in the theory of professions between discerning processes of professionalisation and distinguishing professions from non-professional occupations. The professionalisation approach rests upon the assumption and elaboration of some form

of developmental sequence, for example, in the work of Caplow (15), Wilensky (16) and Moore (14). In this approach stages through which an occupation must pass before it is considered a profession are identified. The second branch of the theory, generally called the attribute approach, started out in relation to single occupations, for example, Greenwood on social workers (17) and Kaye on architects (18). Others have attempted to formulate lists which are applicable to all professions, for example, Barber (19), Cogan (20) and Goode (21). The latter in particular makes a distinction between core characteristics:

'1. prolonged, specialised training in an abstract body of knowledge; and

2. a collectivity or service orientation.' ((21), p.903)

and derivative traits which he sees as descriptive rather than definitive characteristics.

In all the work on professions, medicine, the law and the church are seen as the archetypal professions and it is in the study of medicine that the work of Freidson (22, 23, 24, 25) has cut through the descriptive elements of the theory to one key element - autonomy. He argues that the most strategic difference between a profession and other occupations:

'... lies in legitimate organised autonomy - that a profession is distinct from other occupations in that it has been given the right to control its own work ... Unlike other occupations, professions are deliberately granted autonomy including the exclusive right to determine who can legitimately do its work and how the work should be done.' ((25, p.69)

In arriving at this statement Freidson attacks the attribute approach and deals with Goode's core characteristics specifically. The first criterion conceals three problems of specification in 'prolonged', 'specialised' and 'abstract'. Freidson argues that it is more or less impossible to say what these should be in practice and that they would fail to differentiate between accepted professions and non-professions. In examining nursing he concludes that it is:

'... not training as such, but only the issue of autonomy and control over training granted the occupation by an elite or public persuaded of its importance ... The possibilities for functional autonomy and the relation of the work of an occupation to that of a dominant profession seems critical. And the process determining the outcome is essentially political and social rather than technical in character - a process in which power and persuasive rhetoric are more important than the objective character of knowledge, training and work.' ((25, p.79)

Freidson raises similar doubts about the characteristic of service orientation. He says that we do not know how many professionals have this orientation, whether this orientation is held more intensely or widely than any other orientation, and whether the distribution and intensity of this orientation is greater among professionals than among other kinds of workers. He concludes that:

'The profession's service orientation is a public imputation it has successfully won in a process by which its leaders have persuaded society to grant and support its autonomy.' ((25, p.82).

Freidson's view of the nature of the medical profession has gained considerable acceptance and the importance of autonomy will be taken as a key concept in this work. However, while the hallmark of the profession as a whole may be its autonomy, in the context of the specialty division the focus is upon the nature of relationships between professional colleagues. Research into this has been relatively limited and until Freidson and Rhea's work it has centred mainly upon patronage and support in career development (26, 27) and the way in which the diffusion of clinical innovation occurs through colleague networks (28). The main interest here is in the colleague group in a single work setting.

A division is a grouping of doctors, the majority of whom will be of consultant status. They are at the top of the medical career ladder and as such they are independent of one another, in clinical matters

they are not supervised or controlled by anyone. Fully-qualified professionals have been called a 'company of equals' (29) and this grouping has been described by Barber as follows:

> '... a social group in which each permanent member ... is roughtly equal in authority, self-directing, and self-disciplined, pursuing the goal (of his work) under the guidance of the ... morality he has learned from his colleagues and which he shares with them. The sources of purpose and authority are in his own conscience and in his respect for the moral judgements of his peers. If his own conscience is not strong enough, the disapproval of others will control him or will lead to his exclusion from the brotherhood.' ((30), p.195)

The balance between self control and direction and colleague disapproval has been illustrated by Merton (31). He has formulated a series of norms and values to which physicians are expected to adhere, the catch being that for each value there is an alternate value which, if not inconsistent with the first, makes it difficult for the physician to live up to both. Three of these value dilemmas relate to individual autonomy and group control:

> 'The physician must maintain a self-critical attitude and be disciplined in the scientific appraisal of evidence. <u>But</u> he must be decisive and not postpone decisions beyond what the situation requires, even when the scientific evidence is inadequate.'

> 'The physician must have a sense of autonomy; he must take the burden of responsibility and act as the situation, in his best judgement, requires. <u>But</u> autonomy must not be allowed to become complacency or smug self-assurance; autonomy must be coupled with a due sense of humility.'

> 'The physician must respect the reputation of his colleagues, not holding them up to obloquy or ridicule before associates or patients.

> But he is obligated to see to it that high standards of practice are maintained by others in the profession as well as by himself.' ((31), pp.73-75)

One of the few studies which has attempted to examine relationships within a company of equals and look at the tension between the norms or values outlined by Merton is that of Freidson and Rhea (32). They studied the control of individual practice by the colleague group. Their research was conducted in a clinic in the United States of America with a staff of doctors of consultant or equivalent status. In describing the setting they state:

> 'In very few if any other occupations are the sense of individual responsibility and autonomy, and an objective position of prestige and strength so well developed for the support of a company of equals pattern.' ((32, p.187)

They examine the potential for the control of work in such settings and in response to Barber's general description of the 'company of equals' pose the following question:

> 'It is rather difficult to accept the assignment of such heavy weight to individual conscience and self-direction. Colleague pressures do constitute an external source of control in the definition, but how, if a deviant is permanent and equal in authority to others, can pressure by others influence him?' ((32), p.186)

Freidson and Rhea analyse the way in which their clinic works and it is clear that, because of the individual nature of practice and the fact that what any doctor does is not systematically observable by his colleagues, the basis for a uniform system of control is lacking. However, this is also linked to the willingness of the doctors to use the information which they do accumulate:

> '... while the physicians' access to information about each others' performance is spotty, this would not be so significant if they were not also disinclined to share this information with each other. In consequence, the formation of a

> collective colleague opinion, and the initiation of collective colleague action are made rather difficult. Indeed, deviance is controlled almost entirely on an individual rather than collective professional basis ... Furthermore, what methods of control there are are largely normative in character.' ((32), p.196)

As a whole there was unwillingness on the part of doctors to interfere with, or impinge upon, the practice of other doctors. In seeking to explain this Freidson and Rhea elaborate upon the notion of individual autonomy within the company of equals setting:

> 'In medicine work is seen to have potentially dangerous consequences. Since those consequences are also relatively unpredictable and the law holds him responsible, the physician assumes some unusual risks in his work. By virtue of his willingness to assume responsibility under such circumstances, the physician claims autonomy. Also contributing to the claim as well as the grant of autonomy is the belief that there is no single right way of tackling a problem, that the personal judgement of the man who handles the case cannot be replaced by definite, abstract rules. Colleagues who do not know the case are inclined to suspend some of their judgement of their associate's handling of it. And a sense of vulnerability stemming from this indeterminacy leads to the feeling that one shouldn't criticise an erring colleague because "it may be my turn next", or "there, but for the grace of God, go I." This characteristic perspective on medical work thus leads to norms which encourage granting a large measure of autonomy and privacy to the physicians. It also leads to constant pressure for autonomy and privacy in the organisation of effort.' ((32), p.197)

Freidson has elaborated upon the nature of individual responsibility and autonomy in other places (25) and other writers (14) have also identified it as a key characteristic of the professional worker. The impact of this key characteristic must now be considered in the divisional setting.

The Consultant, the Division and Individual Autonomy

The divisional system in the National Health Service is designed to bring together groups of consultants in the same or related specialties, although other staff, for example, junior medical and senior nursing staff, may also be involved. The consultants are very similar to the physicians in the clinic studied by Freidson and Rhea (32). They have their own patients, their own beds and their own junior staff, possibly sharing the latter with one or two other consultants. They are contractually and professionally independent.

It seems reasonable to suggest that one of the prime values held by consultants will be the maintenance of their individual responsibility and autonomy as this is the main feature of their everyday working relations with one another. The corrollary of this is the view that one doctor's judgement, though different from another's, is equally valid, in that an individual's judgement is in some way sacrosanct and that there is a reluctance to comment upon the rightness or otherwise of work which a doctor's colleagues undertake. This is not to say that such criticism will not occur but that it will be weighed against, and have implications for, the value of individual autonomy in any decision to criticise another's practice, or not to do so. In relation to Merton's double edged norms (31) it would appear from Freidson's work that the premium is put upon individual autonomy and its maintenance rather than the broader professional concern with the control of standards. How will this value of autonomy affect the working of divisions and the way consultants tackle the functions for which they were designed?

It is clear that the development of autonomy as a professional value is related to the nature of professional work and its practice. The work of divisions is only partially concerned with the practice of medicine on an individual basis. As the Hendry report states:

> 'The objectives in the formation of a division are to provide means whereby all the doctors working in the service can come together in suitable groupings to meet their obligations to organise clinical work, to improve standards of patient

> care, to assess and evaluate their own work in relation to the needs of the community, and to provide soundly-based professional advice to management.' ((11), para. 45)

In some of these areas the value of individual autonomy is implicated. 'To improve standards of patient care' requires a consideration of the standards of individual practice and the comparison of different ways of treating the same conditions. 'To assess and evaluate their own work in relation to the needs of the community' implies a similar process whereby the areas of practice in which individuals choose to work are questioned and evaluated in relation to the presentation of disease. In this also the autonomy of the individual is on the line.

The other areas are less clear in their implications for autonomy. 'To organise clinical work' involves the way in which doctors decide to order their clinical practice. It does not necessarily involve the essentials of clinical work but it may be perceived as being a part of individual autonomy. Finally, 'to provide soundly-based professional advice to management' is also a less specific area. In some decisions, for example, equipment and staffing, individual doctors are expected, on the basis of their clinical work, to decide what additional equipment and staffing, if any, they require. They make this decision on the basis of their professional experience and the exigencies of practice as they see them. If they view this as an extension of clinical practice then autonomy is at stake. In other decisions, for example, being asked by the administration to comment upon the location of an outpatient clinic, autonomy has less chance of being implicated in discussions.

However, as Freidson argues in another context (25), the precise boundary of autonomy is hard to locate. While autonomy is related to technique he also suggests that in organisational contexts autonomy can be extended into other areas:

> 'Granted autonomy in his technique, the professional has a number of advantages which give him a sturdy wedge into other zones of practice. There is, first of all, the authority granted and deference obtained by his conceded expertise ...

> Second, there is influence on non-technical zones of work that is contingent on assessments of the work itself: the professional can argue that he cannot perform his work adequately unless he is near a given group of colleagues or a given set of technical resources; he can argue that he cannot perform his work adequately if he must work alone or if he is subject to structured interference; or he can claim that his cases are too complex to handle safely or well on an average of five an hour. Arguing from his conceded expertise in diagnosis and treatment, he is well equipped to influence if not control many other areas of his work. Only a fellow professional may say no, for counterargument can be justified only by reference to knowledge of the special characteristics of the work. Autonomy over the technical character of his work, then, gives him the wherewithal by which to be a "free" profession, even though he is dependent upon the state for establishing and sustaining his autonomy.'
> ((25), pp.45-46)

In relations with non-professionals the doctor can and does claim autonomy in areas related to and extending from clinical practice. What consultants choose to bring under the protection of autonomy is a function of their own perception of their position as doctors. By the same token it is therefore rather difficult to define clear limits of autonomy in the issues described above. In the divisional system fellow professionals are in a position where they can say no, on the basis of professional judgement. However, as has been indicated above, Freidson found doctors were unwilling to do this in respect of the core element of autonomy, clinical practice:

> 'Being by the nature of the case concerned with practical action for a lay clientele, clinical work, I suggested, leads to an exaggerated sense of limited personal responsibility along with emphasis on the primacy of personal work experience. When these norms are combined with those of class dignity and independence stemming from the

> bourgeois origins of professionals, they lead to an individualism which is as intellectual as it is social. That individualism minimises the value of basic scientific knowledge and the methods by which it is established, and maximises the value of individual opinion based on close personal experience with individual cases. The outcome of such an ideographic mentality is reluctance to criticise or be criticised by another.'
> ((32), p.191)

If this is the case and if autonomy is likely to be claimed or granted in adjacent areas to the central one of clinical practice then the colleague group may be just as reluctant to criticise a claim for a piece of equipment as the way in which somebody operates on patients. If a divisional member claims autonomy in an area, who is to reject that claim?

It is clear, however, that in some areas of decision-making autonomy will be at stake, while in others, individual responsibility and autonomy will not be implicated. Where it does arise will be dependent upon the perceptions and claims of individual doctors. How does the value of individual autonomy affect the structural aspect of role conflict described above?

Role Conflict, Individual Autonomy and the Division: The Structural Backcloth

In the first section of this chapter the role conflict inherent in the role of a member of a division was described and examined. Two expectations were identified as legitimate outcomes of the structure:

1. the presentation and preservation of individual consultant interests; and
2. the making of decisions about what is best for a specialty as a whole.

In the second part of this chapter the concern has been to describe and elaborate upon the main value entailed in individual professional

life which doctors 'bring along' to the divisional setting, the value of individual autonomy. These relatively constant background factors can be seen as the structural constraints within which the action of divisions will take place. How can these two features be expected to interact? Four possible solutions to the role conflict were identified:

a. the presentation and support of subjective interests will be the prime aim;

b. subjective interests will be subjugated to the interests of the specialty;

c. there will be compromise between the two; or

d. situations or decisions which involve role conflict will be avoided altogether.

Does the added value of individual autonomy make any of these alternatives more attractive to consultants? In considering this it is necessary to distinguish between those situations in which individual autonomy is implicated from those in which it is not. As noted above, individual autonomy is involved to a greater or lesser extent in most matters relating to professional work, from monitoring and improving standards, to judgements about the validity of requests for additional staff or equipment.

In these cases the value of autonomy would appear to bias the solution to role conflict in favour of the support of individual interests, or alternatively in favour of not making decisions which involve the value of individual autonomy. At the very least it can be said that, to operate as the structure anticipates, consultants not only have to solve the role conflict by choosing the specialty decision-making expectation, they also have to go against the value of individual autonomy. This is not to say that consultants will not fulfil the broader expectation but that the structure presents consultants with this dilemma. The anticipated functioning of the structure implicates one of the major professional values, shared by all consultants.

There are a number of potential types of decision in which this dilemma may be evident and two of these will be examined briefly.

1. Improving Standards of Patient Care.

In order to do this, doctors have to evaluate their own clinical practice and the practice of others, the aim being to modify or change those aspects of work which are inferior or less effective as judged by the standards of others within the group. This is the expectation of specialty decision-making. It involves rigorous consideration and comparison of the work of individuals vis à vis that of others. This requires both the presentation of data either by the individual or through medical records and a willingness to discuss each other's practice habits. This necessarily involves the autonomy of the individual and the willingness to subordinate this to the question of overall and uniform standards, in the light of the fact that clinical practice is viewed as a matter of individual responsibility and experience. If this is done, and Freidson suggests that even to criticise may break the informal code, and the standards of some divisional members are found to be below those of others then some way has to be found of changing the way in which a physician works. Again this raises the question of autonomy, not only in telling other doctors to change their methods, but also making sure that they do so. In addition for any doctor to impinge upon the autonomy of another by criticising his or her work also opens up the question of his or her own autonomy. By impinging upon others the possibility of them scrutinising and criticising his or her own work is increased. In other words, all members value autonomy, and may be unwilling to contravene a value which they hold themselves.

To take the broader expectation not only rules out the individual interest but goes against the prime professional value. The main predisposition of these background features would therefore seem to push decision-making towards the maintenance of individual autonomy and the avoidance of the specialty decision-making expectation.

2. Mediation Between Individual Claims for Resources

Claims for resources may also involve the value of autonomy as they

arise from individual clinical experience and may only be justified with reference to an individual's practice and consequent perception of and reaction to a deficiency. The first step is to decide whether or not such a claim is invalid. To decide that a claim is valid denies the self interest expectation and if such claims are seen as being within the compass of autonomy then this also involves the denial of the main professional value.

However, at some stage, because of budgetary limitations, claims for the same kinds of resources, for example, equipment, have to be mediated. The aim of the structure is that priority ranking of claims should be undertaken by divisions. The role conflict alone, as outlined above, places those with and without requests in an invidious position. The problem is compounded if individual autonomy is seen to be at stake as well. The idea of putting some claims before others entails judgements about the relative validity of opinions derived from the clinical setting which goes against Freidson's typification of the professional view that one consultant's judgement is as good as that of another consultant. In the same way as the previous example the background features would appear to have a strong potential influence upon the way in which such decisions are made. They would appear to favour the support of individual interest rather than deciding about individual validity or relative priority, avoiding such decisions altogether, or making decisions about resource claims in such a way that autonomy is not threatened.

In those decisions which do not involve autonomy the consultants will only be faced with the role conflict problem or the decisions will not involve self interest, or specialty interest and there should be no structural barrier to a decision.

Conclusion

This chapter has examined individual divisions and the elements of their structure and the values of their membership which may influence the way in which they operate. The main structural feature was identified as role conflict, inherent in the role of member of a division

and involving the potentially conflicting expectations of the representation of self interest and the determination of specialty interest. At the same time it was recognised that the members of the medical profession come into the structure with certain values which are central to the nature of professionalism. Freidson's identification of individual autonomy as the defining characteristic of professionalism was examined in relation to the issues with which divisions are supposed to deal. It was argued that these two features provide the main background forces within which the action of divisions will take place. It was suggested that the structure, if it is to function according to the Joint Working Party reports, asks doctors to go against values which are intrinsic to their professional lives.

To the extent that role conflict and individual autonomy are implicit in any issue they will tend to push doctors towards ways of making decisions which do not embarrass their individual autonomy. The value of autonomy will favour solutions to the role conflict which realise or support individual interests or which avoid those decisions altogether.

While autonomy may be at stake in some decisions it was decided that it was difficult to draw a line between issues where it was implicated and those where it was not, in line with Freidson's argument that autonomy in one area provides a useful stepping stone to the replication of that claim in other areas. However, in those areas where individual autonomy is not at issue and individual interest is not relevant the hurdles standing between doctors and the aims of the structure are much less formidable.

The next chapter will examine the level of the Committee of Divisional Chairmen and again the aim will be to identify those features of both the structure and the profession, at the specialty level this time, which have implications for the operation of that committee.

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Chapter 3. The Committee of Divisional Chairmen: Role Conflict and the Impact of Specialisation

Introduction

The focus of this chapter is the Committee of Divisional Chairmen. This is the level above the individual divisions and the chairman of each specialty division is the representative of that specialty upon the Committee of Divisional Chairmen.

As in the last chapter, the aim is to identify the background forces and features of both this committee and the medical profession which may influence the process by which decisions are made. There is a similar role conflict inherent in the structure to that which applied to the individual division. The possible impact of this upon the process of decision-making will be analysed. Following this the nature of the medical profession at this level will be examined. The unit of organisation is the specialty and the nature of specialisation in medicine will be analysed in terms of its historical development and its current shape. The major features identified are specialty autonomy, lack of detailed inter-specialty knowledge and differential specialty prestige. These are then examined in the context of the aims of the committee.

Once again the intention is not in any sense prescriptive but rather to develop an appreciation of the background features implicit in the design of the Medical Advisory Structure and in the nature of specialties. These elements will be drawn together in the latter part of the chapter when the interaction between role conflict and the corollaries of specialisation is examined in the context of decision-making.

The Medical Advisory Structure: The Committee of Divisional Chairmen and Role Conflict

The use of role conflict theory is the same in this chapter as it was in Chapter 2. The concern is with incompatible expectations inhering in a single role of member of the Committee of Divisional Chairmen which are the logical outcome of the design of the Committee of

Chairmen. The interest is not, at this stage, in the perception of participants but in the implications of the structure and what it has been designed to achieve.

The Committee of Divisional Chairmen was described in the first Joint Working Party report in 1967 as the next stage up from the divisional or individual specialty level:

> 'There are matters which are of common interest to more than one discipline and it is desirable that this should be recognised in the clinical organisation. We recommend that this should be done by forming within each hospital or hospital group a committee composed basically of the chairmen of each of the divisions. This might be known as the "Committee of Divisional Chairmen". The committee would be the body which would deal with all matters of medical policy which have implications beyond a single division.' ((1), para. 62-3)

The overall function of the Committee of Divisional Chairmen is seen as follows:

> 'The main purpose in setting up divisions and having a Committee of Divisional Chairmen would be to further the efficiency of the hospital service ... the divisional structure would be concerned primarily with clinical and professional matters and the best use of resources for patient care.'
> ((1), para. 64)

This rubric covers such areas as the allocation of resources between specialties, matters of inter-specialty interest, the evaluation of medical services and co-ordination between specialties and other branches of the service.

The first report was written in the context of the old Board of Management structure and the later reports relate the divisional organisation to the administrative levels of district and area under the reorganisation plans. However, the general pattern of the Committee of Divisional Chairmen, which is seen as a hospital advisory

committee, is taken as the basis of the Medical Advisory Structure at the higher levels:

> 'Hospital-based divisions have been used to an increasing extent over the last few years as the basis of the medical staff's approach to management. In the light of this experience it should not be difficult either as a concept or in practice to use these divisions as the source of the hospital part of the new District Medical Committee's membership.' ((2), para. 4.12)

> 'We see the need for the creation in each health authority area of a medical committee. Its composition and functions would be similar to those of the Committee of Chairmen proposed in the earlier report.' ((3), para. 151)

In both these cases the general practitioners are also included in the structure.

The pattern of the last chapter will be followed in examining the functions of the Committee of Divisional Chairmen and the implications of these for its members.

When a division has reached a decision on its attitude to an issue or a request of some kind then it generally has to be considered by the next level up, the Committee of Divisional Chairmen. If the issue only affects that division then the committee has to decide whether or not that decision is valid in the hospital context. If, however, there are other requests or proposals from other divisions then the individual divisional claims have to be compared for their validity. Each division is represented by its own elected chairman, who is the spokesman of the specialty or group of specialties concerned. The committee is the main medical policy-making body for the hospital. Its function is to make decisions about medical facilities and practice in the light of requests or opinions from the divisions through their chairmen, or in response to questions or requests from other parts of the structure, for example, the Area Board or the Scottish Home and Health Department.

The role conflict inherent in being a member of this committee is very similar to that applying to the member of a specialty division, members are confronted with two expectations which may be incompatible. First of all, each member is expected to represent his own specialty or division. The Chairman takes the decisions and opinions of his or her division, representing the corporate viewpoint of the consultants in the specialty concerned, to the Committee of Chairmen for a final decision on the passage of a recommendation to some other part of the structure. This is the raw material of the committee. Not only does the structure expect specialty requests and opinions to be brought into discussions in this way, but divisional colleagues no doubt expect their Chairman to obtain agreement for what they want, for this is the main, if not only, means provided by the structure for the achievement of specialty desires. For example, if a division wants an extra member of staff then its representative has to present the case for it and it has to be agreed to by the committee before it can be passed on to the next level for further consideration.

The second part of being a member of the Committee of Divisional Chairmen is that each member has to act as an independent arbiter in deciding what the hospital as a whole needs and to look at the requests and opinions of the various specialties and decide upon their validity as general priorities or policies for the hospital. For example, if a number of divisions have requests for additional staff then according to the structure the members have to decide which requests are most pressing and decide on the priority between them. Therefore as a member of the Committee of Chairmen the individual faces two expectations:

a. a member is expected to represent the interests of his or her own specialty, for this is the only way in which they can be achieved; and

b. a member is expected to act as an objective, independent arbiter over his or her own and other specialty requests in deciding what is best for the service provided by the hospital.

Each chairman knows what his or her specialty wants yet he or she has to appear to be objective in presenting such requests. To appear to be pressing too strongly for his or her own specialty would question any pretext at the expectation of being an independent arbiter.

This situation also has to be seen in the light of the previous structure when a common specialty viewpoint on anything was probably a rarity. The basic unit of organisation prior to divisions was the 'firm' and approaches to the administration would be made through the consultant in-administrative-charge, or 'chief' (4). Potentially there were as many viewpoints, opinions and requests as there were chiefs. At the same time it has been suggested that the chiefs had differential access to the administration either through membership of Boards of Management or Regional Boards, or through informal networks in that there tended to be one or two chiefs who were consulted by the Medical Superintendent if a medical opinion was required. Hence there were in theory as many viewpoints as there were firms - even within specialties which had more than one firm - and the success of requests was often determined by informal access rather than intrinsic worth. With the divisional system all specialties have a mechanism for presenting their requests to the Committee of Chairmen and all specialties have the same formal access to the structure of decision-making. By broadening out the medical organisation on a specialty basis there has been a change, specialties are no longer only <u>of</u> themselves, they are also <u>for</u> themselves.

At the same time, however, the chairman representing these interests is aware that specialty zeal must be tempered with objective consideration of his or her own requests in the light of viewpoints from other specialties, and the needs of the service as a whole.

However, not all decisions entail these two expectations, the types of decision where they are implicated will now be examined.

Decisions which Place Members of the Committee of Divisional Chairmen in Role Conflict Situations

As in the case of individual divisions role conflict is most likely to occur in decisions which involve requests or the representation of interests by chairmen on behalf of their divisions. For individual one-off requests the members have to consider whether the claim itself is valid. In other cases, claims from different divisions may be made upon a limited budget. In these situations the members have to consider the relative validity or priority of the various requests. If priority decisions have to be made then the potential difficulties are similar to those facing the member of a specialty division.

1. Chairmen with specialty requests have to argue their case in relation to the overall needs of the hospital. There may be some difficulty associated with pressing for a sectional specialty interest as if it was a hospital interest because it might appear that they were putting specialty interest first. At the same time they have the pressure of their own divisional colleagues behind them, their fellow consultants expect them to achieve agreement for what they want.

2. Those with requests have to argue their case against requests from other divisions. They have to compare what their division wants with what other divisions want and thereby may have to criticise others in defence of their own claim. This again could be seen as pushing for their own interest and favouring one expectation rather than the other.

3. Those without submissions have to judge the overall and relative validity of the various specialty claims. While in any one decision they only have to adhere to the independent arbiter expectation a longer term view of Committee of Chairmen interaction must be taken. Although they are the judges in this instance they will be the judged in others. In the future they will have to present their own specialty requests which they will want the committee to accept, they will have their own division behind them expecting a successful outcome and they will have their request assessed by people whom they have judged in the past. If they take the broader expectation when

they do not have requests this may affect the way in which other members react to claims which they make in the future.

Again, following Gross (5), there are four possible solutions to the conflict:

a. the representation of divisional claims and interests is seen as the major or most important expectation and the Committee of Chairmen is used for either the ratification of specialty requests or decisions are structured by arguments between specialty interests rather than broader concerns;

b. the hospital decision-making expectation is seen as most important and members will not go all out for their own divisional interests. Decisions will be made on the basis of broad considerations unaffected by the desires of divisional members further down the structure;

c. there will be a compromise between these two alternatives; and

d. situations or decisions in which the expectations conflict will be avoided altogether. This may not always be a feasible alternative. If they were faced with patient care evaluation, an issue which they are supposed to cover, it would be possible to skirt the issue and not discuss it, thereby avoiding the problem. If, however, a decision involves a request for equipment then the committee has to say 'yes' or 'no', it cannot by-pass it. It could refer the matter to a sub-committee, but not to take a decision would in fact result in a decision. To fail to say 'no' is in this instance to agree to the request and thereby give the specialty representation expectation primacy.

There will be some issues in which these expectations are not relevant, either because specialty interest is legitimate, for example, if the issue demands a separate response from each specialty, or because specialty opinion is not involved.

Thus far the Committee of Chairmen has been examined in structural terms, ignoring to a large extent the nature of specialty groupings within the medical profession. It is to this other input into the Committee of Chairmen that this chapter will now turn.

Specialisation and the Committee of Chairmen

The basic units of organisation in the divisional system are first of all, the individual consultant:

> 'The new structure of clinical organisation must be based on the individual consultant. The basic entity would be the "consultancy" which we define as the consultant and that part of the hospital staff and resources which are directly available to him.' ((1), para. 26)

and secondly, the individual specialty:

> '... we argue the case for the establishment of "divisions", each with a chairman who will normally be elected, and each corresponding to an agreed field of clinical or para-clinical practice ... These larger groups are seen as a mechanism for the pooling of resources and are, therefore, to be regarded as aggregations of medical staff with like interests ...' ((1), para. 24-5)

For example, in the Hendry report (2) six specialty groupings are named as illustrations of the way the structure might develop:

> 'Surgery - including, for example, general surgery, urology, orthopaedics, ophthalmology.
>
> Medicine - including, for example, general medicine, geriatrics, dermatology, nephrology.
>
> Psychiatry.
>
> Obstetrics/Gynaecology.
>
> Anaesthetics.
>
> Laboratory specialties.
>
> Radiology.' ((2), Diagram A)

In practice, the precise number and type of divisions, and the combinations of specialties which might result are to be left strictly to the doctors in the hospitals concerned, to identify where joint interests lie and where they do not exist.

In the same way that individual autonomy was considered in relation to the consultant in the division, the concommitants of specialty, as the unit or organisation in the next level of the structure, must be examined. What does specialisation imply in terms of the values and attributes which are brought into a forum which has specialty as its basis?

The answer to this question requires an examination of the nature of specialisation within medicine, its development and the way in which it influences the hospital service on a day-to-day basis. In order to do this, this chapter will now examine the historical development of medicine from the specialty viewpoint. The major features of this will be teased out of the picture which emerges. In the final part of the chapter these will be looked at in the context of the Committee of Chairmen and in conjunction with the potential role conflict.

The Development of Specialisation within Medicine

The relations between groupings within most professions have not received much detailed examination. As Smith comments:

> 'In the study of occupations and professions little attention has been paid to the range of differences of behaviour which may be encompassed within a single profession ... Rather there has been a concentration upon establishing the norms, the central tendencies of professional behaviour.'
> ((6), p.285)

While this is least true of medicine there has still been a tendency to see this profession as a unitary body. Freidson suggests two main reasons for this; the greater visibility of the medical degree rather than the professional segments, which tends to limit public

awareness to the grosser more symbolic aspects of the profession, and the selective recruitment into the profession of people who are prone to share the same outlook on work (7). Another possible reason is the interest taken in relations between the profession and the public which has stressed the common elements of the former. Bucher and Strauss, on the other hand, take a less charitable view in arguing that a spurious unity is maintained before the public view (8).

However, the initial concern here is with the development of functionally specific groups in medicine. Medicine has two main branches, the preventive and the curative, the former represented by public health, or what is now community medicine, and the latter by hospital medicine and general practice. Sokolowska has drawn attention to the differences in perspective which these two aspects of medicine predicate (9). The preventive approach sees man as an individuum connected with the environment while the curative approach concentrates upon single organisms and specific approaches to disease. Although these approaches are complimentary the relationship between the two is not always harmonious. Even within the broad curative categories of general practice and hospital medicine there have been arguments, in part stemming from their historical development and their different contributions to the treatment process. Political considerations have further exacerbated their relationship, as exemplified by the National Health Service negotiations and the competition for influence between the British Medical Association and the Royal Colleges (10). However, the main concern here is with hospital medicine and the rest of this chapter will be devoted to that branch of the profession. (Much of the following will draw heavily upon the work of Carr-Saunders and Wilson (11) and Stevens (12).)

The first developments occurred in the two broadest specialties of the present day, medicine or physic and surgery. By 1300 they were both full-time occupations but from then until 1800 their separate development was markedly different. The break was made in 1353 after an unsuccessful attempt to form a conjoint faculty, from then on medicine developed mainly in an academic context and surgery came under the guild organisation.

The usual method of becoming a physician was to take an arts course and subsequently graduate in medicine. The fifteenth century revival of learning exerted considerable influence upon the study of physic and in 1518 Henry VIII granted a charter to the Royal College of Physicians of London. Following certain modifications the powers of the college were confirmed by the 1522 Act which stated that no person, other than a graduate of Oxford or Cambridge, was allowed to practise physic unless he was examined and approved by the College. Power to examine in medicine was also granted within a seven mile radius of London and the oversight of physicians and scrutiny of medicine was entrusted to four censors of the College, elected on an annual basis.

The physicians further differentiated themselves from the surgeons with the passage of an Act in 1540. This gave them the right to practise surgery and forbade surgeons prescribing for their patients or performing a major operation without the consent of a physician. After the failure of the attempt to form a conjoint faculty the surgeons had a more troubled course. In the early fifteenth century they organised a guild of the usual form. It remained a fairly exclusive body and in 1435 still had only seventeen members. These were mainly court and army surgeons and for a time they ranked with the physicians. However, because of this lack of academic development they moved towards the craft form of organisation and formed a close liaison with the barbers which was consolidated by the formation of the Company of Barber-Surgeons in 1540. This illustrated the decline of surgery from art to trade and for two centuries there was a wide gulf between surgeons and the physicians.

In the seventeenth century the surgeons began to move towards the model of development provided by the physicians. The standards required by the company were raised, the quality of practice improved and in 1684 the surgeons tried to split off from the barbers, but their petition was unsuccessful. A second petition achieved this and an Act of 1774 dissolved the company and formed two separate guilds. The rise of the surgeons after this was rapid. The company was dissolved in 1796 and a new charter, secured in 1800, severed all

connections with the City of London and incorporated the Royal College of Surgeons of London.

The other main group at this time were the apothecaries. Although they later developed into what are now general practitioners their relationship with the physicians and the attitude of the latter to the surgeons is clearly summed up by Waddington:

> 'These three groups were organised in a hierarchical structure, with physicians forming "the first class of medical practitioner in rank and legal pre-eminence" ... the disdain which physicians, as a body of learned men, felt for manual work, had led to a contraction in their duties. By the eighteenth century, the practice of the physician was held to be properly confined to prescribing of drugs to be compounded by the apothecary, and in superintending operations performed by surgeons in order to prescribe what was necessary to the general health of the patient, or to counteract any internal disease.' ((13, p.107)

During this period other colleges had been formed in other parts of the country, in 1599 the Royal College of Physicians and Surgeons of Glasgow, and in Edinburgh the Royal College of Surgeons in 1505 and the Royal College of Physicians in 1681.

The main desire on the part of physicians and surgeons was to carve out a legitimate autonomy over an area of practice backed by law and to control entry into that area of practice.

For a long period these two specialties dominated medical practice and this operated against the development of other specialties in two respects. First of all, in the organisation of hospital practice and consequent control over resources:

> 'The staffing system of the voluntary hospitals did not encourage innovation ... Vacancies arose only through the death or retirement of an incumbent. The aspirant could not afford to be an innovator; he was compelled to pay at least

> lip service to the practices and beliefs of his seniors ... The physicians who were fellows of the Royal College and ran the hospital were general physicians; the most influential surgeons were general surgeons.' ((12), p.26)

Not surprisingly most of the beds were allocated to general medicine and general surgery. Physicians and surgeons were not appointed as specialists and although they could develop special interests a second factor deterred them from doing so, that is, certain areas of the body had tended to be excluded from medical practice. In taking the example of eye disease, Rosen comments upon this phenomenon:

> 'The disrepute of these peripatetic occulists and of other practitioners of the same ilk was so great that when certain men within the medical profession began to devote themselves to the diseases of some organ such as the eye, or a particular class of disease, they did so at the risk of inviting aspersions upon their professional integrity and being ostracised by their colleagues. There can be little doubt that group pressure, operating in the form of specific social sanctions such as ostracism, was indeed effective in retarding the rise of specialties.' ((14), p.105)

Within the same area of deterrence was the question of disease and morality in treatment of venereal and genito-urinary diseases. Considerable social disapprobation was the lot of victims of syphillis and gonorrhea and this extended to those medical men who treated them. The result was that in these areas as well patients were driven to quacks and other marginal practitioners.

With the lack of both structural provision and social acceptance the only way for new specialties to develop was through the formation of specialist hospitals and the development of academic or group legitimacy in the mode of medicine and surgery.

In the case of the first there was a rapid development of specialist hospitals throughout the country in the nineteenth century. In

London alone four new special hospitals were founded in the 1830's, seven in the forties, eight in the fifties and sixteen in the sixties (15). In this way specialist hospitals were established in infectious diseases, obstetrics, ophthalmology and paediatrics. Others followed in more esoteric areas and the adverse reaction on the part of the major specialties and the general hospitals contained within it a variety of objections:

'There undoubtedly were hospitals providing somewhat spurious treatments and hospitals which involved an unnecessary duplication of facilities. This became more evident when belatedly the general hospitals set up special departments in the fields whose neglect had contributed to the growth of special hospitals. Both these factors do not wholly account for the indiscriminate condemnation of special hospitals by the leaders of opinion, both medical and lay. Many doctors were opposed to specialisation as a matter of principle, others resented the loss of "teaching material" and private practice: both the lay governors and the medical staffs of the general hospitals objected to the diversion of charitable funds elsewhere. In 1853, the British Medical Journal made a bitter attack on special hospitals: "Half the special hospitals (were) founded in the grossest self-seeking on the part of some individual ..." In the same year, The Lancet spoke of the special hospitals as a "monstrous evil - an evil which springs from within the profession" ... In 1864, the formation of St. Peter's Hospital for the Care of the Stone in the Bladder and Urinary Diseases was derided by the British Medical Journal: "Cutting for stone and crushing stones are very limited occupations ... The establishment of a small home under the very shadow of Middlesex Hospital, is it not, in a charitable sense, playing the farce of charity?" The hospital had on its staff a Mr. John Walter Coulson who was also a surgeon at St. Mary's Hospital. St. Mary's told him to either leave the staff of the hospital or give up the special hospital. He decided to leave St. Mary's. Similarly, the Treasurer of St. Thomas' Hospital laid it down that no member of the medical staff could work in a special hospital.

> In 1864, on the other hand, Moorfields (an eye hospital) laid it down that no surgeon could hold an ophthalmic appointment in another hospital.' ((15), p.28-30)

These objections cover several professional concerns.

1. The concern with the maintenance of generalist control over the whole of medicine;

2. arising from this, condescension about the nature of practice in limited areas, as in stone removal;

3. concern over the morality of some areas of practice, for example, St. Thomas' Hospital did not form a department of gynaecology until 1888 for fear that such an immodest subject might corrupt the souls of medical students; and

4. non-professional objections such as the diversion of funds and the loss of patients.

However, once specialties had an institutional base it was difficult to deny their existence or halt their development, and this process was stimulated in the First World War in areas like psychiatry, orthopaedics and plastic and thoracic surgery. In addition:

> '... advances applicable to medical practice were being made in non-clinical fields - biochemistry, bacteriology, and endocrinology ... Radiotherapy was being adopted in a number of hospitals, diagnostic radiology was expanding. By the early 1920's medical specialisation, although deplored by those who saw that medicine was irrevocably disunited, was generally accepted as necessary and inevitable. Many specialties were gradually evolving from a general interest in a particular sphere of general medicine or general surgery to bodies of knowledge in their own right.' ((12), p.38)

Although the specialties gained the legitimation of a hospital base they could be practised by members of the two main colleges and there was no separate legitimation, other than experience, by which specialties could be identified. The other side of their develop-

ment was therefore at the group level. Although they were already members of a profession the development of the specialties in the formation of associations and the drive for certification of one kind or another bears remarkable similarities to Wilensky's typification of the development of occupations into professions (16). One example of such broad organisational legitimation is psychiatry. This began in 1841 with the establishment of the 'Association of Medical Officers of Asylums and Hospitals for the Insane'. In the first years it made a small impact but through the establishment of a journal it achieved a broad following among those involved in psychiatry. In 1865 it adopted a new name, 'The Medico-Psychological Association'. Shortly after that it initiated a Cerfiticate in Psychological Medicine, and elementary forerunner of the Diploma in Psychological Medicine and in 1908 a draft training scheme was submitted to the universities and colleges which resulted in the acceptance of five examining bodies for the diploma in 1911. In 1926 it became the Royal Medico-Psychological Association (17). Other specialties were slower to develop and this reflected:

> '... the struggle between the Royal Colleges which wanted to retain medicine as a unified whole, with the emerging groups which wanted to raise standards in their own special fields and advance their own status.'
> ((12), p.38)

In addition, the Royal Colleges still provided the only further professional qualifications of any standing. The aspiring consultant in any specialty was expected to have the Membership of the Royal College of Physicians (MRCP) or the Fellowship of the Royal College of Surgeons (FRCS) or the university M.D. or M.S. before he would be considered for appointment to a major voluntary hospital. Members of any specialty were expected to be affiliated to one or other of the colleges although this began to change in the first years of the twentieth century with the proliferation of special certificates and diplomas in a number of specialties.

A Diploma in Ophthalmology was established in Oxford after a comment by the General Medical Council on medical students lack of knowledge

in the field. The Council of British Ophthalmologists was founded in 1918 and the Conjoint Board of the Royal Colleges introduced a postgraduate Diploma in Ophthalmic Medicine and Surgery in 1920. A special Diploma in Otolaryngology was set up by the Conjoint Board in 1920. A degree in orthopaedics was established at Liverpool University in 1924 and this was complemented by the formation of specialty societies, the British Orthopaedic Association in 1918 and the International Society of Orthopaedic Surgery in 1929. These were still largely supplementary to the two college qualifications and even these diplomas were still under the control of the Conjoint Board.

The first specialty to attempt to step outside this domination was obstetrics and gynaecology. However, there was still a sharp division between obstetrics and midwifery and problems of obtaining adequate beds for both treatment and training purposes. Physicians and surgeons would not give up beds to obstetrics and gynaecology until they were required to do so by the Colleges or the General Medical Council and as those bodies were dominated by consultants from the teaching hospitals they were not willing to press for the release of beds. As a result, leading obstetricians and gynaecologists began to demand the formation of a college of their own as the two existing Colleges were not serving their interests. This presented the Colleges with a dilemma:

> 'Up to this point the specialties had been contained within their walls - either because specialisation naturally followed from the M.R.C.P. or F.R.C.S. diploma, or through the new specialty diplomas arranged by the universities or through their own Conjoint Board. University diplomas did not present a problem of authority for the Colleges, but the creation of a new professional college challenged their traditional supremacy as the great leaders of medicine. Not surprisingly, the Royal Colleges objected to a new foundation ... The Colleges insisted that any diploma given by the obstetricians should carry no legal qualification to practise, and then reluctantly agreed to the new foundation.

> The British College of Obstetricians was duly established in September 1929. The Royal Colleges had moved too late. Although they set up a rival diploma in the same year - which, the President of the Royal College of Physicians loftily pronounced, was a "guarantee of a high standard of attainment" in the subject - their diploma quickly failed. The College of Obstetricians established ... a membership examination (now the M.R.C.O.G.) for consultants in 1936. Membership in the College became a sine qua none for consultant appointments in obstetrics and gynaecology, as the M.R.C.P. and F.R.C.S. were for medicine and surgery.' ((12), p.45)

A similar debate was occurring in radiology. Their initial problem had not been the dubious morality of dealing with the reproductive organs but rather their position as technicians (the same problem applied later to anaesthetics, pathology and physical medicine). A diploma was established at Cambridge in 1917 under the sponsorship of The British Association for the Advancement of Radiology and Physiotherapy and in 1930 London University established a chair in radiology. In 1932 the Conjoint Board's Diploma in Radiology was established and an Academic Diploma in Medical Radiology was introduced in London in 1933. In 1934 the British Association of Radiologists was formed and as a precursor to a more exclusive specialty organisation it only allowed fully fledged practitioners to become members. However, even this was not enough:

> 'Despite this progress there was still pressure for a college to afford the ultimate level of prestige on a par with the physicians, surgeons, and now obstetricians and gynaecologists. The title "College of Radiologists" was opposed by the older Colleges, and finally the new organisation, by amalgamation of the Association of Radiologists with the Society of Radiotherapists, was called the "Faculty of Radiologists" (1939), with two sections, to accommodate the two branches of the subject. The faculty, although independent of the Colleges, did not try to compete with the existing radiology diploma of

> the Conjoint Board. Instead it created its own fellowship (F.F.R.) above the standards of the existing diplomas; this became a more advanced examination in its specialty than either the F.R.C.S., M.R.C.P., or M.R.C.O.G..'
> ((12), p.47)

Another service specialty, anaesthetics, also suffered, partly because it was seen as an adjunct of surgery and partly because of the general distrust of technicians on the part of clinicians. It was also practised by general practitioners and this did little to enhance the status of the specialty. Pathology, at that time encompassing bacteriology, haematology, biochemistry and morbid anatomy, had similar disadvantages and the pathologist:

> '... like the radiologists, ... was still of lesser status than the general physician and general surgeon. He was often employed on a salary; he had little or none of the trappings of private practice; and he lacked the ultimate status symbol: responsibility for a specified unit of hospital beds.' ((12), p.50)

Paediatrics also suffered from associations with general practice but like dermatology, cardiology, and neurology it was happy to remain with the Royal College of Physicians. Similarly, thoracic, plastic and urological surgeons, among others, were content to stay within the Royal College of Surgeons but as Stevens points out the development of associations and colleges with powers of examination outside the old college structure had changed the character of specialisation:

> 'Specialties were no longer merely indications of scientific interest, marked by attachments to a special hospital and attendance at after-dinner discussion clubs or the appropriate section of the Royal Society of Medicine. They had become professionalised groups, each conscious of its own particular needs; inclusion of their subject in the undergraduate curriculum, raised standards of training (and simultaneously the status of the specialty, and representation on appropriate administrative and professional bodies).'
> ((12), p.50)

The newer specialties were most concerned about their future status but many of the changes in the early part of the century did little to consolidate it. The M.R.C.P. and F.R.C.S. were the main meal-tickets recognised by the voluntary hospitals and the diplomas of the Conjoint Board did not replace them. Apart from obstetrics and gynaecology and one or two others the diplomas of the 1920's and 1930's conferred neither social status nor practising privileges. They were merely evidence of vocational attainment. However, it was not a one way process. The Royal Colleges reacted to this pressure and with the National Health Service looming large the Colleges had to assess their future position as educational and representative bodies. There was pressure from the burgeoning specialties for examination either within or outwith the College structure and at the same time the Colleges were acting as spokesmen for all consultants in the National Health Service negotiations. This implied that they were representative of all areas of medical practice but this was clearly not so with the Faculty of Radiologists as one excluded group and the domination of college representation by general physicians and general surgeons. If the two major specialties ignored the claims from within their ranks then the lessons of the past showed that such groups might resort to the establishment of external organisations. In the build-up of pressure and the reaction to it the Royal College of Surgeons was the first to come under fire.

In 1944 the Royal College of Surgeons agreed to co-opt additional members to the College Council from the following specialty societies: the Council of British Ophthalmologists, the Association of Otolaryngologists, the Faculty of Radiologists and the Association of Anaesthetists. Dental Surgery was added to the list and in 1946 the Royal College of Obstetricians and Gynaecologists was invited to nominate a member. The dental surgeons were similarly agitated and in 1946 a semi-autonomous Faculty of Dental Surgery was formed and a Fellowship in Dental Surgery was created in 1947. In the same year the Association of Anaesthetists requested a faculty similar to that established for the dental surgeons. This was approved along with a special fellowship. Lastly, following

pressure from the specialist societies, the F.R.C.S. in ophthalmology and the F.R.C.S. in otolaryngology were instituted in 1947. In contrast, orthopaedics, neurosurgery, plastic surgery, and urology exerted no pressure on the college, for as Stevens points out:

> 'They were already status specialties, able to exert influence within the Royal College of Surgeons ... The needs of these groups could well be served by their small exclusive specialist societies or through the appropriate section of the Royal Society of Medicine. These surgeons continued to take the general F.R.C.S. examination ... before embarking on apprenticeship in the registrar and senior registrar grades in their chosen surgical field.' ((12), p.114)

In the Royal College of Physicians pressure for change was less noticeable in the 1940's. This was in part attributable to the different nature of specialty development in medicine. While surgical development focussed upon limited areas of the body and used advanced technical skills, medical specialties tended to be broader in outlook. Specialties like paediatrics, geriatrics and psychiatry were strongly linked not only with general medicine but also general practice. In addition paediatrics, at that time, was not so much a separate specialty but more general medicine applied to a sector of the population. However, while specialties like neurology were firmly established within the college, paediatrics was already developing a strong claim to separate recognition in the immediate post-war period:

> 'Symbolic of the rise of paediatrics during and after World War II was the increase in the importance of the role of the British Paediatric Association (B.P.A.). By the end of the war it had become usual for a hospital, about to make an appointment in a new paediatric department, to seek the association's advice, and the B.P.A. thus played a part in planning paediatric services within the National Health Service.... The Paediatric Committee set up by the Royal College of Physicians suggested in its report (1945)

> that pediatrics be regarded as a major clinical subject. Among its detailed proposals for both undergraduate and postgraduate education, it proposed a period of not less than one-third of that devoted to clinical medicine to be set aside for clinical paediatrics, that from the departments of psychiatry, radiology and pathology a member of staff should interest himself particularly in the problems of childhood, and that questions of paediatrics should be included in the undergraduate final examinations...' ((12), p.117)

The same questions applied to psychiatry and pathology. However, they were larger than paediatrics, outside the major teaching hospitals and members of both specialties generally held one of the special diplomas rather than the M.R.C.P. which consultant paediatricians favoured. At the same time specialisation was occurring within psychiatry and pathology. Inevitably comparisons were made with the liberation achieved by the surgical specialties and it was suggested, for example, that dental surgeons had more in common with otolaryngologists than psychiatrists had with pathologists. The obstetricians and radiologists had established a disturbing precedent for the colleges and while the debate mainly revolved around the specialist/generalist argument two other factors, mediated by the National Health Service, added further weight to the arguments for separation. First of all there was the question of size. Both specialties had expanded rapidly under the new service and by 1964 each specialty contained ten per cent of consultants in the service. They were exceeded in size only by general medicine, general surgery and anaesthetics. They outnumbered obstetricians and gynaecologists by five to three.

Secondly, there was the issue of representation. Psychiatrists and pathologists had to obtain their M.R.C.P. and be elected as fellows of the college before they could even begin to influence the stand of the college on particular issues. If they felt that their interests were not looked after by the college then logically they were not properly represented on the various bodies composed of

college nominees, for example, the Distinction Awards Committee and the General Medical Council. The issues for pathology and psychiatry were examinations, and thereby academic legitimation and self-determination, status and professional representation. Pathology reacted to these attractions before psychiatry. Discussion was conducted by two major bodies, the Association of Clinical Pathologists and the Pathological Society of Great Britain and Ireland and although the debate started in 1953 there was still some equivocation in 1958:

> 'Circulars among members of both the A.C.P. and the Pathological Society in 1958 elicited a favourable response to founding a College, but there was still considerable doubt about the wisdom of such a step. It was argued that even if a separate examination was devised for pathologists, it would have to be similar to the M.R.C.P.; that is, an examination taken early in the career to pick out the best available candidate for further training, rather than a test of competence as a consultant. The stumbling block in this case was not the purpose but the existing bias of the M.R.C.P. toward the selection of clinicians rather than scientists. Nor could many see an overriding need for a separate college as a political organisation, since the A.C.P. had for several years spoken on behalf of hospital pathologists both directly to the Ministry of Health and through the mediation of the Joint Consultants Committee. Connection with the Royal College, it was stressed by many, merely needed to be modified.'
> ((12), p.343)

In 1959, as a reaction to these discussions and a desire to keep pathology in the fold, the college offered the pathologists a faculty along the same lines as that set up for the anaesthetists. However, this initiative was forestalled by a ballot of the two pathology bodies which indicated that a majority were in favour of a new institution. A joint committee was set up, the College of Pathologists was founded in 1962 and the first examination for membership was held in 1964.

Meanwhile, in psychiatry, a similar debate was taking place within the Royal Medico-Psychological Association (R.M.P.A.):

> 'It was claimed that the psychiatrists were being forced into the position of considering a complete breakaway from the Royal College of Physicians because, like the pathologists, they were not receiving equal treatment with members of other specialties within the College. The complaints of the psychiatrists were, however, refreshingly different from those of the pathologists, who had claimed that there was no room in the College for scientists; it was claimed by some psychiatrists that obtaining the M.R.C.P. needed "extensive training in and dedication to clinical medicine, which was increasingly based on mechanistic disciplines like chemistry and physics and was in danger of becoming a technology". Another view was that the application to the College for a faculty for psychiatrists would surrender control to a body whose very history and chief membership would tend to keep psychiatry as an "ancillary science to something they would call medicine"; and several claimed that it was "extremely rare" for a non-teaching hospital psychiatrist to be elected a fellow of the Royal College of Physicians.' ((12), p.346)

By 1963, proposals for a college had been circulated to members and they had the example of the pathologists' success to encourage their efforts. At a meeting in November of that year:

> 'The R.M.P.A. held a debate ... on the possibility of founding a College of Psychiatry. ... although it was asserted that the Royal College of Physicians was about to change the regulations for the M.R.C.P. examination (the result, said one speaker, of "death bed repentence"), the meeting formally resolved to establish a separate College, subject to a favourable response to a postal ballot. The Royal College of Physicians made its announcement in the middle of May 1964 - only shortly before the R.M.P.A. ballot was due. After a long period of debate the M.R.C.P. was

> to be radically changed. In future, part of the examination might be taken in special subjects instead of in general, or internal, medicine. This was the first major change in the examinations of the College since the M.R.C.P. had been introduced ... It was thus a landmark in the College's history as well as an apparent attempt to restrain certain groups from separatist action.' ((12), p.346)

However, it was too late and a large majority of the association voted for their own college and the council of the R.M.P.A. recommended that an application be made to the Privy Council to change the name of the association to the Royal College of Psychiatrists. This was agreed by the membership and the Privy Council agreed to the use of the royal epithet in 1971.

The Analytical Components of Specialisation

These have been the major specialty developments in the profession of medicine since the establishment of the Royal College of Physicians. This chapter will now examine the main factors involved in this process with a view to providing the professional 'inputs' to the Committee of Chairmen.

As a process, specialisation involved a number of separate but interrelated elements. These elements are not particularly complex but it will be argued that they have utility in understanding the professional forces at work at the specialty level.

1. Knowledge. The development of a distinct area of knowledge about a particular area of the body or a particular type of disease provided the basis for specialisation such that any new area could be seen in distinct contrast to the specialties already in existence. Through this came claims that special training or experience was necessary for a doctor to practise in a specialty.

2. Autonomy. It is clear from the above that at certain points in their history specialties began to claim that their knowledge base and interests were sufficiently developed and sufficiently different from established specialties to justify separation from them.

In a sense the various specialties within medicine have gone though a separate process of professionalisation, or 'autonomisation' within the profession. This process has been crystallised in the development of specialty certificates and colleges or faculties and the outcome, if not the aim, of these developments has been to give the emergent specialties legitimacy within medicine, and autonomy from the two main colleges of medicine and surgery.

3. Specialty Differences and Status. Leading on from this it is axiomatic that specialties are different across a range of criteria, the types of patients they deal with, how they deal with them, their position in the treatment process and so on. However, difference begs the question of relative importance and status. Looking initially at the reasons why some specialties developed and others did not and the way in which medicine as a whole has been represented on bodies like the General Medical Council it would appear that the older specialties have had more status and more potential for influence than some of the specialties of more recent origin.

These strands in the development of specialties will now be examined in some detail and the discussion will be oriented towards the Committee of Divisional Chairmen.

Knowledge and Specialty Development

The development of a knowledge base was one of the reasons or claims for justifying a specialty's existence. This was the springboard which launched the development of separate interests and the dawning realisation that such interests were not served by the two major specialty colleges. At this stage the concern is not with the antecedents of that knowledge or the way in which it was built upon, but rather the impact of separate knowledge bases upon the profession and its practice. At its simplest this involved doctors becoming interested, for one reason or another, in an area of the body or an approach to illness which was not already covered by the general physicians or surgeons. While they were members primarily of one or other of these older specialties, increasingly, with the development of facilities and practice, it became clear that there was a

separate body of knowledge which was not catered for or reacted to by the older colleges. The growth of such a knowledge base provided the justification for a separate specialty with its own legitimacy.

As diplomas in the burgeoning specialties were established there was an interim period in which doctors still took the memberships of the major colleges and the diploma in the areas in which they wished to specialise. However, with the formation of separate faculties and colleges most doctors planning to practise in one of the new specialties took only the relevant membership or fellowship, for example, the M.R.C.O.G.. An obstetrician might well take the F.R.C.S. but in recent years that alone would not be seen as guaranteeing expertise in obstetrics. Nowadays, for a doctor to become a consultant within the National Health Service he has to obtain the necessary postgraduate qualification and experience in the specialty concerned.

Part of the reaction against specialisation by the old Colleges was motivated by a respect for the generalist but in more recent years the pressure to obtain specialty qualifications and the breadth of knowledge which any specialty covers has had a considerable impact upon the careers of newly qualified doctors. Because of the range of specialties and their increasing complexity young doctors have tended to start specialising at earlier and earlier stages in their careers. The Todd Report on medical education was concerned, among many other issues, with specialty training (18). In looking for better ways of achieving this the report mentioned some of the problems of the past and present relating to early specialisation:

> 'In our view the years immediately following the intern year present the most urgent problems, both because of the numbers of trainees involved and because of the present disorganised state of training in these years. The present provision of separate and unrelated courses for specialist qualifications takes up a great deal of teachers' time and although important differences of interest, knowledge and skill will no doubt remain between specialties, at least for a long time to come, we think that if adequate training is made available to all doctors every effort must be made

to find and emphasise the common features, which are often substantial, rather than the differences.' ((18), para. 74)

In this, Todd suggests that segmental training has been a natural trap to fall into. However, while he recommends a more broadly-based approach, in covering the present patterns of training he touches upon one of the most important pressures for early specialisation:

'During the next two years or so in the Registrar grade, the intending specialist hopes to obtain a higher qualification by passing examinations such as those for the Membership of the Royal College of Physicians or the Fellowship of the Royal College of Surgeons ... Unless he succeeds he will have little chance of being selected for further specialist training in the Senior Registrar grade; indeed in some specialties in which the number of applicants for Senior Registrar posts far exceeds the number of vacancies, qualification is certainly no guarantee that a Senior Registrar appointment will be obtained.' ((18), para. 74)

The passing of examinations for memberships, fellowships and diplomas have become basic requirements for promotion, not only for the consultant grade but also for Senior Registrar posts. This, coupled with the competition which occurs for limited posts ensures that specialisation starts soon after graduation as experience and publications have to supplement paper qualifications and differentiate between applicants with the same basic certification. Todd makes recommendations to counteract this but these still suggest that specialisation will begin four years after qualification. Even taking that as the baseline and the average age of consultant appointment as being thirty-five, this means that doctors will have specialised for around ten years prior to obtaining a consultant appointment. This is certainly true of the period prior to the Todd report, which it is at pains to criticise, but even for more generally trained and older consultants there is another factor which contributes to a narrowing of their knowledge base. This is the rate at which medical

knowledge has increased within specialties over the last thirty years. Not only has this encouraged greater specialisation within specialties, for example, neurosurgery within general surgery and nephrology within general medicine, it has made it increasingly difficult for doctors to keep up with developments within their own specialties, let alone those in other specialties. The existence of journal clubs in many hospital specialties testifies to this but does not solve the inter-specialty divergence of knowledge.

These factors have also had an impact upon the organisation of medicine within hospitals and the delivery of care to patients. Patients are referred to consultants in hospitals by general practitioners. Such referrals are made to consultants in specific specialties, for example, E.N.T. surgery, obstetrics, paediatrics, and particular wards and areas of the hospital are utilised by these specialties alone. There is segregation by specialty which means that invariably consultants work in isolation from one another. The result is that doctors in one specialty probably know very little about the details of work in most of the other specialties. They know what they are concerned with but they have few official contacts which might keep them abreast, in a meaningful way, of developments in other specialties, or remind them of things which have not changed and which they have forgotten through lack of usage. There are exceptions. Some specialties work together in certain aspects of their work, surgeons and anaesthetists work together in theatre, paediatricians and obstetricians have contact in relation to newly born infants, but in the main cross-specialty contact and exchange of knowledge is limited and hampered by the organisation of specialties in hospitals. This is not to say that organisation in this way does not have real benefits but it is certainly not designed to counter the pressures towards specialisation and separate specialty development.

In these ways the specialisation of individual doctors, the development of more esoteric knowledge within specialties and the way work is organised in hospitals operate against widespread cross-specialty knowledge among consultants.

To touch briefly upon the Committee of Divisional Chairmen, this committee is composed of a representative from each of the main specialties. As elected chairmen in the specialty concerned they are likely to be senior consultants. It will have been a long time since they received their general medical training. Development of knowledge has been considerable since then and the nature of their day-to-day work does not make it easy for them to keep abreast of what is going on in other specialties, in terms of either innovations in knowledge, or the realities of practice. This raises questions about their ability to judge requests and assess opinions and claims from other specialties if they relate specifically to those specialties. Do they know enough about other specialties not only to judge the validity of individual specialty claims, in the hospital context, but also the relative validity of claims and opinions from different specialties?

Autonomy and Specialty Development

For any group of doctors interested in a particular area of medicine a body of knowledge was not enough to mark them out as a specialty group. Problems of developing an institutional base mainly bound up with the control of resources on the part of physicians and surgeons have been considered in some detail, the short term solution was generally the establishment of special hospitals. Other issues were also involved. In the early stages not only were the older colleges unwilling to recognise such knowledge by providing special qualifications but also these developing groups, which felt they had a separate identity and different interests from the established specialties, found that in a number of arenas they were dependent for representation upon the older colleges. For example, up until the 1950's and 1960's pathology and psychiatry were only represented on bodies like the General Medical Council and the Distinction Awards Committee through the Royal College of Physicians. Concommitantly they had reduced influence over such things as control over standards of doctors entering the specialty, their suitability for the specialty and the representation of group interests on a broader level.

The desire for more appropriate examinations and separate legitimating

bodies was an attempt to remove themselves from the rather unsympathetic hegemony of the older Colleges. The reaction to the specialty diplomas of the Colleges and the Conjoint Board, which were designed to deter the separation, indicated that it was not just examinations but also self-determination. That is, to make themselves autonomous. Seen in this light the development of specialties can be viewed as a secondary process of professionalisation involving the quest for autonomy, but in this instance from the control of more powerful groups within the profession.

In this way, and through the necessity of specialty qualifications before consultant practice can be undertaken, specialties can be seen as autonomous groups within the profession. Through examinations and other activities specialties can therefore claim the control of practice and standards.

On the Committee of Divisional Chairmen individual specialties are represented. The chairmen of the divisions, fully-qualified in terms of experience and qualifications in their own specialty put forward the views, opinions and desires which their specialty colleagues have developed as a result of the perspective, position and work of their specialty. Any specialty viewpoint is arrived at through the mediation of expertise in that specialty and the particular contingencies which surround its practice in the hospital. If doctors have to pass stringent examinations and have considerable experience in a specialty before they can practise it then even if the members of other specialties are able, through their own knowledge, to comment upon views and claims from other specialties, then the factor of specialty autonomy raises the question of whether they will be willing to criticise or even comment upon matters raised or expressed by other specialties.

Specialty Differences and Status

Specialisation is not only a matter of differences in knowledge and the attainment of autonomy, it has other implications which have been elaborated upon by Johnson:

'Professionalism is associated with a homogeneous occupational community. Homogeneity of outlook and interest is associated with a relatively low degree of specialisation within the occupation and by recruitment from similar social backgrounds. Where the norm of "general practice" has given way to the proliferation of highly-specialised sub-groupings, the community identity of the occupation is threatened by divergent interests and "missions". It is likely then that a fully developed system of professionalism can emerge only where specialisation is relatively low. However, the culturally divisive tendencies of specialisation may be contained within an occupation already characterised by professional institutions. For example, the medical associations in Britain and the United States have been partly successful in containing the disruptive consequences of the increasing pace of specialisation by subordinating new specialties to the control of the dominant clinician and general practice groups.' ((19, p.53).

This view is certainly true historically insofar as the attempts made by the old specialties to control the new were partially successful but a lot of the newer specialties now have their own separate institutions and as yet the most recent super-specialties, within general medicine and general surgery have been content to remain within the two generic colleges. However, the relationship between the specialties will be examined in this section to analyse whether or not the historical advantages of general medicine and surgery have any impact upon inter-specialty relations in the present. Specialties through their development have, almost by definition, exhibited distinctive characteristics in relation to factors like their clientele, the nature of their work and so on and this seems to have contributed to specialty images. As Bucher comments following an examination of specialty journals:

'The expectation that there would be distinctive identities for medical specialties was more than borne out by this literature. The journals of each specialty were permeated

by discussions which conceptualised the specialty as a distinctive group, with a special area of study, a unique contribution to make to medicine, and special problems of implementation ... Further, the literature gave indications of some concommitants of specialty development. Foremost among these was a general disavowal or dissociation with inappropriate images, and a concentration upon new images of the specialty ... Surgeons did not want to be thought of as mere technicians ... Urologists still smarted under their origins as the doctors who treated venereal disease ... These substitutions of identification point to rhetorical battles which take part as a general struggle for position within the medical world on the part of the specialties.' ((20, pp.6-7)

In a similar way Zola and Miller remark upon the relative rate of development of specialties within medicine:

'The subgroups (segments) of the medical profession are not all of the same kind. Some are established and their claims to intellectual or technical superiority have been recognised. Internists and surgeons are examples of recognised specialties or established subgroups within medicine. Other subgroups of physicians are not so well established - for example psychiatry and physical medicine.' ((21), p.155)

Certainly the differences in character between the older specialties of general medicine and general surgery have been well documented in the distinction between the art of medicine and the trade of surgery with its present day hangover in the doctor/mister distinction. However, these rather sharp dichotomies still seem to have some meaning for doctors as Sir Robert Platt, president of the Royal College of Physicians recently stated:

'Surgeons, I suspect see themselves in a setting of glamour, conquering disease by the bold strokes of sheer technical skill. Physicians quietly remember that they were educated

gentlemen, centuries ago, when surgeons and apothecaries were tradesmen. They see themselves as the traditional thinkers of the profession.' ((22), p.83)

In talking to doctors it was clear that these images still had some present day reality in the way specialties conceptualised one another. A pathologist put it like this:

'The physicians are the intellectuals and the surgeons are the action men, they attract different kinds of people, the one thoughtful and introspective, the other impulsive and almost impatient.'

A gynaecologist made this distinction even clearer and suggested certain implications of such differences:

'You see I'm a surgeon, I act, if I don't know what's wrong then I open the patient up and have a look, whereas the physicians, they think too much. I saw a girl privately the other day about a gynaecological matter, although she was run down as well. She had been seing a physician in another hospital and it was obvious to me that she had X and Y but he hadn't seen those things because he was thinking too much. They're generally better at talking than we are because they think so much, and when you get a professor as well, they think a lot too, and when you have a physician who is also a professor well with that combination he can think and talk better than we can.'

For other specialties there were other images which seemed to be appropriate. One of the obvious distinctions is between clinical and laboratory medicine. A pathologist commented upon the type of people who went into laboratory medicine:

'There was a time when the perfect image of the pathologist was a man who wore a tweed jacket, flannels, didn't polish his shoes, smoked Capstan Full Strength and peed in the sink to avoid leaving his lab. I used to smoke Capstan until I took up the pipe. His lab was everything, he

lived in it, that's changed a bit now though, it's become a lot more scientific.'

At the same time, and possibly reflecting the lack of contact with patients there was a certain defensiveness on the part of laboratory specialties in referring to clinical specialties, as a bacteriologist said:

'Take the paediatricians, they're always going on about how difficult it is to find veins in young children and babies. It makes you sick, we have to find veins in rats and even smaller animals to inject them, and the veins are much smaller, and they have all that fur as well.'

And in slightly more pragmatic terms a radiologist referred to the position of radiology in the treatment process relative to that of clinicians:

'Those boys in medicine and surgery are probably more important than we are, they are in the front line, we are just the supply columns, they get all the emergencies, they are at the forefront of medical problems.'

These images and comparisons suggest certain strong contrasts between specialties. However, as expressed here these differences are not neutral, they contain notions of relative importance and status. In order to examine such differences there is a need to return to the broad patterns of specialty development and difference. Specialties developed from four main sources:

1. through movement into areas of treatment which had previously been spurned by the general physicians and surgeons;

2. through segmentalisation within general surgery;

3. through segmentalisation within general medicine; and

4. as a result of technological and scientific developments.

It has already been indicated that specialties were built upon esoteric collections of knowledge but in some cases it is clear that

the knowledge was not in limbo waiting to be picked up, it had been rejected by the major specialties of the time as being unworthy of consideration, partly because it was practised by quacks and in a more crucial way because it dealt with areas of the body which were seen as trivial or immoral. This was particularly true of eyes, ears, noses, throats and the genito-urinary system. Doctors who moved into these areas were ostracised and looked down upon by those in the mainstream of medicine. Over a period of time they did gain acceptance but they still carry the burden of being relatively narrow in their viewpoint and even in the present this factor still seemed to affect the way in which they were seen by more mainstream clinicians. The following discussion took place, in one of the Committee of Chairmen meetings, about special training for general surgery:

Mr. X (General Surgeon): You see what happens is that certain juniors who want to specialise in general surgery are selected for special intensive training.

Dr. Y (General Physician and Postgraduate Tutor): What happens to those who aren't selected? Do they get a second chance?

Mr. X: Well they don't, no, they have a lower level of training.

Dr. Y: Well what happens to them and the ones who fail the course?

Mr. X: Oh, they can do ENT or ophthalmology or something like that

The implication of this is that doctors do not have to be of such a high standard to practise in the sub-specialties. Similarly in another context a general surgeon was talking about the chairman of the Medical Staff Association, an Ear, Nose and Throat surgeon, who for some purposes would act as a medical liaison with the administration and the nursing staff. He thought this was bad because the chairman happened to be an ENT surgeon, and said:

'... why he's not even a clinician in the true sense of the word.'

The implication here is that ENT surgery is inferior to general sur-

gery in the nature of its practice.

Another example of this is psychiatry which again has associations with inappropriate images. Smith identifies the historical origins of psychiatry as being problematic:

> 'The historical background of psychiatry ... is involved in its marginal status. It has been said that psychiatry, born out of jails and almshouses had a more ignoble birth than other branches of medicine.' ((6), p.286)

Its approach is also radically different to other clinical specialties:

> 'One is causality - thinking in terms of unitary cause and effect rather than multiple determinants of behaviour. Second is the concern of medicine with parts rather than wholes. A third point is medicine's concern with what and how rather than why. And, finally, medicine has distrusted the validity of subjective data. These differences have contributed to the "outsider" status of psychiatry in medicine.' ((6), p.286)

In addition he mentions changes in psychiatric therapy and its links with disciplines outside medicine:

> 'The specialised technique of psychiatry has moved with time from a medically respected base in neurology to a psychodynamic orientation with emphasis upon psychotherapy. The peculiar techniques of psychotherapy, which might be called the unique skill of psychiatry in medicine, were developed outside the body of organised medicine and are, in fact, broadly shared with members of other non-medical occupations and professions.' ((6), p.285)

As was outlined above similar problems beset obstetrics, gynaecology, urology and venereology and the taboos concerning the sexual organs which had resulted in lesser mortals dealing with problems in these areas.

Initially of course these specialties were colonised by members of the two Royal Colleges but it is interesting to note that all of them have, in time, successfully sought and taken separate legitimation. They suffered from their subordination within the college structure.

The second type of development occurred within general surgery, for example, orthopaedic surgery, plastic surgery, thoracic surgery, neurosurgery. These specialties have chosen to remain within the College and it may be surmised that they are satisfied with the service which is given by the college to their interests, suggesting in turn that they have more legitimation within the college than the specialties of ophthalmology and otolaryngology, among others, were able to secure.

In medicine, the third category of development, there has been much less agitation for separate organisations. Cardiology, nephrology, neurology, gastroenterology and so on have apparently been happy with their position while, as mentioned already the specialty of psychiatry with its tainted background chose to move outside the college. While the majority of these developments restricted themselves to particular areas of the body there are two exceptions to this, paediatrics and geriatrics, these restrict themselves to particular age groups in the population. Their position is possibly less secure than that of the other specialties still within the college.

The final source of specialty development has been through technical and scientific innovation. This is particularly the case with the service specialties and all of them have decided to move outside the old college structure and form their own legitimating bodies, although anaesthetics has done this within the Royal College of Surgeons in the form of a faculty. This latter had the additional early disadvantage of widespread practice by general practitioners. As compared with general medicine and general surgery all other specialties appear to have suffered some disadvantages and in some cases continue to suffer from them. The main ones are:

1. links with inappropriate professional images;

2. not having patients of their own but acting in a service capacity for other specialties; and

3. restricting themselves to particular categories of patients or parts of the body.

It might be argued that some of these differences are associated with historical circumstances which have little influence upon the present. While more recent indices are limited it is possible to look at a number of areas which may indicate whether the historical advantages accruing to general medicine and general surgery influence the nature of the profession at the present time. There are three indicators available which provide some information on this, they are:

a. merit awards;

b. the popularity of specialties within the profession indicated by (i) medical student career preferences and (ii) the ease with which appointments can be attained in the various specialties; and

c. studies dealing specifically with the relative prestige and status of the various specialties.

a. Merit Awards

Merit or distinction awards were introduced in 1948 to reward merit in the National Health Service which prior to that would have been apparent in differences in salaries from private practice. They are awarded on top of the basic salary and as Stevens comments:

> 'The distinction system was created as, and has remained, an intraprofessional matter at a very high level. The overall number of awards is centrally controlled, but decisions on the allocation of awards are made by an advisory committee appointed by the Ministry of Health. This committee is in effect a symposium of the English and Scottish consultant bodies, including among others the presidents of the three English Royal Colleges and senior representatives of the Scottish Colleges.' ((12), p.213)

There are four awards and in 1975 they were worth the following:

A+ £7,947; A £6,030; B £3,540; C £1,506.

For the purposes of looking at the allocation of awards between specialties the number of awards at each level have been added together. These are shown in Table 3.1 (23). It would be a mistake to draw any definite conclusions from this ranking as at any point in the list the differences between consecutive specialties in terms of the percentage of awards received are relatively small. However, a number of broader points can be made.

First of all, the first eight specialties are all within the two oldest colleges of medicine and surgery and the next five specialties either were in the Royal College of Physicians or are still in it, for example, dermatology. Secondly, the fringe specialties of the eighteenth and nineteenth centuries are at the bottom of the list, venereal disease, psychiatry, ophthalmology, ENT surgery. A number of individual comparisons are also of interest. Radiotherapy is higher than radiodiagnosis, radiotherapists treat patients, radiodiagnosticians do not. Paediatrics is much higher than geriatrics. General medicine, with 12.9% of consultants has 19.2% of the awards, whereas anaesthetics with 11.1% of consultants has only 5.7% of the awards. It is difficult to know what precise inferences can be drawn from these figures. It has been argued that they reflect to some extent the biases of representation on the awarding committees which still accrue to the older colleges but this does indicate that in one area where merit within the profession is visible on a specialty basis the historically advantaged specialties still do better than those which have emerged since then. However, at least some of the following conclusions may be true:

1. some specialties are more important to the service than others;
2. some specialties contain more talented people;
3. some specialties are more easily defined in terms of merit than others;

Table 3.1. Allocation of Merit Awards in Scotland, 1974. (23)

Specialty	% of Specialty With An Award	% of Consultants in the Specialty	% of the Total Awards Held By Consultants in Each Specialty
Surgical Neurology	73.3	0.9	1.8
Thoracic Surgery	72.7	0.6	1.3
Plastic Surgery	58.3	0.7	1.1
Paediatric Surgery	58.3	0.7	1.1
General Medicine	53.1	12.9	19.2
General Surgery	52.1	9.1	13.4
Neurology	43.7	0.9	1.1
Paediatric Medicine	43.4	3.1	3.7
Pathology	43.1	5.1	6.2
Microbiology	41.0	3.6	4.1
Dermatology	40.7	1.6	1.8
Haematology	40.6	1.9	2.1
Clinical Chemistry	39.3	1.6	1.8
Radiotherapy	38.5	1.5	1.6
Ob/Gyn.	34.5	6.6	6.4
Orthopaedics	32.5	4.7	4.2
Dentistry	32.2	3.4	3.1
Radiodiagnosis	30.6	5.7	4.9
Infectious Diseases	29.4	1.0	0.8
Respiratory Diseases	28.9	2.2	1.8
ENT Surgery	25.5	3.0	2.1
Ophthalmology	23.0	3.0	2.0
Anaesthetics	18.8	10.6	5.5
Geriatrics	18.7	2.8	1.5
Psychiatry	18.4	11.1	5.7
Venereal Disease	11.1	0.5	0.2

4. the allocation indicates the internal status system of the profession, in view of the fact that the profession is responsible for the allocation and if this in turn merely reflects advantages of representation then these also cannot be ignored as present day indicators of the differential status and influence of specialties within the profession.

Whatever the reason it would point to present day advantages in status and prestige for general medicine, general surgery and their related specialties.

b. The Popularity of Specialties Within the Profession

(i) Medical Student Preferences

Another way of looking at the status or popularity of specialties is to consider medical student career preferences. While student experience of the various specialties is limited by the medical curriculum this provides a good idea of how they have seen those specialties within medical school. In addition, because specialisation begins soon after graduation such information is close to the time when student career choice points occur and if they are subsequently unsuccessful in following their student preference this is as likely to be due to competition for limited specialty places as it is to any change in the perceived desirability of different areas of practice.

The Todd Report (18) investigated student career preferences and these are shown in Table 3.2 (the figures for students intending to enter non-hospital specialties have been removed and the remainder expressed as a percentage of those wanting to enter hospital practice). In the same table the percentage of consultants in the various specialties are given according to the merit award list in Table 3.1. While there are problems in this comparison because it takes no account of changing percentages and differing age structures of consultants in any specialty it is one way of making sense of the relative popularity of specialties as preference will to some extent be a function of specialty size. The following points can be extrapolated from the comparison of specialty preferences and consultant posts:

Table 3.2. Medical Student Specialty Preferences. ((18), p.359)

Specialty	Number of Students	% of Students Wanting To Enter Each Specialty	% of Consultants In Each Specialty
Medicine (inc. Cardiology, Neurology)	269	22.1	13.8
Surgery (inc. Neuro. and Thoracic)	241	19.0	11.3
Ob/Gyn.	223	18.3	6.6
Paediatrics	193	15.9	3.8
Psychiatry	94	7.7	11.1
Traumatic/Emerg.	48	3.9	4.7
Anaesthetics	35	2.9	10.6
Pathology	32	2.6	5.1
Ophthalmology	21	1.7	3.0
Basic Medical Science	19	1.6	
Radiology/Radiotherapy	15	1.2	7.2
Dermatology	12	1.0	1.6
ENT Surgery	9	0.7	3.0
Microbiology	5	0.4	3.6

a. some specialties are more attractive to medical students than others, these are general medicine (including cardiology and neurology), general surgery (including neurosurgery and thoracic surgery), paediatrics and obstetrics and gynaecology. These are all specialties high on the merit award list;

b. this conclusion is drawn because the proportion wanting to take up these specialties are well in excess of the proportion who will be able to reach consultant status, this means that these specialties will have considerable choice in selecting newly qualified doctors for these specialties;

c. other specialties are undersubscribed in terms of the proportion who want to enter them, for example, radiology, anaesthetics, ENT surgery;

d. this implies that these specialties will recruit some doctors whose first choice was not among these specialties; and

e. such people will go through their medical careers in specialties which are second choice for them.

It is not the intention here to draw any definite conclusions from this but the figures here point in the same direction as the merit award allocation.

There is also some evidence in a study by Martin et al, based on a sample of medical students throughout Britain, that academic ability among specialty recruits varies considerably:

> 'There are significant differences in the academic record of recruits to the main branches of medical practice. Recruits to pathology, bacteriology, basic medical sciences and internal medicine include the highest proportion of distinguished graduates, and recruits to general practice, obstetrics and gynaecology, include the highest proportion who failed examinations. At both extremes the difference from the distribution of examination pass rates in the class as a whole is significant at the 1% level.' ((24), p.815)

Graduates with honours by specialty recruitment are as follows:

Internal Medicine	7.7 %
Basic Sciences, Pathology, Bacteriology	6.7 %
Paediatrics/Psychiatry	4.9 %
Surgery	3.5 %
Anaesthetics/Radiology	3.1 %
Obstetrics/Gynaecology	2.8 %
Dermatology, ENT, Eyes	2.8 %
General Practice	0.98%

While the picture is less clear here in both the pattern of merit awards and student preferences general or internal medicine comes out on top.

(ii) Competition for Specialty Posts.

The next indicator is the potential ease with which junior medical staff can obtain senior posts in different specialties. Figures on this are calculated by the Department of Health and Social Security on the basis of information such as the number of posts coming available each year and the number of applicants for posts. Prospects of obtaining senior registrar and consultant posts by specialty are shown in Table 3.3. The precise order in which specialties appear in the list is not significant because the basis of the ranking is the number of stars awarded to specialties. However, a broad indication of popularity and the equation of that with prestige can be obtained in looking at the specialties in which it is very difficult to obtain a post and those in which it is comparatively easy. Following the pattern involved in merit awards and student preferences it is most difficult to obtain posts in general medicine, general surgery and their related specialties, along with one or two others like obstetrics and gynaecology and infectious diseases. Similarly the bottom of the list is dominated by psychiatry, anaesthetics, geriatrics and venereology, it is relatively easy to gain senior registrar and consultant appointments in these specialties.

Table 3.3. Career Prospects at Senior Registrar and Consultant Level in England and Wales, 1973. ((25), (26))

Specialty	Prospects for Senior Registrar Posts	Prospects for Consultant Posts
General Medicine	*	*
Cardiology	*	*
Nephrology		*
General Surgery	*	*
Neurosurgery	*	*
Paediatric Surgery	*	*
Ophthalmology	*	*
Urology	*	*
Obstetrics and Gynaecology	*	*
Infectious Diseases		*
Neurology	*	**
Nuclear Medicine		**
Chest Medicine	*	**
Thoracic Surgery	*	**
Plastic Surgery	*	**
Orthopaedic Surgery	*	**
ENT Surgery	*	**
Clinical Physiology		**
Physiology		**
Radiotherapy	**	**
Paediatrics	**	***
Dermatology	**	***
Forensic Psychiatry		***
Blood Transfusion		***
Adult Psychiatry	**	****
Haematology	***	***
Histopathology	***	***
Rheumatology/Rehabilitation	****	****
Medical Microbiology	****	****
Neuropathology		****
Immunopathology		****
Radiology	****	*****
Mental Handicap	*****	****
Chemical Pathology	*****	*****
Child Psychiatry	*****	*****
Anaesthetics	*****	*****
Geriatrics	*****	*****
Venereology	*****	*****

NB. The gradings ***** to * refer to the prospects of obtaining a post at senior registrar or consultant level. Five stars indicates that the prospects are excellent, one star denotes severe competition for posts.

c. Studies Concerned Directly with the Relative Status of Specialties

A number of studies have looked directly at specialty status, although two of the three mentioned here were conducted in America and it would be unwise to attach too much importance to them in the British context. Shortell (27) makes use of a typology of doctor-patient interaction developed by Szasz and Hollender who suggest three main forms of doctor-patient interaction:

Active-Passivity:	in which the physician actually does something to the patient and the patient acts as a passive recipient.
Guidance-Co-operation:	in which the physician tells the patient what to do and the patient co-operates.
Mutual Co-operation:	in which the physician helps the patient to help himself and the patient acts as an active participant.(28)

Shortell uses this to construct the following hypothesis:

> 'Specialties which adhere to the more active-passivity model of doctor-patient relationship will receive higher prestige ratings than those which adhere more to the guidance co-operation model and the latter, in turn, will receive higher ratings than those specialties characterised by the mutual participation model.' ((27), p.2)

This related to control over patients. His alternate hypothesis concentrates upon the degree of specialty autonomy:

> 'The higher a specialty's functional autonomy, defined as being least infringed by other specialties, and vice versa, the higher its prestige.' ((27), p.2)

He administered a questionnaire to doctors, hospital patients and graduate business students and asked them to rank the specialties. He concludes, following analysis, that:

'The data suggests ... the basic nature of the relationship between the specialist and his patient is much more related to a specialty's prestige than its ability to carve out a separate domain over its work.' ((27), p.6)

This is not all that surprising in the light of the material that has been covered above because the apparently less prestigious specialties have had little difficulty in carving out a separate domain for themselves, the older specialties while being defensive showed no desire to move into the areas of work like venereal disease, radiology and so on. Shortell's final ranking list is shown in Table 3.4.

Schwartzbaum et al conducted a similar study although they did not have hypotheses about the reasons for the particular order in which specialties were placed (29). His results are also shown in Table 3.4. Finally, there is a study by Hudson (30). He was not concerned with status or prestige as such but inferred these attributes from the status of the schools which consultants in the various specialties had attended. His sample was also restricted. He looked at all the doctors in Who's Who? and classified them according to specialty and attendance at English Headmaster's Conference Schools. His ranking is based upon the percentage of doctors in a specialty who attended such schools. His conclusions owe more to anatomy than any other variable:

'In summary, we may say that those specialties concerned with the living as opposed to the dead, the head as opposed to the lower trunk, the male as opposed to the female, and the surface of the body as opposed to its insides, are in each case more likely to come from English HMC schools than one would expect by chance.' ((30), p.22)

Hudson's ranking is also shown in Table 3.4.

The rankings produced by these three studies present a less unanimous picture than those which arose from more objective measures like the allocation of merit awards and competition for jobs. This is understandable in view of the arbitrary judgements which must be made in

Table 3.4. Specialty Status Ranking in Three Studies

Shortell (27)	Schwartzbaum (29)	Hudson (30)
Thoracic Surgery	Neurosurgery	Plastic Surgery
Neurosurgery	Internal Medicine	Ophthalmology
Cardiology	General Surgery	Dermatology
Neurology	Thoracic Surgery	Internal Medicine
Internal Medicine	Ob/Gynae.	Otolaryngology
Ophthalmology	Ophthalmology	Urology
Plastic Surgery	Neurology	Paediatrics
Pathology	General Practice	Orthopaedics
Orthopaedics	Radiology	Thoracic Surgery
Radiology	Orthopaedics	Anaesthetics
General Surgery	Paediatrics	General Surgery
Paediatrics	Education	Neurology
Gastroenterology	Psychiatry	Cardiology
Obstetrics and Gynaecology	Pathology	Psychiatry
Psychiatry	Otolaryngology	Pathology
Urology	Anaesthetics	Dental
Otolaryngology	Proctology	Gastroenterology
Anaesthetics	Dermatology	Pharmacology
Social Medicine	Allergy	Ob/Gyn.
Dermatology	Social Medicine	Bacteriology
Allergy	Occupational Medicine	Anatomy
General Practice	Administration	Social Medicine
Physiatry		Physiology
Dental		

ranking a list of twenty or more specialties. Accepting the limitations imposed upon any attempt at comparison the ranking produced by Shortell and Schwatrzbaum do not run counter to the picture developed above. The top half of the rank order in both of these studies tends to be dominated by general medicine, general surgery and their related specialties. Five specialties appear in the first seven in both rankings, thoracic surgery, neurosurgery, neurology, internal medicine and ophthalmology. Hudson's study is slightly different and was not concerned with rank order as such but school attendance, it is therefore much more difficult to draw any specific conclusions.

This section has examined the relative prestige and status of specialties within medicine and the extent to which the historically dominant specialties have continued to hold pride of place within the profession. In looking at such indicators as merit awards, medical student career preferences, job opportunities and less formal types of ranking one constant feature has emerged, general medicine, general surgery and the specialties which have developed within them have pre-eminence within the profession.

To look briefly at the Committee of Divisional Chairmen, this committee is a representative body of the profession, and yet some parts of it, if the national picture is anything to go by, would appear to have more prestige than others, specifically general medicine and general surgery. This body will in large part determine the nature and future of the practice of medicine within any hospital, in as far as these things can be determined at the local level, for example, staffing changes are proposed locally, facilities and equipment are chosen and so on. Zola and Miller have suggested that the internal relations of the profession have implications for the direction in which the profession moves:

> 'The members of a specialty are a constituency within medicine whose common interests and purpose lead them to wield power to guide the policies and practices of medicine, supposedly for the good of all but particularly to advance their special interests and facilitate the purpose of their group. When referring to the organisation of the medical profession, we

have in mind the interrelationships of these sub-groups and assume the actual organisation of medicine to be, at any time, determined by the activities and tactics of these sub-groups.' ((21), p.156)

This would suggest that what comes out of the Committee of Divisional Chairmen, in terms of the overall pattern of decisions which affect the future of medicine, will in some way reflect the stature and prestige of general medicine and general surgery rather than other specialties.

The Features of Specialisation: A Summary

The aim of this section on specialisation in medicine has been to draw out the key elements of that aspect of the profession because it is the unit of organisation at the level of the Committee of Divisional Chairmen. Before looking at the impact of these factors upon the structural feature of role conflict it will be useful to give a brief overview of these elements.

Inter-specialty Knowledge

The development of specialties in medicine was seen as being partially characterised by the movement into and development of distinct areas of knowledge and practice. As these areas of knowledge became enlarged practice in any specialty demanded experience and learning and the manifestation and legitimation of this, specialty qualifications. Qualifications have since become the sine qua none of consultant appointments in any specialty in medicine. At the same time it was indicated that the segregation of specialty practice in hospitals gives little opportunity for inter-specialty contact on a day-to-day practice oriented basis, apart from particular specialty links such as surgery and anaesthetics. Another factor has been the speed of change in medical knowledge which has made it increasingly difficult for a doctor to keep abreast of developments within his own specialty let alone those in other specialties.

As a result of this it was argued that consultants probably have limited knowledge of what goes on in other specialties on a day-to-

day basis and that through lack of contact and speed of change they find it hard to remember or keep up with changes of practice in other specialties unless they have specific contacts with them.

Specialty Autonomy

The second feature is specialty autonomy. At the national level in the latter part of the nineteenth century and throughout this century, various specialties other than general medicine and general surgery sought some independence from the two specialty colleges. This was linked with specialty knowledge and its legitimation through specialty qualification, and the influence which they desired but could not have upon the profession and external organisations. Those specialties which wanted autonomy have now gained it through separate colleges or largely autonomous faculties. Claims to autonomous specialty control were taken or grudgingly acceded to. In the same way that individual autonomy was seen to be a value of the individual practitioner, specialty has its own related dimension. In clinical terms this is recognised by the need for experience before practice can be undertaken at consultant level in any specialty, the need for specialty qualifications and the existence of separate national specialty organisations.

Inter-specialty Status

Leading on from these two points is the question of specialty prestige. The other two features of knowledge and autonomy were biased in historical terms. Some areas of practice and knowledge were eschewed by general medicine and general surgery because of their narrow concern or their dubious morality. Some specialties always had autonomy, others had to fight for it. Historically the controlling groups were general medicine and general surgery. An attempt was made to see if these advantages are carried over to the present day. Few indices are available but those which exist suggest that general medicine and general surgery and the specialties which have developed within their respective colleges and stayed within them still have more status, prestige, merit and popularity than those which developed after them or chose to move outside of them.

The Committee of Divisional Chairmen, Role Conflict and the Characteristics of Specialisation

The last part of this chapter will look at the interaction of the features of role conflict associated with the design of the Committee of Divisional Chairmen and the specialty characteristics of knowledge, autonomy and status.

There are four possible solutions to the role conflict for the members of the committee:

1. the representation of specialty or divisional claims and interests is seen as the most important expectation and the committee is either used for the ratification of specialty requests or decisions are structured by arguments between specialty interests;

2. the hospital decision-making expectation is seen as most important and decisions will be made on the basis of broad consideration about the nature of patient care and the overall service provided by the hospital;

3. there will be a compromise between these two alternatives; or

4. situations or decisions in which the two expectations conflict will be avoided altogether.

There will now be an examination of the implications the characteristics of specialisation have for the attractiveness of these alternatives.

Inter-Specialty Knowledge and Role Conflict.

How do the limitations of inter-specialty knowledge affect the choice of role conflict solutions? If chairmen know little about the day-to-day practice in other specialties and find it hard to keep up with changes in knowledge and practice in other specialties then this would suggest that they are not in a good position to judge requests for staff, equipment, changes in specialty policy and so on which are raised by chairmen from other specialties. This implies that they will not be able to take the broad hospital decision-making expectation. Not only is their own perspective limited by their own knowledge base, in addition, they may find it difficult to judge issues which they

know little about. In this case the easiest option is to take the word of the specialty chairman concerned - as long as the decision does not involve a choice between specialties - accepting the fact that the chairman concerned knows more about the situation than they do. Alternatively they could avoid such decisions, which would be difficult as many decisions have to pass through the committee, or make some compromise. The main point is that they will not find it easy to take the hospital decision-making expectation.

This particular problem is likely to arise in any decision which involves a matter internal to a specialty, for example, innovations in practice or applications for additional staff.

Specialty Autonomy and Role Conflict.

The second influence, specialty autonomy, can be expected to act in a similar way. The chairmen represent autonomous specialty groupings and in bringing any request or opinion to the committee have the weight of their specialty colleagues behind them, it is not only their view, it is the view of their specialty. To reject any specialty viewpoint or request is to deny the autonomy of that specialty to determine its own position and practice. Because of this, chairmen will be unwilling to deny claims from other specialties, and here the argument is the same as that applied to the individual consultant in the division.

All the chairmen value the autonomy of their specialty and again the long-term process of the committee must be considered. All chairmen will find that their autonomy is on the line at some time or other and to deny the autonomy of others is to set a precedent which opens the way to the denigration of the autonomy of all specialties on the committee.

As a result the hospital decision-making expectation would appear to be the least desirable of the alternatives. Furthermore, the representation and ratification of individual specialty requests and opinions would appear to be the expectation most in tune with the

maintenance of specialty autonomy. Alternatively they could avoid decisions which might compromise specialty autonomy, but avoidance is not always possible and to avoid saying 'no' to a specialty request is to say 'yes'. Finally, the compromise solution is a possibility but in this forum it is difficult to see what form compromise might take.

However, the Committee of Chairmen will not always be able to agree with everything which every specialty wants. They operate within a system where resources are limited and ratification cannot always be the lot of all specialty requests. Sometimes choices have to be made between alternatives, for example, in deciding what items to buy with the budget for medical moveable equipment, or coming to decisions about policy as regards visiting hours. In such situations some specialties will be successful, others will not. This brings us to the third feature of specialisation.

Differential Specialty Status and Role Conflict.

The two features above indicate the barriers between the profession and the hospital decision-making expectation. In the first case they are more or less unable to make decisions which require inter-specialty knowledge, and in the second they are unwilling to do so because of the threat this presents to specialty autonomy. As a consequence the system will tend to focus upon the specialty representation expectation. It is unlikely that chairmen will be able to lend their support to everything, either because of shortages of money or the need for a single unqualified statement on an issue. In these cases how will decisions be made? The chairmen have a specialty mandate to put forward their division's case and because of the difficulties associated with a broad outlook it will be hard for them to step back from decisions in which they are competing with others for resources or the acceptance of their specialty's line on an issue. It may therefore be argued that when decisions do not allow for specialty ratification or acceptance of all specialty viewpoints the decision will be dependent upon the interaction between the specialties. Furthermore that success will be determined not so much by the rationality of claims or opinions in

the light of hospital needs (as the Joint Working Party reports suggest) but by the ability of any specialty to get its claim accepted. Decisions will reflect the relative influence of different groups within the profession.

Following on from the discussion of status within the profession it is clear that if any groups have a better basis for influence than others they are general medicine and general surgery. They have more status and prestige reflected in things like the allocation of merit awards, the popularity of their specialties and the competition to obtain posts in their specialties. If decisions do become a matter of argument between specialty interests then general surgery and general medicine should have the most going for them in gaining acceptance for their requests and opinions.

Although at this stage the concern has been to paint in the structural backcloth against which the process of the divisional system will take place, certain areas of action can be examined in relation to what might happen when the chairmen on the committee cannot avoid making decisions between specialty claims and viewpoints.

As Zola and Miller (21) point out specialties and groups within medicine have particular interests and purposes which are peculiar to them and may be either concrete or general. It has already been argued that the structure brings about a distinct change in medical organisation which has implications for the expression of these interests and purposes. Previously under the firm system specialties were unco-ordinated and fragmented into units, indeed one aim of the divisional system was to bring together medical viewpoints and facilitate their expression. However, this means that specialties are no longer just <u>of</u> themselves with interests in common but not necessarily acted upon. The structure creates specialty groupings which, by the nature of that structure, are <u>for</u> themselves. Furthermore, if the structure is set up and adhered to in its recommended form, they can only be <u>for</u> themselves in one arena, the Committee of Divisional Chairmen. Most specialty interests and purposes have to gain the acceptance of the Committee of Divi-

sional Chairmen before they will be accepted by the higher levels of the structure or the administration at the local level.

If specialties find that they cannot get what they want through the mediation of the variables of knowledge and autonomy identified above, or if choices have to be made between specialties, then it may be anticipated that specialties will try to get what they want as interest groups. Because this is an option in the possible process of the Committee of Divisional Chairmen it will be useful to look at the nature of interest groups on a more general level, and this may inform the discussion of the process of the system should such activity take place.

Divisions and Interest Group Activity

Interest groups have been defined by Ehrman as:

> '... voluntary association(s) of individuals who band together for the defence of interest.' ((31), p.486)

Such a group may also be active and should the group attempt to influence others, which the defence of interest may well involve, then the interest group is also a pressure group, which Moodie and Studdart-Kennedy see in the following terms:

> 'By pressure group we mean, simply, an organised group which attempts to influence government decisions without seeking itself to exercise the formal powers of government.' ((32), p.60)

Interest and pressure groups have been studied mainly in the context of national and local politics, as in the work of Dahl (33) and Polsby (34) and in that context have been a part of broader arguments about the nature of the democratic process in the United States. This revolves around the question of whether interest or pressure groups improve or destroy the constitutional democratic machinery. People in the Dahl camp have tended to argue that the opportunities for involvement in the political process are there for any group which cares to organise itself and that through this, participation in political decision-making can be broadened to cover interests

which want to have an influence and which cannot find access through a geographically derived political system. Opposition to this analysis has come from a variety of sources. The most renowned are the studies of Mills (35) and Hunter (36). Their argument is broadly that there is an elite in America which controls the political decision-making process for its own ends and thereby subverts the democratic process. Mills, at least, sees the elite of the military, industrial and political complex as being relatively fixed, but in terms of Dahl's position that can be interpreted by saying that these groups have access and others do not, that the system is therefore not open to all and that some groups have influence and power and others do not even have a chance of acquiring them. This is not the place to present a detailed analysis of the very different conclusions which accounts of the same system have produced but a brief overview of some of the factors in this will prove useful. One major area is the reasons why such different conclusions have been reached. There appear to be three factors in this.

First of all, the ideological position of the writer. Ricci (37) has argued that the results of studies have been affected by the political perspective of the writer, mediated by disillusion with naive ideas about democracy. In this Dahl is seen as offering an apologia for the system, and Mills is viewed as taking a Marxist swipe at the system. Secondly, there is the discipline of the writer. Sociologists have tended to produce elitist conclusions, political scientists have drawn pluralist conclusions. Bacharach and Baratz (38) tie this to differences in disciplinary approach. They say that sociologists tend to ask 'Who runs this?' rather than 'Does anybody run this?', that they assume stability in the power structure and that they equate reputed with actual power. On the other hand, political scientists are criticised for the way in which they have employed decision-making analysis. This is partly because they take no account of any restriction of decision-making to safe decisions and also because they have no criteria for distinguishing important from unimportant decisions. The third factor is the methodology used by the writer which to some extent follows the

disciplinary breakdown, there are three main study approaches, the reputational, the postional and the decision-making analyses. The reputational method, used by Hunter (36), utilises people's assessment of who is powerful and has influence. This has been criticised from a large number of standpoints, as Rose has commented:

> 'If a reputational analysis yields a power structure similar to that revealed by the positional approach, or for that matter any more direct approach, its critics denounce its claim to expert inside knowledge, for if it appears that power is not exercised incorrectly, there is thus no need to employ an indirect method of study. If, however, reputational analysis yields a power structure different from anything determined by more direct methods, its critics claim there is no basis for validation.' ((39), p.266)

The positional approach assumes congruency between power or influence and position in any official or semi-official hierarchy and thus cannot deal with any informal influence. The issue analysis approach analyses decision-making processes and this invariably produces pluralist conclusions. The criticisms of Bacharach and Baratz (38) of the way this approach has been used have been mentioned above. Their criticism has not been of that approach as such, rather they suggest that it has been used in ways which ignore crucial elements of political and interest group activity. Since the methodology of this study will involve descriptive and analytical accounts of the way in which decisions are made within the divisional system it will be worthwhile looking at the gaps which Dahl, among others, has been criticised for. These can be looked at under two broad headings.

The Selection of Issues.

One criticism has been that Dahl chose issues in which conflict over a decision was apparent. Ricci suggests that this choice may be unreliable for two reasons. First of all, in terms of salience, the elite, or the more powerful groups may not be interested in certain issues and may not participate at all, or to the full extent of their

resources, when a conflict occurs. Danzger has dealt directly with this problem:

> '... two elements determine which actor is dominant in a conflict: resources and the desirability of the goal. If power is considered to be potential ability (rather than willingness) to effect a favourable outcome (in other words possession of the requisite means or resources - which in turn provide lines of action), then to determine power we must be able to separate this potential ability from the importance of the goal.' ((40), p.715)

Secondly, if issues where conflict flares are considered then the result of the conflict may lead to the conclusion that it has been democratically arrived at. It may be more important to consider issues where conflict does not surface as these may indicate that power is so rooted as to be unopposed. This is linked to a point made by Freidrich in his rule of anticipated reactions:

> '... certain people do not have to be involved in a decision to get what they want.' ((41), p.589)

In this case if people or groups are recognised by other participants as being more powerful then they may not have to exert any influence to get what they want. A similar concept has also been used by Scott in his work on horse racing. His concept is the 'deference boon' which he describes as:

> '... the unstated, largely unconscious, co-operation of individuals to permit a rival of higher social status to succeed in a competitive game.' ((42), p.61)

These criticisms are partly concerned with the way in which issues are selected for analysis and equally importantly the way in which they are analysed, in terms of the construction which is put upon particular events. Powerful groups, if they exist, may not exercise power on the course of every issue, and even on issues which are salient to them, they may not have to exercise power because their wishes may be anticipated.

Non-Decision-Making.

The other main group of criticisms is concerned with biases which exist before the issues which are open to analysis come on the scene. This view of politics has been expressed chiefly by Bacharach and Baratz (38) and Schattsneider (43). The basic idea in this is that all forms of organisation are biased in favour of some groups and against others:

> 'All forms of political organisation have a bias in favour of the exploitation of some kinds of conflict and the suppression of others because organisation is the mobilisation of bias. Some issues are organised into politics while others are organised out.' ((43), p.71)

This is put into a decision-making context by Bacharach and Baratz:

> '... power is exercised when A participates in the making of decisions which affect B. But power is also exercised when A devotes his energies to creating or reinforcing social and political values and institutional practices that limit the scope of the political process to public consideration of only those issues which are comparatively innocuous to A. To the extent that A succeeds in doing this B is prevented for all practical purposes, from bringing to the fore any issues that might in their resolution be seriously detrimental to A's set of preferences.' ((44), p.948)

This approach is not without problems as non-decisions are difficult to grapple with, however, they do suggest a basis for an approach which avoids the problems of taking issues which appear and taking them in isolation from their context. They suggest that the researcher should approach this by:

> '... investigating the particular "mobilisation of bias" in the institution under scrutiny. Then having analysed the dominant values, the myths and the established political procedures and rules of the game, he would make a careful enquiry into which persons or groups, if any, gain from the bias and which, if any, are handicapped by it. Next, he would investi-

> gate the dynamics of non-decision-making ... Finally, using his knowledge of the restrictive face of power as a foundation for analysis and as a standard for distinguishing between 'key' and 'routine' political decisions, the researcher would, after the manner of the pluralists, analyse participation in decision-making of concrete issues.' ((44), p.952)

In the American context there are many groups which might participate in the political process at either the national or local level, the argument outlined earlier has been about the extent of involvement and/or influence of these groups. Dahl argues that all groups can and do participate if they want to, Mills argues that even if participation is relatively open influence is not and that the number of people or groups which do have influence and power is sufficiently small for the term 'elite' to be applied to them. It is therefore possible to see this dichotomy in terms of a continuum with pluralism at one end and elitism at the other. In the light of the above criticisms any attempt to discover what the situation really is would have to examine three major factors which are crucial in determining the nature of the political system. These are:

1. The bias of organisation or an analysis of the extent to which the basic structure of politics bestows advantages on some groups rather than others, if advantages did exist preconditions would exist for a system which approached the elitist end of the continuum.

2. The distribution of political resources. If resources used in politics were unequally distributed then this too would be a precondition for a system which approached the elitism end of the continuum.

3. The use of resources by interest groups. This would involve an analysis of decision-making, bearing in mind the issues of decision-making and non-decision-making, salience, the law of anticipated reactions and the other below-the-surface factors which may be important indicators of the nature of the political process.

The divisional system is not the same as national politics and before a brief look is taken at the way in which these factors might be used in the divisional context the major differences between the interest group situation in politics and the interest groups in the divisional system will be outlined.

The Divisional System and Interest Groups: A Comparison

There are three major qualitative differences.

a. The degree of structure involved.

In the political system the amount of contact between the interest or pressure groups themselves is relatively limited. While some of them may meet together to decide common ground, and some of them may be co-opted either formally or informally, their main interest is in influencing government and they tend to do this separately, they do not argue their interests out with one another, they argue their case with and lobby the government. In the divisional system, however, the interest groups meet together to decide what they as a group want or which of their various interests are going to receive the effective support of all the other interest groups. They have formal access but the power they exercise, if they do exercise power, is first of all in terms of their relationship with one another, and secondly in terms of the power of the committee as a whole in relation to the administration. While this situation is more structured this does not rule out informal politicking with either other interest groups, or the administration, but if the structure works as it is recommended then the results of that politicking have to pass through the forum of the Committee of Divisional Chairmen. What is of interest here is the extent to which groups are more influential in their relations with one another rather than how influential they are separately in relations with the administration.

b. The spectrum of involvement.

Related to this is the fact that the Medical Advisory Structure has been designed to represent all medical interests equally or at least the major specialty groupings. In the political system the extent of access to government may vary between groups and is one of the possible signs of bias in the organisation.

c. The outcome of interest group interaction.

In Dahl's terms pluralism is supposed to come up with the 'will of the people' in so far as it is seen as supplementing the basic system of democracy. The divisional system has been designed to produce something a little more exact than that. The Committee of Chairmen is not supposed to facilitate the achievement of what different groups want, its objective is:

> '... the establishment of a medical organisation ... which can give good advice to management.' ((3), para. 147)

Put in a slightly different way, pluralism is hallowed for its method rather than its outcome, or at least the outcome is justified by the method. If all groups can become involved, then the system is, by definition, good. In the Medical Advisory Structure all groups are involved or represented from the start so the mere fact of involvement or opportunity for involvement can hardly be a measure of the 'goodness' of the system. The structure goes further, all groups are involved and are supposed to come up with 'good advice to management' and presumably this means more than just 'good advice is any advice that is the product of the full representation that is provided through the divisional system'.

The first two differences are largely ones of degree, degree of structure and degree of involvement, they put more emphasis upon the interaction between the groups than between individual groups and government. These do not radically effect the potential utility of the concepts used in the analysis of political decision-making. The last difference brings us back to the problem we started with, whether the groups or their representatives will be concerned mainly with their own interest or the interest of the hospital as a whole. It should be remembered that while all the evidence concerning the structure of the medical profession and the divisional system itself points to a system based upon specialty interests this may be overcome by the participants. Even if they do primarily take the specialty representation role they may successfully avoid issues which involve them in making decisions between specialties. However, if they have to make these decisions

and they turn into an argument between interests then we want to have concepts which can deal with that eventuality. The last section of this chapter will therefore look at the three factors of the bias of organisation, the distribution of resources and decision-making.

The Divisional System as an Interest Group Process

The concern here is to look briefly at the three factors which determine the kind of political system which results from interest group interaction, in terms of the two extremes of equal involvement and influence, and elitism.

The Divisional System and the Bias of Organisation.

The Committee of Divisional Chairmen, the official forum in which any interest group action will take place, provides for the representation of all groups. However, it should be remembered that this committee is derived from the interests which make themselves evident in any hospital, the profession chooses the interest groups it wants. It is possible that through discussions within the profession some groups will be represented on the committee and others will not. This would be taken as a sign of bias in organisation which might be a precondition for greater influence for some groups and less influence for others. In the analysis there will therefore be a concern with the way in which the structure is set up, the people who organise first, those who get left out, if any, and so on. It will be desirable to know if the actual organisation in any hospital seems to favour some groups or be potentially detrimental to others. The importance of the status differences within the profession comes in here as well. The structure is not a neutral entity, it will be constructed out of the profession and the profession brings to it characteristics which may affect its shape. In line with the analysis in previous pages we would expect that if any biases exist they will favour general medicine and general surgery rather than other groups.

Specialties and Political Resources.

Again at this stage we do not know exactly what political resources will be used, if any are used, in the divisional system. However,

in terms of hospital resources the specialties of general medicine and general surgery would seem to have advantages if any groups have them. They generally have more staff, more beds, more space and equipment than most other specialties and these might be used as political resources. In the same way if something like the deference boon is seen as a resource then the physicians and the surgeons will probably be the ones who are in receipt of it and this might also be an aid to success. Again political resources in themselves do not mean that the structure will regularly favour or be dominated by some groups rather than others, but if there is benefit to be had from this element general medicine and general surgery would seem to be in the best position to reap it.

The Use of Resources by Specialties or the Outcome of the Divisional Process.

However, the true test of the structure is the way in which decisions are made, the previous two elements, in particular bias of organisation, if such exists, can only help to illuminate the analysis of decision-making. In this the concern will be to examine the way in which decisions are made but with an awareness of the concepts which have been used to criticise the work of Dahl and others. As much attention will be paid to decisions over which there is conflict as to decisions in which there is no conflict, because the interest is in the process as a whole. Similarly decisions which are shelved will be looked at and hopefully some appreciation of non-decisions will be gained by studying the sources from which business comes to the meeting. None of these issues have easy solutions but the next chapter will be concerned with the methodology of the study and the problems raised will be posed in the following pages.

Conclusion

This chapter has been about the second level of the Medical Advisory Structure, the Committee of Divisional Chairmen. As in the last chapter the concern has been to look at the structural features within which the action of the divisional system takes place. There were two main elements in this, the nature of the structure itself and the

features of the profession at that level, which are brought into that structure.

The major structural contribution was the role conflict inherent in the role of the chairman of a division sitting on the committee. The main features of specialisation were lack of inter-specialty knowledge, the importance of specialty autonomy and the status and prestige differences between specialties. General medicine, general surgery and their related specialties were identified as those with most status.

In looking at the interaction between these two sets of inputs it was argued that the representation of specialty interests would be the most likely solution to the role conflict, or at least the hospital decision-making expectation was the least likely to be fulfilled. It was argued that where possible the committee would support individual specialty requests and opinions, but that where this was not possible or did not happen then the decisions coming from the committee would be the result of the interaction of interests rather than the product of more broadly based considerations. Furthermore, that if this was the case then some groups would be more successful in this competition between interests, specifically general medicine and general surgery, and that the process involved could be usefully analysed using the concepts developed in relation to interest group analysis of political systems, bearing in mind the previous criticisms made of such analyses.

The next chapter will be concerned with the methodology of the study and specifically the way in which the data were collected and the way in which the material will be described and analysed.

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Chapter 4. Theory, Fieldwork and Methodology

Introduction

In Chapter 1 the structure of the National Health Service was described in both its original and reorganised forms. Detailed attention was paid to the nature of medical involvement in management, in particular the nature of Medical Advisory Structures as recommended in the Joint Working Party reports (1,2,3). The next two chapters examined the structure and the theoretical difficulties which it faces in operational terms. Chapter 2 was concerned with specialty divisions and the nature of the profession and its values at the consultant level. In Chapter 3, the Committee of Divisional Chairmen was similarly examined in terms of the aims of that committee and the nature of the profession at the specialty level.

The main purpose of this chapter is to summarise the theoretical ideas developed in the last two chapters and to describe the fieldwork and methodology which were employed to study the structure.

The Division and the Decision-Making Process

Divisions are intended by the Joint Working Party proposals (1,2,3) to make policy and management decisions for individual, or groups of related, specialties. It was suggested in Chapter 2 that the intended operation of divisions entails a role conflict for their members. They are expected to fulfil the following expectations:

a. the representation of their own interests as consultants practising within a specialty; and

b. making decisions on the basis of what is best for the specialty as a whole and the service it provides.

These expectations may not always be compatible and in cases of incompatibility there are four possible solutions to the role conflict:

a. and b. to concentrate upon one or other of the expectations, in this case this would involve merely ratifying what consultants wanted or considering in

detail whether or not individual requests or interests were valid in broader terms;

c. compromising between them; and

d. avoiding the role conflict altogether.

What factors might influence which solution is preferred by the participants? It was argued that doctors, in trying to operate the divisional system, have other values which they bring into the division. In examining the nature of professional relationships at the consultant level individual autonomy was identified as a key value and characteristic.

If this value is prevalent then it was argued that its major influence would be to deter consultants from impinging upon one another's professional space. It was therefore suggested that the likely outcome in cases of conflict would be to deter members from making decisions on the basis of broader criteria. The result would be that the expectation of representing individual interests would be fulfilled and divisions would merely ratify individual requests - in this way autonomy would be preserved. Alternatively some compromise or avoidance of decisions involving conflict might be the pattern. In all three possible ways of dealing with the conflict the structure would not be living up to the intentions of the Joint Working Party proposals.

The Committee of Divisional Chairmen and Decision-Making

Chapter 3 was similarly concerned with the Committee of Divisional Chairmen. This committee is designed to act as a decision-making body for the whole hospital in terms of policy for and management of medical care. It is composed of a representative, the chairman, of each specialty division in the hospital. It was argued that chairmen, as members of this committee, face a similar role conflict to that experienced by members of a division. In this case the two expectations are:

a. the representation of the interests and views of their specialty or division; and

b. decision-making on the basis of broader criteria, including the service provided by the hospital as a whole.

Again it was argued that these expectations might not always be compatible. In such cases the solutions open to the chairmen are to stick to one or other of the expectations, adopt a compromise or avoid decisions involving a conflict. What factors might influence the way in which the conflict would be solved?

It was argued that there are professional values and characteristics associated with specialisation which chairmen bring with them to the Committee of Divisional Chairmen. In analysing the development of specialties within medicine, three characteristics of the profession at the specialty level were identified:

a. a lack of inter-specialty knowledge;

b. a concern for specialty autonomy, similar to the value of consultant autonomy at the individual level; and

c. differences in the status of the various specialties, with medicine and surgery having higher status than other specialties.

How would these factors interact with the expectations facing chairmen in producing a solution to the role conflict? Lack of inter-specialty knowledge would mean that chairmen would be unable to comment on some matters raised by chairmen of other specialties. They would be reliant upon what they were told by the chairman concerned and would tend to agree with what other chairmen stated or wanted within their own fields. A mutual concern with the autonomy of specialties suggests that chairmen would be reluctant to impinge upon other specialties and this would also encourage them to agree with what other specialties wanted. In both of these cases the forces from the profession suggest that the hospital decision-making expectation would be avoided and that specialty requests would be ratified almost automatically.

However, such reciprocity would not always be possible because of limited resources of all kinds and there might be occasions when specialties were in competition with one another. In such instances it was argued that specialty status might have an impact and that specialties with more status and by implication more influence, would be more likely to get what they wanted. If this did happen it was argued that specialties as formally created interest groups might be expected to demonstrate similar properties to political systems in which groups compete for influence and limited rewards. It was suggested that if this did occur it would be manifested in biases in organisation, differences in resources for achieving ends, and the use of those resources for that purpose. High status for a specialty might be seen as one possible resource in the achievement of interests. In the same way it will be interesting to know if the structure does act as a mobiliser of bias (4) and, favour some specialties rather than others.

It has therefore been argued that the outcome of the structure is dependent upon two major influences. First, the contribution of the nature of the system in what it asks consultants to do, this is the role conflict. Secondly, the contribution of the profession in terms of its values and characteristics. In both cases it has been suggested that the latter in influencing the former will tend to divert the structure from its intended mode of operation.

The Fieldwork

In order to assess the operation of the structure as intended by the Joint Working Party, test the theoretical ideas and arrive at an account of how the structures actually operate, research had to be undertaken within one or more hospitals. In view of the large number of committee meetings within the Medical Advisory Structure it was decided that it would be possible to cope with two hospitals. It was also thought to be desirable to work in areas with contrasting characteristics to give the structure and the theory a chance in different settings.

In Scotland there are three main types of area, central teaching areas with university connections and teaching hospitals, more peripheral areas including some industrial towns and/or country areas, and the large sparsely populated areas in the north of Scotland. A study of the latter would have been difficult from a practical point of view and it was decided to work in a Health Board with teaching functions, and a Health Board in an intermediate area. This also had implications for the nature of the hospitals studied. Hospitals in the peripheral areas tend to be less well staffed and have fewer specialties than the teaching hospitals but it was felt that it would be useful to have Medical Advisory Structures which varied in their basic components.

The two areas chosen were the Lennox Health Board and the Aldershire Health Board. It was decided to work in a single district and in the major hospital within the district. Two hospitals were selected, partly because the researcher had some informal contact with them from a previous study which was desirable in view of the type of information and access required. The fieldwork was started in 1973 when the Boards of Management were still in operation. It was conducted over a two-year period, one year before the reorganisation and one year after it. This meant that the development of the Medical Advisory Structures in the two hospitals could be observed more or less from the start.

Initial approaches were made to the Medical Superintendents of the two hospitals and through them to the Medical Advisory Structures which at that time were in an early stage of development. It was decided that the best way to study the process of the divisional system was to attend the meetings of the committees themselves, at hospital, district and area levels. Although this study concentrates mainly upon the hospital level this enabled the researcher to see the hospital committees in the context of the whole structure. Access to the meetings within the two hospitals and to the District Medical Committees was reasonably easy to arrange. There were some problems of access to individual divisions, some because they never met, some because meetings were held sporadically and others because the members

of one or two very small divisions felt that they would be embarrassed by the presence of the researcher. Most of these difficulties were overcome. Access to the two Area Medical Committees was more difficult to arrange. In Lennox an approach was made by letter to the Chairman of the Interim Area Medical Committee, but he felt that it would be better to wait until the full committee was constituted and this was subsequently arranged. In Aldershire the secretary of the Interim Area Medical Committee happened to be the Medical Superintendent of the hospital being studied and access was arranged through him.

Meetings of all levels of the Medical Advisory Structure from the specialty to the area level were therefore attended for two years. During that period, and after, most of the committees sent the researcher their agendas and minutes and access to previous minutes was also arranged. In addition, various Board of Management and ad hoc committee meetings were attended where these were appropriate.

The Methodology

The aims of the research required that as complete a picture as possible of the way in which the structure handled decisions had to be obtained. Observation of the meetings of the Medical Advisory Structure was therefore chosen as the main method of collecting data. In general a distinction is made between participant and non-participant observation and in a real sense it was impossible for the researcher to achieve the true participant observer role in respect of the meetings of the committees which involved only consultants. However, the following definition of Schwartz and Schwartz is a lot broader than very strict interpretations and it does point to some of the major difficulties which any form of observation entails:

> '... we define participant observation as a process in which the observer's presence in a social situation is maintained for the purpose of scientific investigation. The observer is in a face-to-face relationship with the observed, and, by participating with them in their natural life setting, he gathers data. Thus, the observer is part of the context being

> observed, he both modifies and is influenced by this context. The role of the participant may be either informal or formal, concealed or revealed; the observer may spend a great deal of time or very little time in the research situation; the participant-observer role may be an integral part of the social structure or largely peripheral to it.' ((5), p.91)

In this particular case the researcher was obviously an observer and the consultants on the various committees knew what he was doing and had agreed, on that basis, to his attendance at the meetings. For the medical profession, especially in a teaching hospital, research was generally seen as being worthwhile. This is not always the case with people in other settings where revelation of the fact that a participant is a researcher may cause antagonism - in this context it seemed to give the observer a certain legitimacy. This was possibly evident in the slightly different response of the peripheral area. They had few links with the university and would have liked to increase their involvement in teaching and research. In this Health Board the name of the researcher always appeared in the Area Medical Committee minutes as an 'Observer from the University', and so the presence of the researcher may have been seen in a flattering light.

While acceptance at this level was forthcoming the observer is undoubtedly part of the social setting - particularly in a committee meeting - the danger is that the presence of the observer will change the way in which business would be handled normally. However, the researcher was a permanent fixture for two years and in some cases there was someone else who was 'stranger' attending the meetings, for example, an administrative trainee or a nursing officer attending for a specific item on the agenda. It should be remembered that these people were senior members of the profession and that they had the power to stop the researcher's attendance at their meetings rather than let him 'cramp their style'. In general the position of the researcher seemed to be accepted.

At the other extreme there is the problem that the researcher may become over-involved with those being studied to the extent that it impedes the research. Miller refers to this in his own research using participant observation:

> 'The error in question is "over-rapport". This neologism ... expresses the idea that the researcher may be so closely related to the observed that his investigations are impeded. Studies of the participant observation method concentrate on such problems as how to gain entry and achieve rapport ... But is it not possible to gain too much rapport?'
> ((6), p.97)

Miller's difficulty was that he became too closely involved with leaders of a trade union he was studying. It became difficult for him to pursue penetrating lines of investigation and also tended to separate him off from the union rank and file.

In this study a certain rapport was established - as might be expected over a two-year period and certain 'friendships' were developed mainly with consultants who had an interest in the research. However, the worst problem this led to was the researcher being asked questions like 'How are we doing?' and 'Do you think we are going wrong anywhere?'. To have answered these questions directly may well have involved the danger of affecting the way in which some of them acted in committees and so this was avoided by getting them to talk about their feelings as to how they were managing. In a similar way and after a period of time the researcher was occasionally asked questions during the meetings, for example, 'What is the name of the District Administrator?' and 'You probably know more about this than we do, what is the situation about the old Board of Management?'. This may have been an attempt to bring the researcher into an acceptable role within the meetings, but such questions were infrequent and seemed to involve genuine gaps in knowledge. There was no consistent attempt to draw the researcher into the meetings and such questions were taken as a sign that the researcher was accepted by the group.

Detailed, more or less verbatim notes were taken at the meetings and typed immediately afterwards. Recording what was said openly may have been a problem but the researcher generally sat in the corner of the room and there were often others in the room taking notes as well.

While the researcher could never be an active participant an attempt was made to get as close as possible to the various types of data which Becker and Geer see as the inherent advantages of participant observation:

> 'The most complete form of the sociological datum ... is the form in which the participant observer gathers it: an observation of some social event, the events that precede it and follow it, and expectations of its meaning by participants and spectators, before, during and after its occurrence.' ((7), p.28)

In addition to attending the formal meetings the researcher spent a considerable amount of time in the hospitals, talking to consultants before and after meetings. There was also discussion over lunch, at coffee and tea breaks and in corridors and offices. At the same time it was not possible to be everywhere at once and so inevitably an incomplete picture is developed.

Also involved is the problem of the representativeness of the data collected because it is not random and may be dependent in part upon the development of friendships. Moser and Kalton mention this in connection with 'overheards':

> 'These provide the researcher with a valuable, but uncontrollable, source of data, rather like unsolicited documents, in interpreting which it is always necessary to remember that some people are more self-expressive than others. 'Overheards' may give an unrepresentative picture of the views of his constituents.' ((8), p.247)

In view of difficulties like these it was felt that the observation by itself was not a totally satisfactory data source. It has undoubted

strengths but their corrollary is weakness of the kind mentioned above. It was decided to conduct formal interviews with consultants involved in the structure to provide a broader and more generalised data base complimenting the proceedings of the committees themselves. A semi-structured questionnaire was drawn up to enquire about the major aspects of the operation of divisions. It was intended that these questions would provide the basis for a discursive interview with each consultant (the interview schedules for the two hospitals are reproduced in Appendix 1). The interviews were conducted at the end of the observation period and in this way it was possible to discuss general issues with reference to specific incidents which the researcher had observed and the consultant had participated in. The other advantage of this was that by the time of the interviews the researcher was well known to most of the respondents and there were therefore fewer problems in gaining their confidence.

The teaching hospital contained over 80 consultants and it was decided to interview all the present and past chairmen of divisions (there were 15 of these) in order to get a reasonable number of responses to questions about the Committee of Divisional Chairmen. A further 27 consultants were selected randomly such that each division was represented in direct proportion to its size.

The hospital in the periphery was smaller and it was decided to attempt to interview all of the 29 consultants who did most of their work in that hospital. Two declined to be interviewed and so 27 interviews were conducted.

The interviews were taped using a cassette recorder. The length of the interviews varied from twenty minutes to two hours. The tapes were transcribed in full. In analysing the interviews they were coded, where appropriate, in simple terms but in the following chapters extracts from the interviews have been employed as well. Two respondents in the smaller hospital refused to have the cassette recorder on while they were being interviewed but even without it they seemed to be less forthcoming than the majority of those interviewed.

The two hospitals were slightly different in that the teaching hospital had adopted the divisional system, whereas the smaller hospital did not eventually do so and ended up using the Medical Staff Association as the basis of the Medical Advisory Structure. Because of this the questions asked in the two hospitals were not the same although they were still focussed on the same issues. In addition, there were some questions about why the consultants in the smaller hospital had rejected the divisional system.

This factor also complicated the use of the theory which was specifically tailored to the divisional system. However, the Staff Association was expected to perform the functions of the bottom level of the Medical Advisory Structure and its members faced the same potential role conflicts as members of divisions and the Committee of Divisional Chairmen. The major difference was that both individual requests and specialty requests would be handled by the Medical Staff Association whereas in the divisional system they were dealt with at separate levels. This also has some benefits because the two hospitals provide something of a contrast in their structure.

The Presentation of the Results

The results of this study are presented in the next five chapters. In Part 2, Chapters 5 and 6 deal with the development of the Medical Advisory Structures in the two hospitals at the hospital, district and area levels. Chapter 5 deals with Overton Hospital in the teaching area and Chapter 6 is concerned with Allan Hospital. These provide a detailed picture of the structures within which the analysis in the following chapters takes place. At the same time the way in which consultants thought about the structure and the choices they made and strategies they used in doing so provide important clues as to how they will approach decision-making. In terms of the theory there is also a concern to see if the nature of the organisation chosen contains biases in favour of some specialties rather than others.

In Part 3, Chapters 7, 8 and 9 describe and analyse the operation of the Medical Advisory Structures in the two hospitals. One of the

major problems which was partially considered in the last chapter is the selection of case study material for coverage. This is not only a problem because it is impossible to cover everything that has been observed. More seriously, selection of any kind can lead to the charge that the decisions chosen for detailed analysis are biased or unrepresentative. Indeed Bacharch and Baratz would argue that the very restriction to issues which are discussed in the open is the most fundamental bias (9).

This has been dealt with in the following chapters by attempting to choose crucial areas of decision-making, for example, requests for additional consultant staff and then covering all cases of such requests which arose during the period of fieldwork. In this way at least the selectivity has been conducted at a higher and clearer level. The criteria for selection of the general area of decisions which have been covered is governed by two factors. First, this study is attempting to find out whether or not Medical Advisory Structures are doing what they were designed to do. Secondly, it is concerned to find out what influences the way in which they work and the extent to which the theoretical ideas summarised earlier in this chapter have an impact upon the structure. In a sense therefore issues have been chosen which test the structures.

Chapter 7 deals with matters internal to the profession at the level of the individual consultant and the specialty division. The decisions dealt with include requests for additional medical staff, requests for equipment and the evaluation of patient care. These are decisions with which the structure is supposed to deal and they involve the hypothesised role conflict. They therefore provide a test for the theory and a test for the structure. Both hospitals are considered and the case study and interview material are presented in tandem.

Chapter 8 analyses the same issues at the level of the specialty and the Committee of Divisional Chairmen in a similar fashion. Again the aim is to find out how far the hospital level of the structure is living up to its intended functions and also whether or not the theory relating to that level is of use as an explanatory device.

In Chapter 9 issues relating to the management of the hospital are dealt with. These are more complex and involve the profession in considerations which affect other groups within the hospital. Decisions relating to bed use and allocation, requests for and the allocation of non-medical staff and the implementation of policies are described and analysed. These provide a broader test for both the theory and the structure.

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PART 2. THE INTRODUCTION OF TWO MEDICAL ADVISORY STRUCTURES

Chapter 5. Overton Hospital: The Development of the Medical Advisory Structure.

Chapter 6. Allan Hospital: The Development of the Medical Advisory Structure.

Chapter 5. Overton Hospital: The Development of the Medical Advisory Structure.

Introduction

The first of the two hospitals in which this study was conducted is Overton Hospital, one of the main hospitals in Lennox, a large industrial city in Scotland. In this chapter the development of the Medical Advisory Structure will be described from the hospital up to the area level. While the later chapters, which examine the operation of the structure, concentrate upon the hospital, it will be useful at this stage to look at the formation of the structure right up to area level for two main reasons. First of all, it provides descriptive background and places the divisional system in its broader context and secondly, it will also indicate some of the dominant concerns of the profession in setting up the structure, and enable any biases in the structure to be identified.

The chapter starts with a short description of the hospital, the district and the area. This is followed by a chronological account of the formation of individual divisions and the Committee of Divisional Chairmen in Overton Hospital, the Overton District Medical Committee, the Lennox Interim Area Medical Committee and the definitive Area Medical Committee. Where it is relevant these developments will be examined in relation to the Scottish Home and Health Department recommendations and the theoretical position advanced in Chapters 2 and 3.

Overton Hospital and the Lennox Health Board

The Lennox Health Board administers the health service in the city of Lennox. Prior to reorganisation Lennox was the major city in one of Scotland's five Regional Hospital Boards. The area is now divided into five districts which are roughly contiguous with the five main Boards of Management which were within the city under the old structure. Overton Hospital is the main hospital in the Overton District. It was built in 1901 as a corporation hospital but has developed from that into one of the five teaching hospitals in Lennox.

Its achievement of this status began in 1936 when a professor of the University of Lennox Medical School was allocated beds in Overton Hospital.

Up until April 1974 Overton was under the administration of the Overton Board of Management and this included most of the hospitals which are now part of the Overton District, they are:

Overton Hospital:	a general hospital with several university departments and consultants in all the major specialties. It has approximately 1000 beds and 86 consultant staff.
Reeve Hospital:	mainly infectious diseases, chest medicine and geriatrics.
Wallace Hospital:	mainly chest medicine, geriatrics and obstetrics and gynaecology.
Strone Hospital:	geriatrics.

With reorganisation a large mental hospital and a mental subnormality hospital were added to these to make up the Overton District. The main focus will be upon Overton Hospital but because the divisional system cut across hospital lines the smaller hospitals will be mentioned in some contexts.

At the time of the research Overton Hospital contained the following medical staff:

Junior House Officers	35
Senior House Officers	25
Junior Hospital Medical Officers	1
Registrars	42
Senior Registrars	17
General Practitioners	9
Senior Hospital Medical Officers and Medical Assistants	9
Consultants	86

Prior to any changes in line with the divisional recommendations the medical staff were organised according to the firm or unit system, there were three medical units, two general surgical units, one medical paediatric unit, one dermatology unit, one geriatric unit and so on. Each of these units had a consultant in-administrative-charge, and most of the specialties consisted of a single unit.

The main organisation for the medical staff at that time was the Medical Staff Association, composed of all consultant staff in the hospital (the smaller hospitals also had their own Medical Staff Associations). Although this played a part in some issues the main influence of the medical staff upon management and administration was through medical membership of the Board of Management. Nominations for membership came from a variety of sources, including the Medical Staff Association and in the last Board medical membership consisted of:

3 General Physicians
1 General Surgeon
1 Obstetrician
1 Paediatrician

The Formation of Specialty Divisions

The first Joint Working Party report was published in 1967 (1). By March of that year the Medical Superintendent had sent a memorandum to physicians and surgeons in the hospital with a view to arranging meetings at which the concept of divisions could be discussed. Early progress was slow and the main worry appeared to be the impact of such a drastic change upon individual consultant autonomy. This was emphasised by a memorandum circulated by the Medical Superintendent in September 1968 in which it was stressed that:

'... the clinical independence of each consultant ... should in no way be affected.'

This influenced the general physicians who formulated divisional proposals in October, but they were in marked contrast to other specialties. Only the general surgeons held meetings specifically

to discuss the divisional system. However, neither the physicians nor the Medical Superintendent did anything about the proposals and in May 1969 the Secretary of the Medical Staff Association wrote to the Superintendent:

> 'I have been asked by the Medical Staff Association to express the anxiety of the physicians in the hospital that no further action has been taken with regard to the medical division. You will remember that plans for this were completed at the end of last year.'

As a consequence the Medical Division had its first meeting in June 1969 and Dr. Gregor, one of the former consultants in-administrative-charge, was elected Chairman.

At this stage even the discussions in surgery had ceased and it took a meeting addressed by Brotherston, the Chief Medical Officer for Scotland, to create renewed interest. The result of this was the formation of a working party to plan a weekend residential conference at which the divisional system would be discussed. This was held in May 1970 and consisted mainly of lectures and syndicate discussion sessions. The result was the broad approval of the establishment of a divisional system in the group as a whole although some areas were left undecided, for example, the exact number of divisions, and how inclusive they should be. Should the minor surgical specialties have their own division, or should they go into a division of general surgery? Overton and Wallace both had units in obstetrics and gynaecology, would they agree to form a single division? Reeve and Wallace both had units of chest medicine, would they agree to form one division?

Despite the agreement reached at the conference and partly because of the questions left unanswered, it was another year before the other specialties, apart from general medicine, began to organise. In March 1971 the ophthalmologists and E.N.T. surgeons formally agreed to join the Surgical Division. Mr. Scott, the consultant in-administrative-charge of one of the surgical units, was elected chairman in April. The division eventually held its first meeting

in September 1971, over two years after the formation of the Medical Division. By October 1971 most of the divisions had met at least once and these are listed in Table 5.1, although even this list does not give a true picture as by February 1975 the Division of Radiology had still held only two meetings.

The major anomalies are the two divisions in chest medicine and obstetrics and gynaecology. Other divisions, like geriatrics and laboratory medicine cross-cut the hospitals in the group but the consultants in chest medicine and obstetrics and gynaecology refused to form a single division. This was not a matter of size as the number of consultants in both of these specialties was relatively small but they argued that they served different populations and would gain nothing by amalgamation (this attitude changed several years later and this will be covered later in the chapter).

From this point on most of the divisions met on a regular basis, apart from the Radiology Division, but there were considerable variations in frequency. The Medical Division met once a month while the Laboratory Division met once every three months. In addition, most of them had executive meetings and full meetings, the former consisting generally of consultants and senior registrars and some senior nursing staff and the latter involving all medical staff and more junior nursing staff and ancillary staff as well.

The next stage was the formation of the Committee of Divisional Chairmen.

The Committee of Divisional Chairmen

A constitution and standing orders for this committee were drawn up in the autumn of 1971. The duties and functions of the committee were outlined as follows:

'(a) to consider all areas of medical work and related administration and research which involve more than one division;

Table 5.1. Divisions in the Overton Group of Hospitals, October 1971.

Specialty	Division	Executive Membership
1. General Medicine. Dermatology.	Medicine.	19
2. Geriatric Medicine.	Geriatric Medicine.	11
3. General Surgery. Orthopaedic Surgery. Paediatric Surgery E.N.T. Surgery. Ophthalmology. Oral Surgery. Cardiac Surgery.	Surgery.	31
4. Medical Paediatrics.	Medical Paediatrics.	5
5. Psychiatry.	Psychiatry.	8
6. Infectious Diseases (Reeve Hospital).	Infectious Diseases (Reeve Hospital).	7
7. Virology. Bacteriology. Biochemistry. Haematology/BTS. Pathology.	Laboratory Medicine.	13
8. Anaesthetics.	Anaesthetics.	11
9. Obstetrics and Gynaecology (Overton Hospital).	Obstetrics and Gynaecology (Overton Hospital).	6
10. Obstetrics and Gynaecology (Wallace Hospital).	Obstetrics and Gynaecology (Wallace Hospital).	6
11. Chest Medicine (Wallace Hospital).	Chest Medicine (Wallace Hospital)	4
12. Chest Medicine (Reeve Hospital).	Chest Medicine (Reeve Hospital).	5
13. Radio-Diagnosis and Radiotherapy.	Radio-Diagnosis and Radiotherapy.	4

(b) to consider the development of medical policy within the Overton Group in conjunction with the Group Medical Superintendent and the Chief Nursing Officer;

(c) to consider any matters referred to the committee by the divisions, the Medical Staff Associations within the Group and by the Board of Management or any Standing Committee thereof;

(d) to tender advice and convey to the Board of Management the views of the committee.'

It was also agreed that the Medical Superintendent, the Chief Nursing Officer and the Group Secretary and Treasurer would normally attend the meetings.

The first meeting of the committee was held early in December 1971 and the Chairman of the Medical Division, Dr. Gregor, was elected Chairman of the Committee of Divisional Chairmen. Since that time the committee has met once a month apart from the summer vacation. While this committee had by now become a part of the plan for the reorganised structure it was decided that its chairman should automatically sit on the Board of Management, although coincidentally Dr. Gregor was already on the Board.

The next levels of the Medical Advisory Structure are the District Medical Committee and the Area Medical Committee. Discussions about the formation of these started in 1973. In Lennox the Area Medical Committee was the first to be organised and this body laid down guidelines for the District Medical Committees.

The Lennox Area Medical Committee

The policy of the Scottish Home and Health Department was that shadow or Interim Area Medical Committees should be set up in the year before reorganisation to match the shadow Health Boards which were to be appointed. The Department suggested that the British Medical Association should be the vehicle for this through its local committees. In Lennox the Regional Committee for Hospital Medical Services

and the Local Medical Committee set up a working party to decide upon the constitution of an Interim Area Medical Committee, it decided upon the following:

Hospital Membership	-	12 (One from each of the five teaching groups in Lennox, and seven appointed by the Regional Committee for Hospital Medical Services and including one junior doctor.)
General Practitioner Membership	-	12 (Appointed by the Local Medical Committee.)
Community Medicine	-	3
Lennox University	-	3
Royal Colleges	-	1

This mode of selection produced twelve hospital members from the following specialties:

7 General or Specialist Physicians
(Four from the five future districts and three out of the seven appointed by the Regional Committee.)

1 Dermatologist

1 Obstetrician

1 Anaesthetist

1 Haematologist

1 General Surgeon

1 Paediatrician

The first meeting of the committee was held on the 17th April 1973 and one of the physicians, Dr. Napier, was elected chairman, the vice-chairman was a general practitioner and the secretary a community physician. The method of selection did not appear to contain any bias but it had produced a preponderance of physicians. While at the area level specialty is not a factor in either selection or representation and the members are merely there to represent the profession as a whole the imbalance did receive some attention at the first meeting:

'Professor Tallon had doubts about the value of geographical representation and he thought that a committee consisting of a representative from each of the nine "families" of medicine, together with two general practitioners, one junior staff member, two representatives from the University and one representative from the Royal Colleges - giving a total of fifteen members, would have been more effective. He referred in particular, to the lack of direct representation from the specialties of surgery and psychiatry.'

Dr. Napier stated that the original working party had contained members from the three branches of the profession and that efforts had been made to achieve a reasonable representation in line with the recommendations of the Hendry report (2). Hendry had stated that area committees were not supposed to be representative of any branch of the profession. Despite this the matter was raised again at the next meeting:

'The preponderance of physicians serving on the committee and the reasons for this were noted and Dr. Meaker suggested that the nominations from the Regional Committee for Hospital Medical Services could be reduced in numbers, to enable nominations from the specialties of Mental Health and General Surgery to be obtained directly. Dr. Roper and Dr. Stag pointed out the need to distinguish the problem in the interim situation from that of the long-term statutory committee ... A letter was read from Dr. Milton, Secretary of the ad hoc Committee for the Interim Psychiatric Committee, requesting psychiatric representation. It was agreed that the body be asked to nominate a representative.'

These early discussions are interesting because of the light they throw upon the way participants saw the Area Medical Committee and specialty representation at that level. It was an interim body derived from the geographical and professional components of the area, through district nominees and British Medical Association representatives. It was not designed to be a system of specialty representation. Not surprisingly it failed to produce representa-

tives from all specialties indeed general physicians made up over half of the hospital places and not apparently by design, as four of the five districts nominated a general physician to represent them (the fifth nominating a more neutral, in specialty terms, community physician). Because the procedure for selection resulted in a skewed specialty distribution it was questioned and the suggestion was put forward that direct nominees from general surgery and mental health be appointed. Such a move would have gone against the ethos of the committee as it would give a specialty mandate to those specialties as they would only be there because they were general surgeons or psychiatrists. This dissatisfaction with the membership also implied that decisions might vary according to which specialties were on the committee, that is, that those specialties on the committee would take advantage of their position. Whether or not this is the case, it was clear that if any specialty held advantages it was general medicine. Despite these fears, the interim nature of the committee and the fact that the mode of selection had adhered to the Hendry guidelines seemed to take the day.

However, at that stage one of the unrepresented specialties, mental health, wrote to the committee asking for membership and in spite of previous statements it was agreed that this should be permitted. While this may have calmed some of the protest on the committee it seemed a little strange to overturn a general principle five minutes after it had been stated.

From then on the committee discussed a number of broad issues one of which was the nature of the specialty sub-committee structure at the area level. The other item of interest at this stage was the question of District Medical Committees. At the meeting of the 18th September 1973 two of the districts reported progress in this direction and it was agreed that all of the districts should proceed using the guidelines provided by the Hendry Report (2).

The Overton District Medical Committee

Following this lead a meeting was held on the 25th October involving

the Chairman of the Committee of Divisional Chairmen, Dr. Gregor, the Medical Superintendent and two representatives of the Local Medical Committee working in the Overton District. The outcome was reported to the Committee of Chairmen on the 7th November. It was proposed that the District Medical Committee be composed of seven general practitioners and seven hospital doctors because 'this would enable the main specialties to be represented'. Dr. Gregor suggested that seven hospital members should be:

Medicine, including Infectious Diseases
Surgery, including Anaesthetics
Psychiatry
Geriatrics
Laboratory Medicine, including Radiology
Paediatrics
Obstetrics and Gynaecology

This was agreed by the committee. At the same meeting a certain rationalisation of the divisional system was announced. Dr. Gregor had met with the two Divisions of Obstetrics and Gynaecology and they had agreed to combine and had elected Dr. Leven as chairman. This amalgamation was interesting in the light of their previous refusal to form a single division. It will become clear in the fieldwork chapters that this change of heart was partly because of specialty interest, specifically the fall in the birth rate which made the perpetuation of two separate units in the district untenable. The other change was the agreement of the two Divisions of Chest Medicine at Wallace and Reeve Hospitals to join the Medical Division.

At this stage Dr. Gregor finished his term of office as chairman of the Medical Division and consequently as chairman of the Committee of Chairmen. In terms of the specialty status hierarchy suggested in the last chapter it might have been expected that Mr. Scott would be the next in line but he was about to end his term of office as chairman of the Surgical Division and was therefore ineligible. However, he proposed the new chairman, Dr. Henley of the Laboratory Division and also nominated the two members to meet with the general practitioners to discuss the District Medical Committee constitution,

Dr. Henley and Dr. Leven of the Division of Obstetrics and Gynaecology.

At the first meeting of 1974 on the 9th January the final membership of the District Medical Committee was established:

Dr. Henley: This involves a reduced number of divisions and we need a formal minuting of this. They were Professor Alexander (Medicine), Mr. Scott (Surgery), Dr. Leven (Obstetrics and Gynaecology), Dr. MacAulay (Paediatrics), Dr. Galbraith (Psychiatry), Dr. Malcolm (Geriatrics) and myself from the Laboratories, and that is not necessarily in order of importance, at least after the first two. (Laughter).

Discussions between the general practitioners and the hospital doctors over the constitution of the District Medical Committee continued and one of the major areas of contention was whether members should be allowed to send deputies to the meetings. The general practitioners were against this but the hospital doctors were in favour of it, as the following discussion indicates:

Mr. Scott: If you have seven G.P.'s and only four turn up it doesn't really matter.

Dr. MacAulay: Yes, we represent specialties and we need to be there to put across our view, nobody else can do that.

Mr. Scott: I think so, if I cannot go and something in anaesthetics comes up then I would like to send Dr. MacFarlane along. We should say that we will have deputies and if they don't want them, hard luck.

Professor Alexander: Agreed, they'll send them along if we have them.

This attitude to deputies and the difference between themselves and the general practitioners is instructive in the light of the previous comments upon the nature of inter-specialty knowledge. It was apparent that none of the chairmen on the committee thought that any other chairman could represent the views of his own specialty. This suggests that they saw differences in specialty knowledge but

it also raises the broader question of how specialty attendance at a committee might affect the outcome. Would the presence of a member of a specialty make any difference to any decision about that specialty? If it would make a difference it would presumably be to the benefit of that specialty and if that were the case it would raise doubts about the ability or willingness of members of other specialties to deny that specialty what it requested. Another interesting point is that this discussion took place between the seven chairmen who would be members of the District Medical Committee. The other three specialties of anaesthetics, radiology and infectious diseases had been combined with laboratory medicine, surgery and medicine. These specialties were not going to have the opportunity to speak for themselves suggesting that either they could be represented by other specialties or that they were less important. The Chairman of the Anaesthetics Division commented upon this at the next meeting:

Dr. MacFarlane: At the executive of the Anaesthetics Division I had to use all my powers of persuasion in presenting reasons for the incorporation of the Division of Anaesthetics in the Division of Surgery. They are apprehensive about this and want it to be stated that it wouldn't necessarily be a surgeon who would represent the joint division. They want this written in as an option that might be taken up.

This was minuted and discussed by the Surgical Division at a later date. Mr. Scott, the chairman, thought the problem might be avoided by making the Chairman of the Anaesthetics Division his deputy but he was totally against an anaesthetist representing the surgeons on the District Medical Committee:

Mr. Scott: It would be bad if a major specialty were not represented on the District Medical Committee. There is a case for all major specialties to be represented on that committee.

The surgeons saw the three unrepresented specialties as minor specialties which required no direct representation or could be represented by others.

There was also some concern among the infectious diseases physicians who were also unrepresented at the district level. This was related to specialty committees at the area level and followed discussion of the future role of the Physician Superintendent in mental hospitals. The Chairman of the Division of Infectious Diseases raised the matter:

Dr. Murdoch: Could I bring up something here related to the question of the Physician Superintendent but concerned more broadly with specialty committees at the area level. I wondered if it would have been a good idea to send it to a Psychiatric Committee of the area. Are there any such committees representing specialties?

Dr. Henley: Well we did discuss that and there are a lot of different people writing into the Area Board saying 'I represent the X's can I talk to you?', 'I represent the Y's can I talk to you?'. The problem is that they do not know if these groups are truly representative of the specialty concerned in the Area. The other thing is that there are so many of these little groups, even if you look at General Medicine there are so many little sub-specialties within it that there could be fifteen committees in that specialty alone.

Dr. Murdoch: I ask this because I wrote to the Area saying that I represented a group and I wondered what was happening about this.

Dr. Henley: Well the Area Medical Committee has set up a sub-committee under Dr. Regent to look at the whole problem and report back.

From this it was clear that throughout the Area there were small specialised groups who felt that their interests were not being represented through the District and Area committees. These interest groups had started activity totally outside the developing formal structure and it is possibly no coincidence that infectious diseases was one of the specialties which was not directly represented in the District Medical Committee.

There were further discussions between the hospital doctors and the general practitioners about the District Medical Committee and the first official meeting was held on the 25th April 1974. On the question of deputies the Area Medical Committee decided that these would not be allowed in the interests of continuity and that individual divisions would be responsible for ensuring that their chairman could attend all the meetings.

Further Developments in the Area Medical Committee

Meanwhile the Interim Area Medical Committee was discussing the composition of the definitive Area Medical Committee and the following broad maxim was minuted:

> 'The Chairman and Dr. Roper both referred to the Hendry Report in pointing out that the Area Committee members should represent the whole profession rather than any part, geographical or specialty.'

At the meeting of the 15th January 1974 they decided that the membership should be drawn from the following sources:

Four representatives from each district in the area, including two hospital staff (one by agreement between District Chairmen to ensure representation of certain specialties) and two general practitioners.
Two Community Medicine Specialists.
Two Junior Staff.
Two University Representatives.

Even this broad outline seemed to contradict the Hendry recommendation or at least make it apparent that the members could only represent the 'whole profession' as long as all or 'certain specialties' were on the committee.

Members were to serve for four years with the exception of half of the first intake who would retire after two years but be eligible for re-election.

The first meeting of the Area Medical Committee was held on the 9th April 1974 and on the hospital side the new membership consisted of:

5 General or Specialist Physicians
2 Paediatricians
1 General Surgeon
1 Obstetrician
1 Neuropathologist
1 Pathologist
1 Biochemist

A general physician, Dr. Bruce, was elected chairman and a general practitioner, Dr. Regent, was elected vice-chairman. One of the main items of business was the formation of a sub-committee under the chairmanship of Dr. Regent to plan a specialty sub-committee structure for the area. The specialty breakdown on the committee was also raised:

'The question of representation on the Committee was discussed with particular reference to psychiatry and it was felt that as the present composition did not include a representative of psychiatry consideration should be given to co-opting a psychiatrist on to the Committee.'

At the next meeting on the 14th May the following specialty sub-committees were suggested and accepted by the Area Medical Committee:

Medicine
Surgery
Obstetrics and Gynaecology
Geriatric Medicine
Laboratory Medicine
Anaesthetics
Paediatrics
Radiology/Radiotherapy
Psychiatry
Community Medicine
General Practice

The Area Committee nominated one member to serve on each specialty sub-committee and in the main each District was asked to nominate two members to each committee. In the case of the Surgical Sub-committee it was informally suggested that each District should nominate one general surgeon and one member of the surgical sub-specialties to achieve a balanced membership. However, at the next meeting, when nominations were being received, there was some adverse reaction to the sub-committees:

> 'The Chairman read a letter from the Lennox Accident and Orthopaedic Surgery Council seeking a separate sub-committee for their specialty. After consideration the committee reaffirmed their decision to have one sub-committee to include all surgical specialties.'

This ad hoc council had protested precisely because there was no sub-committee for that specialty. Clearly they felt their interests would not be represented adequately by the proposed structure. This complaint related to the overall number of sub-committees but as nominations started to come in for the sub-committees there were problems of a different kind. These occurred in three specialties, medicine, psychiatry and surgery.

The Medical Sub-Committee

This was the first sub-committee to receive all its nominations and the only difficulty concerned the omission of one sub-specialty:

Dr. Bruce: I think there is a fairly good scatter of the medical specialties.

Dr. Kirk: The important branch missing is neurology. I feel that physicians can speak for most specialties within medicine but neurology is a different matter.

Professor Atholl: Yes and I had thought the university was lightly represented, the obvious choice would be the Professor of Neurology, he could be co-opted.

Dr. Bruce: Right, are we agreed on that?

This addition was agreed to.

The Psychiatric Sub-Committee

When the membership of the definitive Area Medical Committee was known the psychiatrists in the area complained about the lack of a psychiatrist on the committee. This was solved by bringing in the formation of the psychiatry sub-committee:

'The Chairman referred to the absence from membership of the Area Medical Committee of a representative of psychiatry and the consequent difficulty in forming the specialty sub-committee.

The COMMITTEE agreed:

(i) that the Lennox Psychiatry Sub-Committee be invited to nominate one psychiatrist to membership of the Area Medical Committee.

(ii) that the General Practitioner Sub-Committee be invited to nominate one further member to the Area Medical Committee to maintain parity.'

The same thing had happened with the Interim Area Medical Committee and again it was difficult to square this with the state view that:

'... the Area Committee members should represent the whole profession rather than any part, geographical or specialty.'

The stated reason for including a psychiatrist, that it would be difficult to form a sub-committee without one, was not applied to geriatrics, radiology or anaesthetics, all of which were to have sub-committees and yet did not have members of the Area Medical Committee.

Dr. Murray was nominated by the existing Psychiatric Sub-Committee in the area and he solved the difficulty in psychiatry at his first meeting:

Dr. Bruce: The Psychiatry Sub-Committee has yet to be formed, we postponed it until we got a psychiatrist on this committee. We had thought it should be one representative from each district plus three specialists. The psychia-

trists have a committee already but we would like to form one of our own and the existing committee has said that it might be made up of two from each district, one from a large mental hospital and one from a general hospital or special unit. Would you like to talk to this Dr. Murray?

Dr. Murray: The committee was formed in mid-1973, we have a constitution and the membership consists of two members from each district. I feel that there is great rivalry between the mental and the general hospitals and that neither would like to be represented by the other. However, the large hospitals and the general units are not evenly distributed throughout the districts, but I feel it would be preferable to have two from each district rather than one.

It was decided that the sub-committee would consist of two from each district plus one from each of the specialties of Mental Deficiency, Child Psychiatry and Adolescent Psychiatry. Again it appeared that one section of a specialty, in this case split along institutional lines, was unwilling to let another represent it.

The Surgical Sub-Committee

These problems were minor compared with those of the surgeons. It has been described above how an organisation representing the orthopaedic surgeons complained about the lack of their own specialty sub-committee and at the next meeting complaints from other surgical sub-specialties were reported:

Dr. Bruce: Surgery is very important and we have had some communication from a body formed of all the surgical sub-specialties, it includes E.N.T., neurosurgery, plastics, paediatric surgery and so on and they have combined together and expressed concern about the sub-committee structure. They feel that the Surgical Sub-Committee will not be representative enough. I had thought the Surgical Sub-Committee was fairly representative but should we ask them if they want to nominate a member?

Professor Arden (Paediatrics): I thought that paediatric surgery should be on it.

Mr. Ross: It seems a strange body to me there is not really any common ground. Anyway I wouldn't have thought there was any chance of the Surgical Sub-Committee taking a decision in say plastics without getting the views of plastic surgeons.

Professor Telfer: I feel that if we take each representation too seriously then committees will become too large.

Dr. Bruce: What do we feel then?

Professor Arden: I feel the younger age group is not represented and should be.

Professor Telfer: But we do have a Paediatric Sub-Committee.

Dr. Roper: We should remember that these people are appointed in surgery and are not there to represent any particular branch, they are appointed by the districts as the best people in surgery.

While this may have been the case in theory and this point of view was accepted by the committee those specialties which were not represented did not see it like that. They obviously saw advantages accruing to membership and the lack of 'common ground' which Mr. Ross identified was the fact that they were dissatisfied with their representation. Mr. Ross made another interesting comment when he said 'I wouldn't have thought that there was any chance of the Surgical Sub-Committee taking a decision in say plastics without getting the views of plastic surgeons'. This again raised the question of whether they were able or willing to make decisions about specialties without their participation. If they were not prepared to do this then it suggests that participation might have an effect on outcome and presumably this could only be in a positive direction.

Further complaints about the composition of the Surgical Sub-Committee were reported at the next meeting of the Area Medical Committee on the 29th October 1974:

Dr. Bruce: The Surgical Sub-committee met and the CAMO asked me to mention that the Health Board is getting a lot of pressure from other surgical groups including urologists, plastic surgeons, neuro-surgeons and others. So we may have to change the composition of the committee.

Professor Luss: Couldn't we leave it to them to co-opt people if they want to?

Dr. Bruce: Yes.

It was left at this but meanwhile Mr. Ross, the only general surgeon on the Area Medical Committee had to resign through illness, he had also been the Area Medical Committee's representative on the Surgical Sub-committee. Mr. Leith, Mr. Ross's replacement on the Area Medical Committee, was on the Surgical Sub-committee already as a representative of the Endrick District. At the meeting on the 26th November the Area Medical Committee had to appoint an extra member to the Surgical Sub-committee:

Dr. Bruce: We'll take surgery first. We have to appoint a member onto the Surgical Sub-committee from this committee. Mr. Leith, Mr. Ross's replacement, is already on the Surgical Sub-committee from the Endrick District and we have had a lot of pressure from specialties who feel they are not represented. You could make it easy for me, as the recipient of many letters on the subject, particularly from urology. There are two alternatives, we could say that Mr. Leith is on as our representative and drop the hint to the Endrick District that we want them to nominate a urologist to replace him, or we could leave Mr. Leith on, as the representative of the Endrick District and we could appoint a urologist.

Professor Arden: I would put paediatric surgery above urology.

Dr. Ivar: I have a letter from the urologist Mr. Gregg, saying that urology has been disenfranchised under the new structure.

Dr. Humphrey: I don't think it should be stated that it should be a urologist, although it could be a surgeon who happened to be a urologist, but in surgery there are so many interests

and people can represent more than one interest.

Dr. Kirk: I would be unhappy about us nominating a urologist.

Dr. Bruce: O.K. we'll make Mr. Leith our representative and I'll drop the hint now which I hope will get through, that we want the Endrick District to nominate a surgeon who is a urologist.

In this way Mr. Ross's illness allowed the Area Medical Committee to make a concession to one of the dissatisfied groups, the group which had been most persistent in its lobbying of the Health Board, its officers and the Area Medical Committee. The committee showed an understandable ambivalence towards stating that the additional member should come from a specific specialty because this would have made a nonsense of the principle that members were not supposed to represent any branch of the profession. The claim by the urologists that they had been disenfranchised indicated that they did not see the structure in these terms. They had, in their own districts, been responsible for nominating two members to serve on the Surgical Sub-committee and as it happened none of the districts nominated a urologist. Only if they had had no part in nominating representatives would they have been disenfranchised. However, they saw it as an interest group forum with nobody to represent their interests.

The problems in all three of these sub-committees, Surgery, Psychiatry and Medicine, were very similar, involving a tension between impartiality and the representation of different interests. The problems in surgery seemed to be most acute, probably because of the more diverse specialisation within it and a greater sense of sub-specialty identity than was apparent within general medicine. The physicians on the Medical Sub-committee tended either to be general physicians with specific interests in areas of general medicine or specialised whole time in specific areas. In surgery, on the other hand, members tended to be general surgeons or specialists and the coverage of all the specialties within surgery was not feasible.

The formation of the specialty sub-committees put the final touches to the Medical Advisory Structure in the Lennox Health Board. The

position of Overton Hospital within the Lennox Medical Advisory Structure is shown in Figure 5.1.

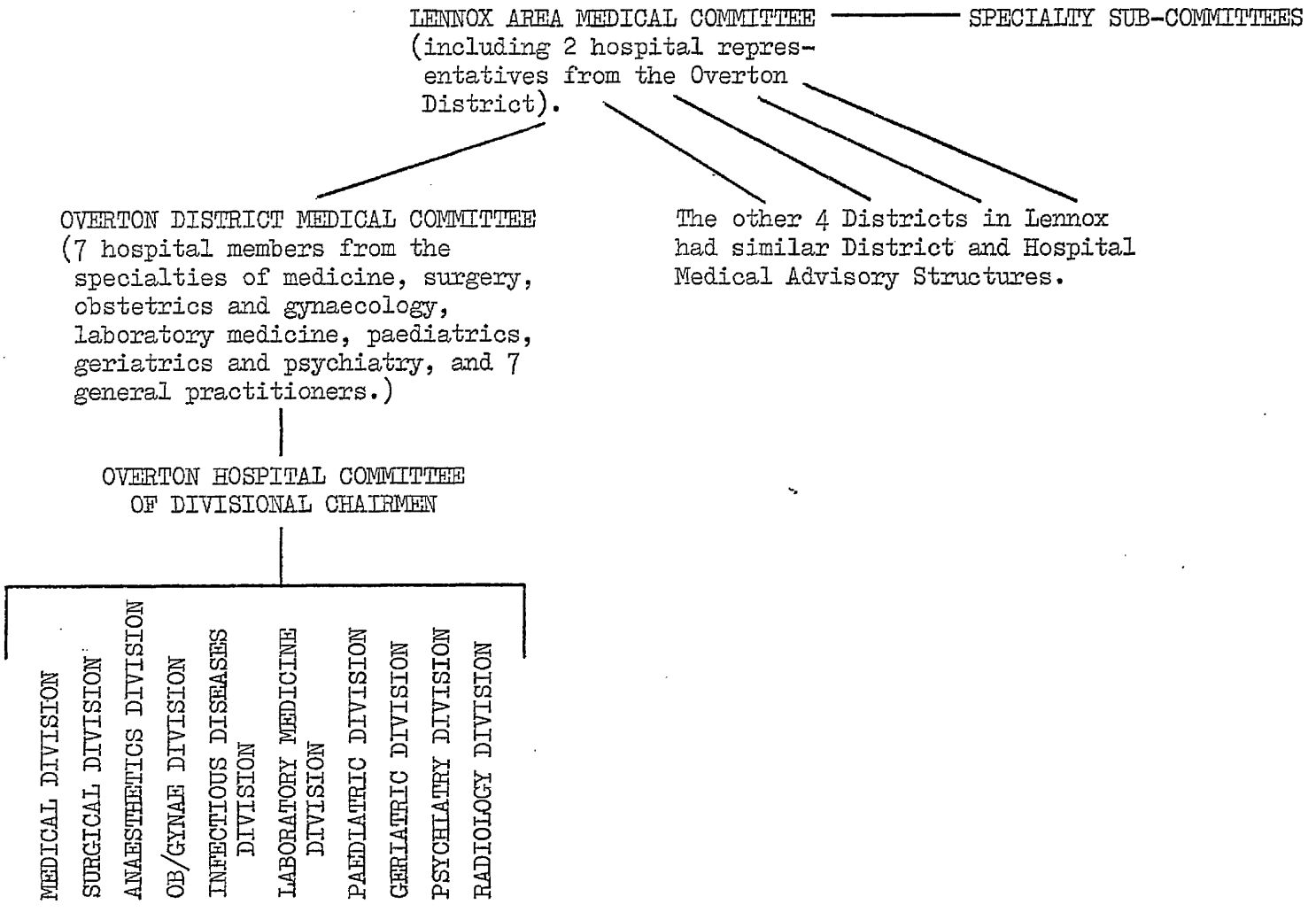
The last section of this chapter will draw together the major dilemmas which seemed important to the profession in setting up the structure and an assessment will be made of the way in which these relate to the theoretical ideas outlined in previous chapters.

Conclusion

This chapter has described the way in which the medical profession in Overton Hospital and the Lennox Area formed a Medical Advisory Structure. It has not been concerned with decision-making by these committees, to which the theory has been mainly addressed, but nonetheless it provides broad indications of the concerns and approach of the profession in setting up the structure.

In Overton Hospital the only specialty to show any great enthusiasm for forming a division was general medicine. The other specialties were much slower and it took a number of years and a weekend conference before they completed the hospital level of the structure. One of the most important factors in this was that the doctors were allowed to decide how many divisions they wanted. Specialties were allowed a free hand in determining whether they wanted a division to themselves or a joint division with another specialty. The result of this was thirteen divisions with the only amalgamations occurring in laboratory medicine and the surgical specialties and in addition there were the anomalies of two divisions in each of chest medicine and obstetrics and gynaecology. This may have gone against the spirit of the Joint Working Party proposals but it allowed for the expression of what were felt to be distinctive interests. The Committee of Divisional Chairmen was a natural progression from this although there was some initial concern about the injustice of having two spokesmen in two of the smaller specialties while other larger specialties only had one. The only worry in the formation of divisions was that clinical independence might be affected, but the doctors appeared to accept the Medical Superintendent's statement that this would not happen.

Figure 5.1. Overton Hospital and the Lennox Medical Advisory Structure.



The District Medical Committee posed the first problems of negotiation between the 'free' development of divisions and the broader format and purpose of the district committee. The Interim Area Medical Committee had decided that the District Medical Committees should comprise fourteen members, seven from general practice and seven from the hospital. This meant that six out of the thirteen divisional chairmen would have to be dropped for district purposes. This was partially solved by the amalgamation of the two divisions of obstetrics and gynaecology and of the two divisions of chest medicine with the Medical Division. This still left ten divisional chairmen to fit into seven places. They decided that seven places allowed the 'major' specialties to be represented and infectious diseases, anaesthetics and radiology were amalgamated with the divisions of medicine, surgery and laboratory medicine for district purposes.

The anaesthetists were very unhappy at the thought of always being represented by a surgeon, but the surgeons were convinced that they should always be on the District Medical Committee, being a 'major' specialty. This distinction between major and minor specialties was made more acute by the discussions about deputies. Those specialties on the District Medical Committee felt that they had to have deputies because 'we need to be there to put across our view, nobody else can do that', suggesting that inter-specialty lack of knowledge was indeed a problem, or that other specialties might not be reliable in putting across the viewpoint of absent specialties. However, those on the District Medical Committee did not seem to think that this was a problem for infectious diseases, anaesthetics and radiology, although the anaesthetists obviously thought that it was. This suggested that either they did not need to be represented at the district, or, unlike other specialties, their viewpoint could be put across by others. While this says nothing about the process of decision-making on the District Medical Committee it means that three specialties, and lower status ones at that, have no direct access to the District Medical Committee and may therefore be disadvantaged relative to those specialties that are represented. There was never any question of the infectious diseases chairman

representing infectious diseases and general medicine, or the anaesthetics chairman representing anaesthetics and surgery.

In theory, the Area Medical Committee was above narrow specialty concerns. While it was accepted that the five districts should provide equal numbers of members for the committee, in line with Hendry:

> 'In an area with several districts it will be necessary to secure a reasonable balance of membership between the districts.' ((2), para. 5.7)

the Area Medical Committee was not to be a forum for specialty viewpoints:

> 'Given that the function of the Area Medical Committee is to take a broad view and that specialty considerations will be the responsibility of sub-committees, it may not be necessary to carry the balance between specialties to extremes.' ((2), para. 5.7)

The Area Medical Committee made it clear that this was their approach as well in the following minuted statement:

> '... the Area Committee members should represent the whole profession rather than any part, geographical or specialty.'

Despite this commitment, the fact that apparently unbiased methods were used in the selection of members for both the Interim and the definitive Area Medical Committee and that in the case of the latter the district chairmen were to co-ordinate nominations in order to achieve some specialty balance, the specialty composition of both of these committees became an issue for discussion. The different selection procedures for the Interim Area Medical Committee and the Area Medical Committee produced a majority of physicians on both committees (seven out of twelve in the first and five out of twelve in the second). This appeared to indicate a genuine bias within the profession. In the case of the interim committee one member had been appointed by each district, and four out of the five districts

nominated a physician. In Overton, the physicians had been the first to form a division and the chairman of that division had subsequently become Chairman of the Committee of Divisional Chairmen. A similar process had taken place in the other three districts which nominated a physician. In the broader political forum of the British Medical Association three out of the seven nominees were physicians. The physicians were quicker to organise themselves and in addition other specialties seemed to be either deferential towards them or think they were the best people for the job. Whatever the reason, physicians had basic structural advantages relative to other specialties, although it should be stressed again that this does not necessarily mean that these advantages were used to the benefit of general medicine. Although undoubtedly other members who complained about the specialty composition did perceive advantages accruing from membership.

In the Interim Area Medical Committee there were suggestions that the number of physicians should be reduced and/or members from other specialties should be added. The former was rejected but the psychiatrists had organised a body to protect their interests and this body pressed for membership of the interim committee. This was acceded to. The same thing happened with the Area Medical Committee when the method of selection again failed to produce a psychiatrist and a nomination was sought from the same body. In both of these cases there were other specialties who happened not to be represented on the committee, for example, geriatrics. However, they did not ask for representation and were not asked if they wanted to be represented. Despite the mode of selection it appeared that the Area Medical Committee could not be seen to 'represent the whole profession' unless all or at least certain specialties were members of the committee.

The next stage of the structure was the formation of specialty subcommittees, but even before this was discussed a number of specialties, for example, infectious diseases and cardiology, pressed for recognition as sources of advice. They were rejected because it was not known if they were representative. A list of specialty

sub-committees was proposed and immediately the accident and orthopaedic surgeons formed an organisation to press for a separate sub-committee, rather than being included in a single surgical sub-committee. This was also rejected by the Area Medical Committee.

Nominations were made from the districts for the specialty sub-committees and in a less homogeneous specialty like surgery groupings of specialists who did not have members started to organise and press for representation. There were problems of inclusion and demarcation in medicine and psychiatry as well but these were dealt with more easily. A number of the surgical sub-specialties combined to lobby the Area Medical Committee, the Area Board and the CAMO. The Area Medical Committee was against specifically stating that members of any specialty should be on the sub-committees because this would give them a definite specialty mandate which was not granted to others. In addition there was a certain ambivalence as to whether members of the surgical sub-committee could represent and speak for unrepresented surgical specialties, some said they could, others said a specialty could be co-opted if an issue directly concerned them.

The group which applied most pressure for membership of the surgical sub-committee was urology and eventually the Area Medical Committee found a covert way of appointing a urologist to the sub-committee, without saying that a urologist should be on the sub-committee. This was despite the fact that the sub-committee had been given powers of co-option and that a number of the other surgical sub-specialties remained unrepresented. These smaller groupings saw themselves as having distinctive identities and interests which they felt could not be served by other surgeons. They felt that membership conferred advantages and as in the case of membership of the interim and definitive Area Medical Committee the group which pressed hardest eventually achieved representation.

The problems which arose in the establishment of the Medical Advisory Structure revolved around specialty representation. While all specialties could be represented at the local level this was not a

possibility or a design at the higher levels. This was aggravated by the over-representation of some specialties, general medicine on the Interim Area Medical Committee and the Area Medical Committee and general surgery and the surgical super-specialties on the surgical sub-committee. The feeling of those who were represented was that members were there to take a broad impartial view and not to repreeent their own specialty interest. The viewpoint of those specialties who were not represented was that the committees would not take a broad view unless all the groups within the profession were represented. They saw lack of membership as being detrimental to specialty interests and membership as being advantageous to specialty interests. While in its formal statements the Area Medical Committee took the official line on the impartiality of membership and the irrelevance of specialty composition it capitulated to some of the specialties which applied pressure, and generally those which applied the most pressure.

In terms of the actual operation of the structure the main concern is with the local level. Specialty representation was not such a problem at that level because all the groups who wanted to be represented were represented. However, the physicians seemed to have some structural advantages within this, they were the first to organise and they were nominated to represent the district at higher levels. There are no indications in the formation of the Committee of Divisional Chairmen at Overton as to whether specialty interest will be in conflict with hospital interest, but if the area level is any guide to the way in which the structure as a whole is viewed then specialty interest and the lack of inter-specialty knowledge would appear to be substantial features.

The next chapter will outline the development of the Medical Advisory Structure in Allan Hospital and the Aldershire area. The treatment will be mainly descriptive but as in this chapter the concern will be to identify the approach and outlook of the profession in setting up the structure.

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Chapter 6. Allan Hospital: The Development of the Medical Advisory Structure.

Introduction

Allan Hospital is the second hospital in this study. It is the main hospital in what is now the Allan District, one of the three districts in the Aldershire Health Board. As in the last chapter the development of the Medical Advisory Structure will be charted from the hospital up to the area level, although in later chapters the major focus will be upon the process of decision-making in the hospital.

The chapter starts with a short description of the hospital, the district and the area. This is followed by a chronological account of the discussions in the hospital about the formation of a divisional system and the subsequent developments at the district and area levels. The aim is to provide an outline of the structure and also to identify the main concerns of the profession in deciding what that structure should be.

Allan Hospital and the Aldershire Area

The Aldershire Area Health Board administers the health services in one of the larger peripheral areas of Scotland. Its catchment area includes a number of industrial and mining towns and a large agricultural community. It is divided into three districts for administrative purposes. Allan Hospital was built under the Emergency Medical Service provision in the Second World War and consequently is made up of a series of single storey buildings which have been adapted to serve longer term requirements. It was absorbed into the National Health Service in 1948.

Prior to the 1974 reorganisation Allan Hospital was administered by one of the three Boards of Management in Aldershire, although the present district boundaries cut across the old catchment areas of these three Boards. The Allan District includes the following hospitals:

Allan Hospital: a 600-bedded general hospital with provision for the major medical specialties of general medicine, general surgery, orthopaedic and accident surgery, E.N.T. surgery, medical paediatrics, child psychiatry, gynaecology, geriatrics, anaesthetics, radiology, pathology and biochemistry.

Tummel Mental Hospital: a large traditional mental hospital.

Craig Maternity Hospital: which provides obstetrics facilities for Allan Hospital.

Comyns Hospital: geriatrics.

Spean Hospital: mainly chest medicine and outpatient facilities (there are plans to build a new district general hospital on the site of Spean which would take over from Allan as the main hospital in the district).

The other two districts are Kenmore, including Kenmore Hospital and Dorian Hospital, and Laggan, where the Laggan District General Hospital is being built.

The area does not include a teaching hospital and, although Allan and the other main hospitals each have a postgraduate tutor, facilities for teaching are limited.

At a more general level there is concern among most of the peripheral areas in Scotland about their poor facilities and staff ratios as compared with the teaching hospitals in the big cities. Aldershire is no exception and a number of discussions, particularly at the area level, centred upon perceived inequalities in the distribution of central resources.

The Medical Staff in Allan Hospital

At the time of the research the medical staff of Allan Hospital were as follows:

Junior House Officers	-	10
Senior House Officers	-	19
Registrars	-	20
Medical Assistants	-	9
Consultants	-	35 (29 of whom spent a majority of their time working in Allan.)

The number of consultants in any specialty was small compared with Overton Hospital, general medicine had five consultants, general surgery had four, orthopaedic and accident surgery had four and most of the other specialties consisted of one or two consultants. The exception to this was anaesthetics which had eight consultants but they served all the hospitals in the area and much of the work at Allan was undertaken by two of them. Apart from anaesthetics there were no consultants in-administrative-charge and each consultant generally had his own ward or wards in the clinical specialties. For example, the general physicians had a male and a female ward each. Despite this most specialties included one consultant who was considered to be senior, by virtue of either age or experience, but there were no official differences between consultants.

The main organisation of the medical staff was the Medical Staff Association, of which all the consultants in the hospital were members (there was also a Junior Medical Staff Association for junior medical staff but this met infrequently and had little interaction with the consultants' Association). The Medical Superintendent attended all the meetings of the Medical Staff Association and this body, through him, was the main source of medical advice to the administration. The other route was through the medical membership of the Board of Management, which in its later years consisted of the senior general physician, the senior radiologist and the senior orthopaedic surgeon. The discussions about the formation of a divisional system were conducted within the Association which, as will become clear, showed considerable resistance to change.

The Medical Staff Association and the Divisional System

The 1967 Joint Working Party Report (1) was first discussed by the Medical Staff Association on the 4th December 1967. The consultants appeared to be quite open to its suggestions as the following extracts from the minutes indicate:

'Dr. Gow thought that the divisional system was coming but wondered if it did not already exist.'

'Mr. Earn thought that we were closer to the divisional system than most other hospitals.'

'During discussion of the report it was pointed out that the anaesthetic and orthopaedic departments were already operating divisional systems.'

Progressive patient care, another concept mentioned in the report, was discussed but they were generally against it. However, no definite decision was made to introduce the system. The Board of Management discussed the report shortly afterwards, gave it their general approval and

'... also agreed that the Secretary should notify the Director of the Scottish Hospital Centre that the Board of Management was willing to support an experiment in self care ...'

The Scottish Hospital Centre replied in January 1968 saying that it would be pleased to help plan a self care or pre-discharge unit. From then on the Board of Management referred to divisions as if they had been formed and were in operation.

At the same time the secretary of the Board, Mr. Turret, circulated a memorandum to consultants in which he went a considerable way towards providing a definitive plan for a divisional system including progressive patient care. He proposed the following divisions:

Medical: including geriatrics, skins, chests, kidney unit, cardiology.

Surgical: including paediatrics, urology, gynaecology, and possibly E.N.T..

Orthopaedic and Casualty: to cover both Allan and Kenmore Hospitals.

Other Specialties: such as radiology, pathology, etc. might be grouped in either of the above or in separate divisions as might be thought best.

He also outlined the advantages of the divisional system and ended by saying:

'A very great interest is being taken in these new concepts at department level ... Money might therefore be available to introduce suitable pilot schemes and there seems to be no reason why Allan Hospital should not offer to make her facilities available for such studies. Not only would this enhance the image of the hospital it would also increase the stature of the staff practising in the new techniques of patient care.'

This was followed immediately by a memorandum from the physician, Dr. Gow. He attacked the proposals, mainly because the Joint Working Party Report was a 'basis for further study' which did not commit anyone to anything. He argued that the divisional system was more applicable to teaching hospitals and stressed:

'The advantages of the unit system in which individuals work together in a team including nursing and medical staff are considerable. There is great advantage in the ability to define the area of medical responsibility.'

There was also some disquiet about the fact that the secretary had specified which specialties should join together to form divisions. For example, paediatrics was a medical unit which happened to have its wards in the surgical block. Neither of the paediatricians saw any reason why they should be joined with surgery, or with any other specialty for that matter.

Despite that the Medical Staff Association decided to establish a divisional system at the meeting of the 5th February 1968. While this did not follow Mr. Turret's recommendations there seemed to

be even more optimism about the existing state of divisional development:

'It was generally felt that there was an inter-hospital divisional system existing in the orthopaedic and geriatric departments and that the medical and surgical units were almost in divisions. The obstetrics units were managed as a regional inter-hospital division and gynaecology from this hospital was to some extent included in this division. The paediatric ward being mainly medically oriented was sited in the surgical block and depending upon subspecialties for its night cover was mentioned as an example of a unit which would have to be arbitrarily put in a division. The question of including geriatrics in the Medical Division was raised but not discussed at any length.'

At the next meeting there were still some doubts but firm moves were made to start the system:

'It was suggested that there should be further discussion on the Brotherston Report with particular reference to the formation of divisions. There was a proposal that there should be a general meeting on the matter, however, a number of individuals were against this feeling that the creation of divisions was accepted at the last meeting.'

Consequently Dr. Rollo, the Medical Superintendent, was asked to carry out a 'preliminary reconnaisance' in medicine and surgery. Two months later, on 3rd June 1968 he reported back to the Association:

'(a) Report on Proposed Surgical Division.
Meetings on the subject had so far been exploratory. The division was to consist of the general surgeons. Regular meetings were proposed and it was thought that the chairman would have no executive authority except in an emergency.

(b) Report on Proposed Medical Division.

It was felt that the division already exists and it should be considered a division in an 'administrative sense not clinical'. At present within the division there were medical and 'chest' physicians. Geriatrics and paediatrics were invited to join the division. The chairman was to be appointed for one year but if there was a strong minority view it was felt that it should be heard at the Committee of Chairmen. The geriatric physicians felt that they would be better in a division of their own.'

The two paediatricians also declined to join the Medical Division. Even this preliminary report was interesting. First, because both specialties made it clear that the divisions were not going to interfere with clinical autonomy, and secondly because none of the smaller specialties in either medicine or surgery wanted to go in with the larger specialties.

The next move came in October 1968 when the Board of Management set up a sub-committee to look at the implementation of the Joint Working Party report. This came to fruition in a letter from the Regional Hospital Board in March 1969:

'Thank you for your letter ... You will recall that in paragraph 4 of the circular, Regional Hospital Boards were asked to identify situations where pilot schemes on the divisional system could be inaugurated at an early date and the Regional Board has suggested to the Scottish Home and Health Department that your area would be suitable for this, and I hope this proposal will be acceptable to you.'

A copy of this letter was sent to the Medical Staff Association but it was not discussed through lack of information. Furthermore, despite the fact that the hospital had been put forward for a national pilot study, the Medical Staff Association did not mention divisions again until two years later, in February 1971. It arose obliquely following a memorandum from two general surgeons in which they criticised the efficiency of the Staff Association:

'The present monthly meetings of the whole Staff Association ... are manifestly too large a body to carry through business in an efficient manner and to take meaningful decisions. It is also wasteful of time for those involved. A more sensible arrangement would be to form an executive committee e.g. the chairman, vice-chairman and up to nine elected representatives, including one from the junior staff. The executive could meet each month and minutes could be circulated for information and comment. The whole Staff Association need only meet once or twice a year.'

This was discussed at the March 1st meeting 1971, no decision was reached and it was put on the agenda for the next meeting. The April meeting again failed to produce a decision and it was discussed again in May when it was pointed out that

'... there was an existing constitutional executive committee which was, by chance, fairly representative of the hospital divisions as a whole.'

No decision was reached and the matter was discussed again at the meeting on June 7th. The minutes reported:

'... Dr. Birnam stated that an executive committee should have divisional representation. The representatives from such divisions should discuss items with their colleagues and at executive meetings represent divisional views. It was noted that in some cases divisions did not exist in the hospital and in other cases it was difficult to place certain specialties in appropriate divisions. Finally it was proposed by Mr. Earn and seconded by Dr. Carty that a sub-committee with executive powers be formed. This committee would then draft a constitution for an executive committee. This was agreed by the Staff Association. The members of the sub-committee would be the present executive committee.'

To recap, the Staff Association had appointed the constitutional executive committee as a sub-committee with executive powers to look at the constitution of an executive committee for the Medical Staff

Association. The sub-committee met and recommended an executive committee consisting of the chairman, vice-chairman and secretary of the Staff Association, a representative from each of general medicine, geriatric medicine, the accident and traumatic unit, general surgery, anaesthetics, radiology, laboratory medicine and two junior doctors and the Medical Superintendent. Despite its executive powers the recommendation of the sub-committee was rejected by the Staff Association mainly because it did not include representatives from all the specialties, for example, paediatrics and gynaecology but also because it included members of the junior staff. The sub-committee was sent away to produce another proposal. This time it was not based upon specialty representation and consisted of the chairman, vice-chairman and secretary of the Staff Association, the Medical Superintendent, one medical member of the Board of Management and three members of the Medical Staff Association.

This was more acceptable but further discussion was forestalled by the circulation of the second Joint Working Party Report, Doctors in an Integrated Health Service (2). The Board of Management discussed and approved it in October 1971. The Staff Association discussed it in November and decided that detailed attention should be paid to the proposals for a Medical Advisory Structure. This was done at the meeting on the 6th December 1971 and in agreeing as to its importance they had to come to a decision about its formation. This took them back into the quagmire of the divisional system:

'It was proposed by Mr. Voil and seconded by Dr. Scone that the existing executive committee perform the functions of this medical advisory body. A counter proposal, that one member from each specialty form such a body was proposed by Dr. Cally, seconded by Dr. Carty. This counter proposal would probably involve representation from Surgery, Medicine, Paediatrics, Geriatrics, Radiology, E.N.T., Laboratories, Anaesthetics, Orthopaedics, Obstetrics/Gynaecology, Child Psychiatry, Accident/Emergency, Mental Health, Public Health and Medical Administration. This would involve at least fifteen members. It was decided at this point having had discussion on the subject, that there would be a postponement of a decision until

the next meeting of the Staff Association to allow the members further consideration of the issue. Mr. Earn was against the postponement.'

In coming forward with this list of fifteen separate specialty groupings, when there were only thirty consultants in the hospital as a whole it was clear that no specialty group, however small, was prepared to be represented by a member of another specialty.

They discussed the matter again in January 1972 but were still unable to decide whether the existing Staff Association executive or a committee upon which medical specialties were represented should form the basis of the Medical Advisory Structure. Instead they decided that:

'Dr. Rollo would attempt to call a meeting of all related medical departments within the next few weeks and if possible submit a recommendation at the next meeting of the Senior Medical Staff Association in February.'

In February Dr. Rollo had not done this and the matter was left until the March meeting when the following was reported:

'At a meeting which Dr. Rollo had had with representatives from the Consultant General Surgeons, Consultant Orthopaedic Surgeons, Consultant Gynaecologists, and Consultant E.N.T. Surgeons ... it was decided unanimously that one representative from each specialty (with some exceptions for specialties which only attract a small amount of service to the hospital) should be elected to an advisory committee. As this meeting only concerned the surgeons in the hospital it was suggested that a similar meeting be arranged by Dr. Rollo with the Consultant Physicians and consultants in allied specialties.'

This meeting with the physicians was reported to the Staff Association on 8th May 1972:

'The general physicians ... had agreed unanimously that the creation of a Medical Division was likely to be the most

satisfactory method of channelling advice to management but in view of the previous decision made by the Surgeons, the Physicians felt that some further discussion with the Surgeons would be helpful in reaching an acceptable and uniform decision.'

What concerned the physicians was that the surgeons looked like having four representatives, from general surgery, orthopaedics, gynaecology and E.N.T. while the physicians would only have one. However, no compromise was reached and the matter was not raised again until six months later when the Medical Superintendent said that the matter was now urgent because shadow Health Boards would be appointed in March 1973 and there would need to be a medical organisation ready to advise them. At this stage initiatives were taken at the area level and discussion at the local level ceased with no very clear idea as to the shape of the Medical Advisory Structure in the hospital. From the very first discussions of the divisional system there were continual reiterations of the intent to form such a system but whenever it became a matter of deciding on the precise number of divisions there appeared to be stumbling blocks which related mainly to the desire of all specialty groups, however small, to be independently represented. The hospital level of the structure is discussed in more detail at the end of this chapter because further developments occurred during the formation of the Area and District Medical Committees.

The Formation of the Aldershire Area Medical Committee

Two separate initiatives on this began at around the same time. One was from the Aldershire division of the British Medical Association and the other was from the Medical Staff Associations in the hospitals of Aldershire.

The British Medical Association Initiative

In line with the Scottish Home and Health Department recommendation that the British Medical Association should play a part in setting up area Medical Advisory Structures, the secretary of the local British Medical Association division wrote to all the hospitals and general

practitioners on 5th December 1972. He suggested that a working party should be set up to plan the formation of an Interim Area Medical Committee, and that the working party should consist of:

Five Hospital Consultants

Two Junior Hospital Doctors

Six General Practitioners

Two Community Medicine Specialists

The Chairman and Secretary of the Aldershire Division of the British Medical Association

and that the meeting should be held on the 22nd January 1973.

The Staff Associations' Initiative

At the same time as the letter from the British Medical Association secretary was sent out, the Medical Staff Associations in Aldershire were planning a meeting to discuss the formation of the Interim Area Medical Committee on January 13th 1973. When the Allan Staff Association received the letter from the British Medical Association they were extremely hostile towards it. In some ways this was hardly surprising because Aldershire was one of the areas in which there had been an upsurge in membership of the Hospital Consultants and Specialists' Association, the rival national body to the British Medical Association. The concern of the Staff Association related to both the involvement of the British Medical Association and the proposed working party.

On the first point they decided that it was not necessary to have the British Medical Association present in the planning of an Interim Medical Committee. On the second point they came up with an alternative working party, consisting of:

Seven Hospital Consultants (two from each of Allan, Kenmore and Dorian Hospitals, plus one psychiatrist from Tummel Mental Hospital and excluding junior staff).

Seven General Practitioners.

Two Community Physicians (one from the hospital and one from public health).

They thought the most important part of this was that it provided for equal numbers of hospital doctors and general practitioners. They had also rejected the idea of junior staff involvement.

The meeting between the four Staff Associations (Allan, Dorian, Kenmore and Tummel) took place in Kenmore Hospital on 13th January 1973. They agreed that the proposed working party should not be sponsored by the British Medical Association, that the number of general practitioners should be equal to the number of hospital doctors, that the hospital contingent should consist of two members from each of the four main hospitals in the area, and that there should be four community medicine specialists.

The Secretary of the Allan Staff Association subsequently wrote to the British Medical Association to 'clarify the position', but clearly set out the resentment about their involvement:

> '... it seemed most unusual that an outside agency should write with suggestions about the make-up of the hospital representative group and at the same time allude to the first intended hospital meeting when they had not been officially informed about it. Possibly this was a well-meant gesture but it must be looked upon as an insulting interference which complicated the meetings of the four MSA's taking part. The original proposal for these meetings was obviously an exercise in co-operation and representation. The purpose of the Steering Committee having been formed is to make contact with other representative bodies, the officers of the present Regional Board, the Local Medical Committee, the Medical Officers of Health and possibly the BMA. Such a Steering Committee has to be carefully formed by the people immediately concerned so that the MSA's of Aldershire know how they will be represented and conversely the Steering Committee will be in no doubt about its remit. In such matters it is unfortunate that any body such as the BMA should make formal proposals and arrange meetings on information that has been casually and not officially come by and they should be so informed.'

Part of the problem here was that the consultants in Allan tended to see the British Medical Association as a general practitioner body and the fact that it had recommended more general practitioners than consultants as members of the working party had reinforced this view.

Despite this the working party met on the 22nd January and although the chairman and secretary of the British Medical Association division acted as chairman and secretary the membership was that which had been set out by the four Medical Staff Associations. At the next meeting they decided that the Interim Area Medical Committee would be composed of eight hospital doctors, eight general practitioners and four doctors from administrative medicine. As the next meeting of the working party was to be the first meeting of the Interim Area Medical Committee, this disposed of the involvement of the British Medical Association.

The Aldershire Interim Area Medical Committee

The first meeting of this committee was held on the 30th April 1973 and on that day the Allan Medical Staff Association nominated Dr. Currie, an anaesthetist, and Dr. Cally, a paediatrician, as its representatives (Dr. Gow, the physician, had been one of the elected representatives but when it was learnt that he was to be a member of the Aldershire Health Board he decided to withdraw). The interim committee elected Dr. Tilt, a general practitioner, as chairman and Mr. Struan, an E.N.T. surgeon, as vice-chairman. The Medical Superintendent at Allan, Dr. Rollo, was elected secretary. The hospital membership consisted of two members from each of the four main hospitals in the area and this method produced the following specialty split:

2 Psychiatrists
1 General Physician
1 General Surgeon
1 E.N.T. Surgeon
1 Anaesthetist
1 Paediatrician
1 Geriatrician

At this first meeting they discussed the question of deputies and it was decided that they would have them (Allan Medical Staff Association subsequently elected two general surgeons, Mr. Earn and Mr. Fillan, to serve as deputies). The other main item on the agenda was the sub-committee structure. The general practitioners said that they already had a sub-committee and the question of hospital sub-committees was referred back to the Medical Staff Associations.

The Allan Staff Association discussed this at its meeting on the 4th June 1973. Dr. Cally, the chairman of the Staff Association and one of the members of the interim committee felt that the hospital sub-committees should not be standing committees but that, when required, members of a specialty should be co-opted onto the Hospital Sub-committee (comprising the hospital members of the interim committee). Other consultants were concerned that all members of a specialty should be co-opted on such occasions so that there was no chance of them being outnumbered by the standing members of the committee. In response to this the head orthopaedic surgeon doubted if his colleagues at Kenmore Hospital would agree to sit on the same committee as the orthopaedic surgeons at Allan.

This was reported back to the interim committee that evening. The hospital members were in agreement that specialties should be co-opted when necessary. Dr. Cally also raised the fear expressed at Allan that a specialty might be outnumbered. Dr. Tilt, the chairman, replied that if members of a specialty were dissatisfied they could always bring the matter to the full Area Medical Committee for resolution.

The other matters raised at the meeting related to the composition of the final committee. A number of proposals were put forward but most of these were left to a sub-committee which was appointed to examine the constitution. It met on the 20th June and attention was focussed upon the eventual size of the committee and the question of specialty representation. Dr. Tromie, of Tummell Mental Hospital, was on the sub-committee and he felt that psychiatry should be repre-

sented on the Area Medical Committee because of the mammoth problems which his specialty faced. However, he recognised that if one specialty was specifically mentioned as having a definite right to membership then others would want to have that right as well. This was not resolved but in more general terms they decided that each district would nominate three hospital doctors and three general practitioners and that in addition the definitive committee would have two junior doctors and three community medicine specialists.

At the next meeting of the Interim Area Medical Committee there were requests from the radiologists and the laboratory medicine consultants that their specialties should have direct representation on the Interim Area Medical Committee. This was rejected:

> 'The members appreciated the points made by the specialists but they felt that the membership of this committee derived from Hospitals/Groups and not from specialties. The unanimous view was that all specialists would continue to be represented via their division and if a particular problem arose within a specialty, the correct approach would be through this committee or through the CAMO who would, in turn, seek the views of this committee.'

Unlike the Lennox Interim Area Medical Committee they were keeping strictly to the Hendry recommendations and not allowing even the suspicion of specialty representation to creep in.

The sub-committee on the constitution met again on the 15th October and agreed, on the advice of the Scottish Home and Health Department, to omit community medicine from the Area Medical Committee. Again they discussed the number of representatives from each of the districts. Dr. Rollo pointed out that the number of beds and doctors in the three districts varied considerably and argued that this might be a basis for having more members from the districts with more facilities. However, the chairman, Dr. Tilt, pointed out that the number of patients within the three districts was almost identical. At the meeting of the Interim Area Medical Committee which followed the problem of equal representation was raised again with the members

from Allan arguing that they should have more members than the Laggan District because Laggan did not have a hospital at that stage. The chairman, Dr. Tilt, retorted:

> 'And they never will be equal if the presently strong districts have greater representation than those districts which have weaknesses in certain facilities ... The G.P.'s look upon themselves as G.P.'s. In the hospital if you could look upon yourselves as hospital doctors looking for the best interests of patients, rather than looking upon yourselves as physicians and surgeons. In Dornay they have fifteen chairmen of divisions alone. Lots of problems disappear if you just think of yourselves as hospital doctors.'

Despite this, the Allan representative, Dr. Cally, was still concerned about the position of his district:

Dr. Cally: The problem is that in the Allan District you have Allan, Tummel and Spey Hospitals among others, whereas in the Laggan District there is only Laggan and that isn't built yet. If there are only three representatives from the Allan District then we will lose out compared to Laggan.

Dr. Tromie: I'm sorry to make things difficult but the psychiatrists had a discussion and one of the points which we want has a bearing on this. We must say that there should be inserted the following words 'no major hospital serving an area function shall go unrepresented on the Area Committee.'

Dr. Rollo: Impossible.

Dr. Cally: We are worried that Allan will not be represented at all on the Area Committee.

Dr. Tromie: We are wanting representation of every major hospital.

Dr. Tilt: But we need to keep to the population numbers. It is not practicable for everyone to be represented. If that is accepted then our proposals are eminently reasonable.

Mr. Struan: You really have to trust your representatives.

Dr. Cally: But people are not that good, they will represent their own interest rather than the interest of the district.

The matter was referred to the hospital sub-committee for further discussion. However, the exchanges which took place here were interesting for a variety of reasons. The main concern of the hospital doctors, at least those from Allan, was with the institutional basis of membership, rather than the specialty base (indeed they had rejected advances by unrepresented specialties to join the Interim Area Medical Committee), that is apart from psychiatry where specialty and institutional concerns coincided. Dr. Cally wanted Allan Hospital to be represented and was worried that if it was not, representatives from the other hospitals in the District would not represent adequately the views of Allan. His charge was that people are not morally good enough to put their own interest below or on a par with the interests of others. Despite the aim and purpose of the committee he thought that outcomes were dependent upon membership, and that if a group was not represented then its interests would not be served. This is one aspect of the role conflict mentioned in the last chapter between self-interest and broader interests.

Whether or not self-interest does dominate is an empirical matter but Dr. Cally's approach was that it would do so. While it was impossible for all interests to be represented it was clear that Allan Hospital thought it should be. The assumption appeared to be that the committee could only do its job and act as a broad discursive body without bias if certain interests were represented, in this case they were institutional interests, in the case of Lennox they had been specialty interests.

At this stage the interim committee reminded the districts that they had to establish District Medical Committees. The general practitioner membership was to be provided by election, the hospital doctors had yet to decide how they would appoint members.

The Development of the Allan District Medical Committee

On the 26th November 1973 the Allan Medical Staff Association discussed the formation of the District Medical Committee. There were to be six general practitioners and six hospital doctors on the committee. The problem for Allan was that there were six hospitals in the District

(Allan, Craig Maternity, Tummel Mental, Spean, Comyns and Spey Maternity, the latter was eventually moved into the Laggan District but at this stage it caused acute problems). With six hospitals and six members the worry in Allan was that they might have only one member on the District Medical Committee. A further complication was that Spey and Tummel were specialty hospitals and would almost certainly want to be represented at the district. Once again this raised the spectre of the divisional system:

Mr. Fillan: Could we have the specialties represented?

Dr. Cally: We took a vote a long time ago not to have divisions and it might be incorrect to move from the Staff Association structure.

Mr. Fillan: The problem is that Tummel and Spey are to be represented on a specialty basis and if we are to compete with them on an equal basis then we really need to have specialties as well.

Dr. Glen: Do we have to restrict ourselves to six members?

Dr. Cally: No we can have as many as we like, however, if we had specialty representation, how many specialties would there be?

Dr. Rollo: There were twenty-three at the last count.

Dr. Cally: Well you have surgery, medicine, pathology, well you know what the twenty-three are, what are they?

Dr. Rollo: Well if you look at the non-clinical there are radiology and the laboratories.

Dr. Cally: You're not suggesting that they should be put together surely?

Dr. Rollo: No I know they wouldn't agree to go together, then there are medicine, surgery, paediatrics, gynaecology, ophthalmology, geriatrics ...

Mr. Fillan: But we want to pick six altogether.

Dr. Rollo: Well suppose we said chronic, acute, service, psychiatry, obstetrics and gynaecology ...

Mr. Fillan: Well you could have obstetrics and gynaecology, psychiatry, surgery, including ophthalmology and orthopaedics, medicine, including geriatrics ...

Dr. Cally: But they won't agree.

Dr. Wade: Medicine don't have a division.

Dr. Cally: Dr. Wade has tried to get a division but the physicians won't have it. We are hoping to have an area division of paediatrics. If the hospital had a chairmen of divisions meeting then everything would be O.K.. You don't have a division in anaesthetics do you Dr. Currie?

Dr. Currie: Yes we do.

Dr. Cally: You don't have an elected chairman.

Dr. Currie: Yes we do.

Dr. Cally: Can we change the divisional proposals?

Mr. Earn: They are only advisory and merely made suggestions, they were not dogmatic. I think we should get down to particulars. Is representation between hospitals to be on the basis of number of beds or number of staff? Not the former because some specialties do not have beds. Also the ratio of staff to beds is no good. We cannot have representatives in each discipline. I would hope we could pick good people from among the staff.

Dr. Cally: So we come back to the Staff Association.

Dr. Rollo: Well augmented by Craig, Tummel, Spey, Comyns and Spean hospitals. I agree with Mr. Earn.

Mr. Fillan: The problem is that people will have to represent interests other than their own.

Dr. Currie: Then we will have to elect the best people.

The possibility of introducing a divisional system had been raised yet again. The major reason for this was that the District Medical Committee was going to include two members from specialty hospitals, an obstetrician and a psychiatrist.

It was feared that they would push specialty interests and that if Allan's representatives were not specialty representatives they would not be able to 'compete with them on an equal basis'. Some of the doctors were therefore anticipating that the District Medical Committee would be a forum for the competition of interests, rather than for the impartial discussion of district issues. While they were quite keen to have specialty representatives the problem arose when they tried to decide which specialties or specialty groupings should be represented and the pattern was the same as in many of the earlier discussions. If specialty groupings were to be used then every specialty wanted a single representative, and this time they decided that there were twenty-three separate interests. This was clearly impossible for the District Medical Committee. However, when broader specialty groupings were mooted it was clear that none of the specialties wanted to be represented under a broader specialty label or by a member of another specialty. As their solution to nominate the 'best' people indicated, they did not mind which specialties happened to be represented but they did not want members to be solely responsible for particular groups of specialties. By 'best people' they meant people who could represent interest other than their own. Whereas if representatives had a specialty mandate then there would be no compunction upon them to represent interests other than their own. Once again they shied away from specialty groupings as a basis for the structure.

The remaining problem was how the six hospital members of the District Medical Committee would be split between the six hospitals in the District:

Dr. Cally: What about the hospitals though, that would mean that Comyns with a couple of medical staff would have as many representatives as us.

Mr. Earn: What are we afraid of?

Mr. Fillan: I think we are more important then they are in terms of the number of patients we deal with.

Mr. Earn: I think it would be hard to justify that.

They failed to come to a decision on this and it was agreed that this should be left to a meeting of all the consultants in the district. This was subsequently held at Spean Hospital and the members from Allan stated that they felt their interests could be represented by three doctors, leaving one from each of Tummel and Spey and one from the other hospitals in the district.

Allan Hospital held a postal ballot to elect their three members. In an interview conducted at the time with the Chairman of the Medical Staff Association he made the following points:

> 'Well we are having a ballot which was done rather quickly and the results will be out on Friday but there are one or two things which worry us. One is that the secretary has told me that some people have voted for themselves and I have not as this goes against the grain. You would not do this if the thing were being decided by a show of hands. Another point is that some groups may concentrate on getting their own representatives on. The anaesthetists have eight people and if you were in a meeting and they all voted for one of their number you would suspect something was up but this will not be apparent through the ballot. The other matter linked with this is that they may only vote for one person and they are supposed to vote for three people as they will have to be represented by three people.'

Even though they had decided that specialty groupings were not the answer to district representation there were still fears that some groups would concentrate upon securing a place for a member of their own specialty. The result of the ballot was announced to the Staff Association on the 4th February 1974, Mr. Earn, a general surgeon, Dr. Cally, a paediatrician, and Dr. Forrester, an anaesthetists were the hospital's nominees for the District Medical Committee. A week later it was announced that Spey Maternity Hospital would be put into the Laggan District for administrative purposes and this eased the problems of representation in the Allan District, Allan Hospital was allowed to nominate another member, the consultant who came fourth in the ballot, an orthopaedic surgeon.

The Allan District Medical Committee held its first meeting in May and Dr. Tilt, the general practitioner and chairman of the Interim Area Medical Committee was elected chairman and Dr. Cally, chairman of the Allan Medical Staff Association was elected vice-chairman.

The Aldershire Area Medical Committee

Meanwhile the Interim Area Medical Committee had been working on the constitution for the definitive committee. They had decided that the committee would include three general practitioners from each district and had been informed by the Scottish Home and Health Department that community medicine specialists were not to be members of the Area Medical Committee. They had also decided that there would be one junior doctor from hospital medicine and one from general practice. The remaining problem was the derivation of hospital membership. They needed nine members to keep parity with the general practitioners but this was confused by the special position demanded by the two specialty hospitals of psychiatry and obstetrics. After much discussion by the hospital members of the interim committee it was decided that there would be two members from each district, plus a member from each of Tummel Mental Hospital and Spey Maternity Hospital (because they served an area function). This left one member and it was decided that each district in turn would nominate an additional consultant and that for the first period this additional member would go to the Allan District because of their worries about adequate representation. The Area Medical Committee had its first meeting on the 29th April 1974 and the hospital membership consisted of the following specialties:

1 Anaesthetist
1 Geriatrician
1 Paediatrician
1 General Physician
1 General Surgeon
1 E.N.T. Surgeon
1 Psychiatrist
1 Obstetrician
1 Thoracic Surgeon

The previous chairman and vice-chairman of the interim committee, Dr. Tilt, the general practitioner, and Mr. Struan, the E.N.T. Surgeon,

were re-elected for the definitive committee.

The position of Allan Hospital within the Aldershire Medical Advisory Structure is illustrated in Figure 6.1.

Further Developments in the Medical Organisation

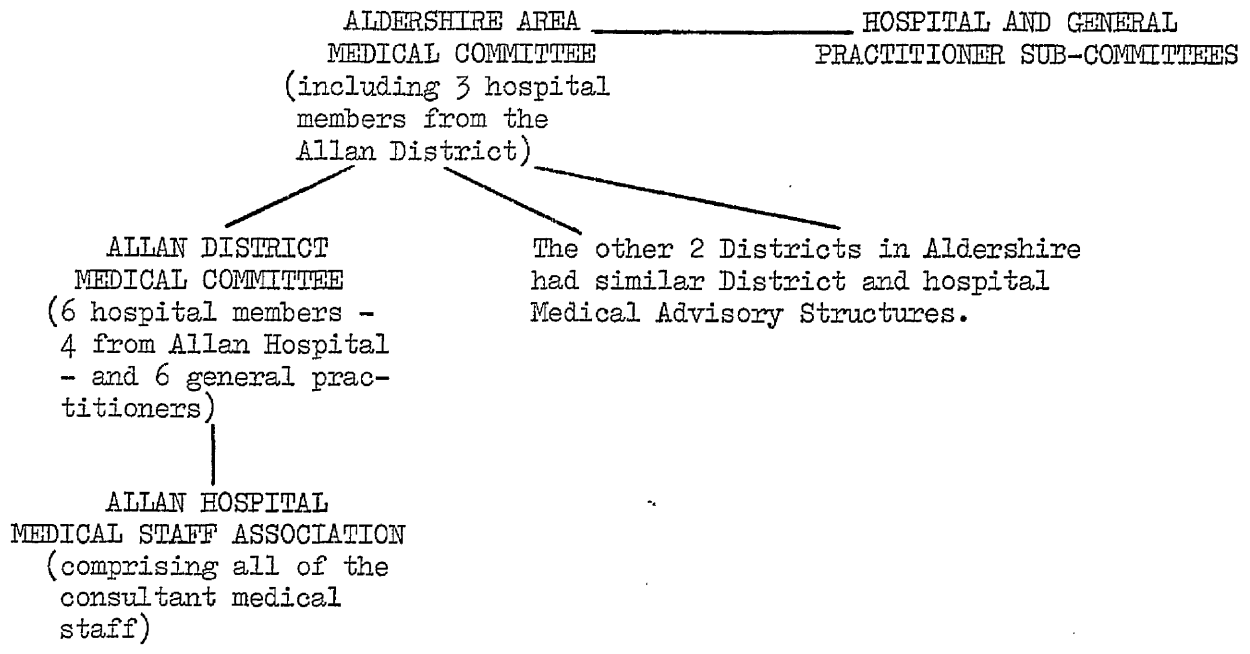
Although formal discussion of the divisional system had ceased a number of divisions emerged while the Area and District Medical Committees were being formed and after they had been finalised. These were unrelated to any decision of the Allan Medical Staff Association and most of them were based upon area specialty groupings. Spey Maternity Hospital had a Division of Obstetrics and Gynaecology which, for that hospital, acted as a Medical Staff Association. An Area Laboratory Division was formed, which included the laboratory staff in pathology and biochemistry at Allan but it split into two after an argument about the siting of area laboratory facilities, both groups wanted them to be built in their own districts. There was an Anaesthetics Division, covering the whole area, although members of other specialties were cynical about its existence. For them, however, it made sense as they provided anaesthetic services for the whole of Aldershire and the division was used mainly for the preparation of duty lists between the various hospitals. The radiologists formed an area division after their approach for membership of the Interim Area Medical Committee had been rejected. An Area Division of Chest Medicine was formed mainly because, as the chairman put it:

'We don't have any direct representation on the Area Medical Committee.'

Finally an Area Orthopaedic Division was established, overcoming the antipathy between the orthopaedic surgeons at Allan and Kenmore.

Apart from these area initiatives the only division to be formed in Allan Hospital was the Medical Division. Again members of other specialties seemed to doubt its existence. Dr. Wade, the geriatrician, who had wanted to form a joint division with the physicians (incidentally the physicians had also asked the geriatricians to join

Figure 6.1 Allan Hospital and the Aldershire Medical Advisory Structure



the Medical Division but the geriatricians had turned this offer down) said that it was:

'... a division in inverted commas.'

However, the division was active at certain times, particularly when the interests of medicine were threatened, for example, when it was proposed that general medical beds be closed in response to a nursing shortage.

The division had elected Dr. Gow, the senior physician, chairman, but, as one of the members pointed out, the independence of each consultant was recognised within the division:

'You see a central part of the unwritten constitution is that any individual consultant has the right of veto - so that if four agree on something and the other disagrees then whatever it is cannot be proceeded with, we wouldn't have a division if that wasn't the case.'

Its relationship with the Medical Staff Association was also unclear as the following extract from one of the meetings indicates:

Dr. Cally: We cannot tell the Medical Division what to do though.

Mr. Voil: Of course we can, its only part of the Medical Staff Association.

Hear! Hear!

In general surgery, the other specialty which had looked as though it might form a division when the matter was discussed by the Staff Association, one of the major obstacles appeared to be the attitude of the senior surgeon. He said in an interview:

'I'm not very good at administration, I can't make decisions. In the Staff Association when there is a discussion I always agree with the last person who speaks, they all seem reasonable to me. I just wouldn't make a good chairman.'

The three other general surgeons mentioned his attitude towards

chairing a division but they were unwilling to form such a division if he was not the chairman, and so nothing happened.

Despite these developments the Medical Staff Association in Allan remained the basis of the Medical Advisory Structure, as did the Medical Staff Associations in the other districts.

In the last section of this chapter the development of the Medical Advisory Structure will be looked at in terms of the concerns which the profession expressed in putting together that structure.

Conclusion

In this chapter the chronological development of the Medical Advisory Structure in Allan Hospital and the Aldershire area has been described. The aim of this conclusion is to examine the dilemmas which the profession faced and the concerns which it wished to protect in designing the structure. This will be supplemented by interview data which relate to consultant opinions about the divisional system and the Medical Staff Association.

The main feature of the divisional discussions at Allan Hospital was the vacillation of the consultants. While at the Staff Association there was a decision on a number of occasions to commit the hospital to the introduction of the system they faltered at the stage of actually deciding what the divisions should be like and how many there should be. This ambivalence was apparent in the interviews conducted with the consultants. The 29 consultant members of the Medical Staff Association who did most of their work in Allan Hospital were approached for interview. Twenty-seven agreed to be interviewed. A number of questions asked them about their response to the divisional system, the first was a general one: '<u>What are your opinions about the divisional system as it was outlined in the Brotherston reports</u>?'. Out of the 27 consultants interviewed

16 were in favour of the system (although 5 of these said that this was only in respect of their own specialty)

7 had mixed feelings

4 were against it.

The second question, 'How did your specialty colleagues feel about forming a division when the proposals were discussed?' produced the following response:

21 said that their colleagues were in favour of forming a division (although five said that this was on an area basis)

4 reported a mixed response

2 said that they were against it (the two paediatricians).

A third general question asked 'When the divisional idea was discussed by the Medical Staff Association what was the general reaction?', in response to this

6 said that the Medical Staff Association had been in favour of it (with 4 of these saying that this was as far as things went)

6 said that Association had been against it

9 said the response of the Association was mixed

5 did not remember or had not been in post at the time of the discussions.

While paediatrics was the only specialty unanimously opposed to the introduction of a specialty division, the consultants, in the forum of the Staff Association, failed to introduce the system. Why was this? In the early stages of their discussions they seemed to be quite keen to interpret their existing patterns of organisation as being divisional in their form - moulding the concept to fit the actuality - hence the talk about the existence of 'an inter-hospital divisional system' in orthopaedics and geriatrics, a 'regional inter-hospital division' in obstetrics, an 'area division' in E.N.T., medicine and surgery being 'almost in divisions'. However, they did not go beyond this. From the various discussions which have been reported above this involved two related aspects. First, the extent to which consultants within a specialty were prepared to form a division and secondly, the number of divisions which would be formed.

In those specialties which discussed the formation of individual divisions the consultants were concerned with the maintenance of clinical and consultant autonomy. The physician, Dr. Gow, in a memorandum to all consultants, referred to the 'great advantage in the ability to define the area of medical responsibility', something he felt the divisional system would endanger. When the initial proposals for divisions were discussed by the physicians and surgeons, the surgeons stressed that 'the chairman shall have no executive authority except in an emergency' and the physicians stated that any division 'should be in an administrative sense not clinical'. Within Allan the only division to be formed was in medicine and again the concern for consultant autonomy was paramount, as one of the members indicated:

> '... any individual consultant has the right of veto - so that if four agree on something and the other disagrees then whatever it is cannot be proceeded with. We wouldn't have a division if that wasn't the case.'

Apart from this the only divisions to be formed at a later stage were on an area or cross-hospital basis and they did not focus on hospital practice but on the representation of specialty interests at the area level and the direction of specialty development in the area as a whole.

The other side of this was the issue of how many separate divisions there should be. None of the specialties in the hospital wanted to combine with any of the others to form a division. The initial suggestion of four divisions, made by the Board of Management Secretary, was given short shrift by the Staff Association mainly because it involved the amalgamation of specialties. When the Staff Association itself attempted to decide upon the number of divisions it identified 15 separate specialty groupings on one occasion and 23 on another. Geriatrics and paediatrics did not want to join a medical division, all of the surgical specialties wanted separate divisions, radiology and laboratory medicine refused to combine. If representation on decision-making bodies for the hospital or higher levels was to be based upon specialties, no specialty wanted to be omitted

or represented by another specialty. The proposal for a specialty-based executive for the Medical Staff Association foundered because it provided representation for only nine specialties. In addition, many of the specialties contained only one or two consultants, for example, geriatrics, paediatrics, gynaecology, E.N.T. surgery, child psychiatry and consequently any committee comprising a representative of each of these specialties would not be much smaller than the Staff Association itself. If all the specialties wanted to be represented, they might as well stick with the Staff Association.

In this way the problem of individual consultant autonomy appeared to deter or shape the divisional development in specialties large enough or dominant enough to consider forming a division and the desire to protect specialty autonomy concerned the smaller specialties who did not want to be dependent upon others to represent their views. Structurally, the Staff Association threatened neither of these concerns, it was not based upon clinical units and it allowed all consultants from all specialties to speak for themselves.

The interview data tended to illustrate these concerns. When consultants were asked about the advantages of forming a division in their specialty

5 said that a division would further 'the representation of specialty interests'

7 saw it in terms of cross-hospital benefits, for example, co-ordinating a geographically spread specialty, organising duty rotas, simplifying the allocation of patients between hospitals

3 referred to advantages of democratic decision-making.

The remainder did not think that there were any advantages or referred to more general attributes of divisions, for example, 'a conglomeration of people with different background interests'.

Most of these advantages referred to benefits in terms of external relationships or specialty influence. Three referred to the advantage

of democratic decision-making but the majority saw no advantages in co-operation between consultants or decisions about the local management of resources which might have implications for consultant autonomy and which are central to the concept of the divisional system.

On the other hand, the disadvantages mentioned focussed much more upon individual and specialty autonomy:

6 referred to the disadvantage of having a chairman in a situation where consultants were used to being in charge of their own beds

4 said that decisions would be taken by votes and that the majority was not always right, the individual should have the right of veto

3 said the smaller specialties would be disadvantaged because they would be unrepresented

1 argued that patients would be uncertain as to which doctor was in charge of them.

Others mentioned broader disadvantages such as the unsuitability of the system in a small hospital and the fact that the districts would compete with one another within area divisions.

Finally, in this section of the interview schedule, consultants were asked 'Were there any particular reasons why the Staff Association was preferred to divisions in Allan?' and in response to this some consultants proferred more than one reason:

14 said 'because it was there'

10 because it was a forum through which all the medical staff had a voice

3 because people could not agree on divisions

2 because people did not trust others to represent them

2 because the Medical Staff Association was small enough to make divisions unnecessary and stopped isolation of consultants

1 because 'men with beds cannot be forced to have divisions'.

The major positive advantage attributed to the Staff Association, in the absence of agreement in implementing a divisional system, was that it allowed for everyone to be represented and have their say.

In both the discussions about the formation of divisions and the interviews with the consultants the constant theme was the concern with individual and specialty autonomy. This was the major barrier between the consultants and the establishment of a divisional system.

On a more general level the Staff Association had become the basis of the Medical Advisory Structure. The executive committee of the officers plus elected representatives met once a month prior to the meeting of the full Staff Association and although this did something to shorten the meetings it did not take decisions outside the forum of the Association. As a decision-making body the Staff Association was not particularly effective in its deliberations over the divisional system. It appeared to have difficulty in making decisions and there was no guarantee that decisions which were made would be implemented. How it dealt with more routine matters will be covered in later chapters but at this stage it appeared that consultants were unwilling to commit themselves to anything which might interfere with their autonomy.

The next level up was the District Medical Committee and one of the major problems in establishing this was specialty representation. Two members of the committee were to come from specialty hospitals of obstetrics and psychiatry (although at a later stage the former was moved into another district). This led to a debate about representation which gave a number of insights into the way consultants saw their position on the committee. The attempt to find a specialty formula for the District Medical Committee commenced with the observation of a general surgeon that two of the hospital members would come from specialty hospitals and that

> '... if we are to compete with them on an equal basis we really need to have specialties as well.'

In terms of the posited role conflict this implied that some consultants did not see the District Medical Committee as an impartial decision-making body, but as a forum for argument between specialty interests. They saw the dominant role expectation as the representation of self-interest rather than that of district decision-making. Once again the reluctance of any specialty to be represented by another made a feasible form of specialty representation impossible. They decided that elected representatives were the only alternative, but even this was viewed with trepidation:

> 'the problem is that people will have to represent interests other than their own.'

Here again the assumption was that the District Medical Committee would be a forum for arguments between interests and the fear was that representatives might not be able or willing to do this for specialties other than their own.

The other district dilemma was institutional representation. Because of the number of hospitals in the Allan District consultants at Allan were worried about the proportion of the membership which they could secure. They again felt that members would not act impartially but would seek to further their own interests, and that if Allan was under-represented then their interests would not be served.

At the area level neither the interim nor the definitive Area Medical Committee demonstrated any specialty bias in terms of their membership, unlike the committees at Lennox. In part this difference was explained by the fact that the membership in Aldershire was derived from the Medical Staff Associations. The Staff Associations were not based upon specialties, the consultant was the 'unit' of membership. In the past at least they had tended to be social as well as administrative bodies. The chairman of each Staff Association was elected on an annual basis and this honour was rotated among the consultants. Not surprisingly the chairmen of all the Staff Associations served on the Aldershire Area Medical Committee and it was largely a matter of chance which specialties they were members of. In Lennox the divisional system, being based upon specialty groupings, was more

likely to produce members from the dominant specialties as representatives on higher level committees.

Like Lennox the derivation of membership in Aldershire did not secure a place for all specialties, but the response to this in Aldershire was very different. A number of specialties applied for membership but these applications were rejected because:

'... membership of this committee derived from Hospitals/Groups and not from specialties.'

The general practitioner chairman was determined that the members were selected to act impartially and were not spokesmen of the specialties to which they happened to belong. To co-opt unrepresented specialties would imply that the members already on the committee were not able to take a broad unbiased approach. The chairman expressed the same concern during a debate about district representation on the Area Medical Committee:

'In the hospital if you could look upon yourselves as hospital doctors, looking for the best interests of patients, rather than looking upon yourselves as physicians and surgeons ... Lots of problems disappear if you think of yourselves as hospital doctors.'

Despite his concern this did seem to be less important in the eyes of the members of the interim committee than the balance of membership between the various hospitals in the area. All the hospital doctors were worried that their hospital might not secure a place on the definitive committee and in discussing this the following exchange took place:

Dr. Tilt: It is not practicable for everyone to be represented.

Mr. Struan: You really have to trust your representatives.

Dr. Cally: But people are not that good they will represent their own interests rather than the interests of the district.

The solution was that all major hospitals had to be represented but this exchange was also interesting in terms of the way in which the

Area Medical Committee was viewed. In role conflict terms the Allan representative again saw members as fulfilling the self-interest expectation, in this case institutional interests, rather than the expectation of impartial medical opinion.

A similar attitude was expressed when it was decided that they would not have standing specialty committees to the Area Medical Committee but would co-opt members to the hospital sub-committee when necessary. The response at Allan was that:

> 'All members of a specialty should attend on such occasions so that there was no chance of them being outnumbered by the standing members of the committee.'

and conversely every chance that they would outnumber the standing members of the committee! While this was rejected by the general practitioner chairman, it was clear that the consultants at Allan thought decisions would be made on the basis of numerical strength and that they wanted specialties always to be in a position to get their own way.

The structure in Allan and Aldershire turned out to be quite different from that in Overton and Lennox. The divisional system was not implemented in Allan, largely because of the desire to protect consultant and specialty autonomy. It was argued in the theoretical chapters that these would be two elements which might stop the structure from acting as the Joint Working Party reports recommended, in Allan they stood in the way of even the introduction of divisions. This had an impact on the higher levels which appeared to be beneficial. Specialties were not organised at the local level and there was less 'specialty consciousness' particularly in the formation of the Area Medical Committee. The way in which the Medical Advisory Structure developed is no guarantee as to the functioning of the structure on a day-to-day basis but a number of statements and exchanges during this process gave strong indications of the way in which consultants saw the structure. It was clear that in Allan they anticipated role conflict between self-interest and broader concerns and further that they thought people would solve this by primarily serving their own interests.

How the structure actually functioned in both Allan and Overton will be the subject of the next three chapters. These will deal with specific areas of decision-making and the way in which decisions are made will be analysed.

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PART 3. THE OPERATION OF TWO MEDICAL ADVISORY STRUCTURES

Chapter 7. Medical Advisory Structures and Individual Autonomy.

Chapter 8. Medical Advisory Structures and Specialisation.

Chapter 9. Medical Advisory Structures and the Management of the Hospital.

Chapter 7. Medical Advisory Structures and Individual Autonomy

Introduction

This chapter will examine the process of the Medical Advisory Structures in Overton Hospital and Allan Hospital with particular reference to the potential obstacles to decision-making which were outlined in Chapter 2. The major focus will be upon the extent to which the professional value of consultant autonomy hinders the structure from what it has been designed to do.

The Medical Advisory Structures in both hospitals dealt with a range of issues and this chapter will concentrate upon one category of decisions, those which may have implications for consultant autonomy and which are for the most part internal to the profession or directly concern professional work. In terms of the success or failure of the structure this is a key area. The divisional system and Medical Advisory Structures were designed to produce a more co-ordinated approach to the practice and development of medicine and health care. The professional value of consultant autonomy will, if it has any effect upon decision-making, be most important in relation to those issues which concern the practice of medicine. The main decision-making topics to be discussed are staffing and equipment developments, the control of standards and other aspects of medical practice. The intention is to examine the way in which Medical Advisory Structures deal with requests and proposals from individual consultants and matters which may affect the way in which they practise.

In view of the differences in Medical Advisory Structures between the two hospitals the analysis will be focussed upon different bodies, in Overton it will mainly be the divisions and in Allan, the Medical Staff Association.

Two sources of data will be employed, the results of interviews conducted with consultants in both hospitals and extracts from meetings. The first part of the chapter will look at Overton Hospital and Allan will be examined in the second part. In the conclusion, the two hospitals will be compared and some assessment of the findings in relation to the purposes of Medical Advisory Structures will be made.

OVERTON HOSPITAL

The divisional system formed the basis of the Medical Advisory Structure in Overton and not surprisingly issues which might potentially be influenced by a concern with consultant autonomy tended to occur at the divisional level. Most of the examples related to requests by consultants for staff or equipment which sprang from their interests and their work. According to the structure the division has to decide whether any request is valid and whether it is the best alternative or development for the specialty.

In previous chapters it was argued that consultant autonomy might impinge upon this process. Divisions entail a potential role conflict between what the individual wants, or thinks is best for him or her and what is best for the specialty as a whole. While these two elements may produce the same answer on many occasions, that is, what is best for the individual is best for the specialty, it was argued that the process could be subverted by the value placed upon individual autonomy by all the participants. If this was so then all consultant requests would be agreed to rather than being put through the hoop of broader specialty considerations.

Some of the questions in the interview schedule were designed to find out if consultants saw any problems in making judgements about one another's requests and proposals. The responses to these are relevant in examining some of the decisions which were made by the divisions. Forty-two consultants were interviewed, 15 were the chairmen of the divisions, or ex-chairmen and the remaining 27 were randomly selected from the other consultants in such a way as to achieve equal proportions from each specialty.

The first question along these lines was the following - Do you think it is a good idea for a consultant's colleagues to decide whether or not things which he or she wants or proposals which he or she has should be allowed to go forward to the next level? The broad response was as follows:

A good idea	32
A bad idea	3
No alternative	2
No difference	2
Don't know	2
Not applicable to the Laboratory Division	1

There was considerable unanimity on this question but within the favourable response of the majority, their reasons for thinking it was a good idea were varied. They suggested that their positive answers did not necessarily mean that the divisions acted as effective screening mechanisms. Six consultants, out of the 32 who thought it was a good idea for consultants to judge their colleagues' proposals did so because it was only used supportively, for example:

'... any ideas that people have had, have had the full support of their divisional colleagues. It is not as if its a blocking mechanism.'

'If anyone has an idea and puts forward a proposal, his colleagues, if it affects him, if it affects the proposer only, no one is going to stamp on it ...'

'I think there's no question that its better that the situation should at least be discussed with the colleagues for their support, so that when an application is made to the source of the money and so on, their application will carry more weight when its supported by one's colleagues, even though they individually may not be terribly interested.'

A further two of the consultants who thought it was a good idea had doubts about the information available to consultants and the extent to which they knew enough about their colleagues' work to make good decisions. Another three mentioned the impact of the democratic process, two positively and one negatively:

'I think that the way it should operate is that there should be a consensus of opinion. It's possible that with a consensus of opinion a strong-minded character will carry the

day but that's the democratic process, at lease he has to convince his colleagues.'

'If the consultant is good enough he can put up a good case and I can honestly say that any particular project of mine has never yet failed to win a place.'

The other response was less complimentary of this same process:

'... there is a feeling of running the thing on a friendlier old boy basis and everyone has got to have their say you see and nobody is really damned out of hand, I suppose it occurs now and again but not significantly and I think that what happens then is that the division produces a compromise rather than one definite idea ... We have gone freedom crazy, you see, freedom very quickly becomes licence for anarchy.'

Another consultant thought it was a good idea in concept but was rarely attained in practice:

'I don't think this arises very much ... you know every consultant once he's appointed does clinically what he wants to do. We have a certain amount of compromise for the common good, we compromise on policies for say looking after post-operative cases because it makes it infinitely easier for the nursing staff and I think that only in as much as that is there any interference with consultants' clinical work.'

Finally one of the physicians who thought the process was a good one indicated that rational concern with developments was not always the determinant in decision-making:

'... a consultant may put forward a proposal for research equipment or some administrative thing to be changed in the hospital. The chances of that being changed in the divisional system are dependent upon the consultant being friends with other consultants, his relationship with other consultants, not always the merit of the proposal ...'

Three consultants thought it was a bad idea for a consultant's colleagues to judge his proposals. Two of these raised the problems of role conflict and lack of appreciation of the position and work of colleagues:

'No I don't think so at all because all of them know that they're in competition with you for the available funds, you see, and none of them can appreicate how important the particular question you're raising is, because none of them have the insight into your particular area that you have yourself.'

The two consultants who expressed this view were both members of the Medical Division which covered a range of medical sub-specialties which may explain the feeling of a lack of knowledge on the part of colleagues in other sub-specialties within the division. The other consultant who thought the system was bad did so because consultants did not judge one another's proposals, they supported them without question. The two who thought the system made no difference used a similar argument about consultant autonomy:

'In this unit it makes no difference, each individual consultant can do as he likes as long as it doesn't impinge on the others.'

The chairman of the Laboratory Division thought the question did not apply to the Laboratory Division because it comprised a number of different specialties:

'I don't think you have arguments of that sort... The Laboratory Division is a very atypical division in that its made up of four discrete departments each with an official head and each independent. The fact that I am the chairman is only a convenience for calling together the meetings or to give support to a department that thinks it needs more anything, more staff, more equipment, more money if they think they need it, they may feel that the acquiescence of their peers in the division will help them.'

While this opinion may have reflected the mixed specialty nature of the division it does not suggest that the division would act as an

informed decision-making body.

Qualitatively the arguments used by consultants in Overton Hospital cut across the distinction between those who thought the system was a good idea and those who thought it was a bad idea. Nineteen consultants thought it was a good idea and gave no particular reasons for this response. A further nineteen consultants argued that divisions did not impinge upon individuals and generally agreed with what they wanted, or that the system worked according to some democratic process in which presentation or popularity was the major measure of validity.

Similar responses were given to the following question which asked more specifically about the process involved in evaluating individual's request: What about situations where the division has to decide about things which other consultants suggest, how easy it is for you to do this? Twenty consultants thought it was easy, three thought it was difficult and the remainder thought it depended upon the issue. Qualitatively the rationales for these answers cut across them. Fourteen consultants thought it was easy without any reservations, the remaining six, in addition to the others who thought it difficult or dependent upon the issue, said that it was used supportively rather than critically because consultants were their own masters, indeed one consultant mentioned the Platt report as the symbol of this. Another commented:

> 'Oh yes I think so. If a man wants something very much he is usually right and we try to get it for him. I think that's the only attitude to administration.'

Or that decisions depended upon trust because of lack of knowledge, for example:

> 'I think this depends upon how much background knowledge (a) is presented, and (b) you happen to know about yourself, depending on how broad your outlook is in the field being discussed. If a specialist comes up and says we cannot run this lab unless we have the best or the latest instrument and this will help everyone in the hospital then I find I

would agree with this, I mean I just take the thing on trust.'

One of the interesting things about this comment is the acceptance of the amount of knowledge 'presented' as a given in decision-making within the division. Despite the limitations which this consultant thought lack of knowledge placed upon informed decisions, he did not appear to consider that consultants should be asked to present more information, the division worked with what consultants cared to provide them with. Another group of respondents thought it was dependent upon the person and what had happened previously:

'... in the Medical Division, if, for example, a person has demanded a large research thing, or demands research things often, its interesting to watch the Medical Division down-grading his subsequent requests, they'll tend to lean over backwards and try to give to a person who hasn't had the advantage of a previous award or decision within the division, it's just human inter-relationships.'

'Well it is and it isn't. You see it depends on whether in the general view the guy who is bringing it up is a reasonable chap, is bringing up a reasonable sort of idea.'

Finally three laboratory consultants mentioned the problem of specialty demarcation which is more a question of specialty autonomy and is illustrative of the way in which they dealt with consultant requests for equipment:

'... if a haematologist, for example, says that he now requires a Coulter counting machine for counting his blood cells, I don't think any of the rest of the division would object to this or even comment upon it. They would just say well if you want it O.K.. Similarly if I said I wanted a new autoclave and somebody outside my own specialty told me I didn't in fact I'd take it very amiss.'

It seemed from this statement that the division merely acted as a rubber-stamping and supporting device for whatever consultants wanted.

These two questions on the extent to which it was a good idea for consultants to evaluate one another's proposals and the ease with which they could comment upon the requests of their colleagues produced a variety of responses. Approximately one half of the consultants thought that it was a good idea and that it was easy. The remaining half were divided as to the answer to the question but united in their reasoning. A large proportion of them thought it was a good idea, or a bad idea, easy, or difficult, because consultants were autonomous and consultants and divisions would not and did not interfere with what individuals wanted. The division was used as a supportive device and some saw this as a good thing and others as something which was opposed to the aims of the system. Another grouping, in the less homogeneous divisions, medicine, surgery and the laboratories, argued that lack of knowledge of some sub-specialties made judgement impossible and therefore trust determined the divisional response to requests. Others suggested that decisions depended upon the requesters rather than the requests. If consultants were respected and friendly with other consultants then what they wanted was supported, if they were not, then their proposals were rejected. Finally a few consultants put this process in a broader perspective. They argued that there was an equalising process whereby benefits were fairly distributed over a period of years, if someone was successful this time then the division would see fair play and give others the benefit in the future. Even those who said divisions discriminated between requests described processes which owed little to judgements about the validity of individual proposals.

These different perspectives on the way in which divisions deal with individual requests provide a number of explanations as to how divisions operate. Undoubtedly some consultants felt that individual autonomy was a key factor in preventing a critical appraisal of anything a consultant cared to put before his division. The responses of consultants may well have been descriptive of their own motivations or approaches in dealing with requests. However, there is still the group which thought that dealing with colleagues' requests was easy and that it was a good idea for a consultant's

colleagues to judge his or her requests without any reservations. The only way to assess the influence of these varied perspectives is to look at the way in which requests and proposals from individual consultants were dealt with.

There are a number of categories of decision which fall within the definition of this chapter and which involve individual consultant requests. The major groupings relate to requests for junior staff, senior staff and equipment. Each of these areas will be looked at separately.

Requests for Junior Staff

Technically requests for junior and senior medical staff have to receive the support of the division concerned. They have to be put to the division and the division then decides whether the request is valid. Successful requests are then passed to the Committee of Divisional Chairman which in turn has to assess the validity of the request. If it gains the support of this committee the request then goes up to the area level and so on. In this way each level of the structure acts as a screening mechanism with regard to the broader arena in which the request is considered. The division is the first official hurdle any request has to jump. Consultant autonomy is one of the features which may stop the consideration of the request in its broader context and may legitimate automatic agreement to consultant requests. Certainly in the period of study no division turned down a request by a consultant for additional junior staff, all such requests, if presented to a division, were supported by it.

The Medical Division decided that it wanted two additional house officers because an Intensive Care Unit and a Coronary Care Unit were about to be opened. There was no discussion of the matter and no attempt to indicate how the opening of the additional beds would require two rather than one or three extra staff. This was not a personalised request but another one, raised at the Medical Division on the 3rd April 1973, was, Dr. Ure, a dermatologist, wanted to obtain a full-time registrar by changing the contract of a general practit-

ioner who was currently undertaking those duties. The minutes of the meeting reported exactly what happened:

'Dr. Ure explained that he proposed to ask the Board of Management to alter Dr. Revel's appointment to the Hospital Practitioner grade or its equivalent. This would leave a Registrar post in Dermatology vacant and he proposed that this be advertised. The Division agreed that Dr. Ure's proposals should be supported and the Chairman agreed to put them via the Chairman's Committee to the Board of Management.'

This entailed an increase in staffing of one full-time registrar but the consultant did not make a case for this in terms of a change in workload and the consultants in the division did not ask for such a case to be made.

In contrast to this was a request for a Registrar in cardiology, again in the Medical Division. The consultant cardiologist, Dr. Collis, sent a memorandum to the division in February 1974. The following is an extract from this memorandum:

'As you know our junior staff apart from House Officers consists of one 'permanent' Registrar and two juniors at Senior House Officer grade who are in the rotation scheme and with us for four months only at a time. As a result, too many commitments have to be undertaken by the Registrar because in addition to his duties as Registrar in a General Medical Unit he is having to accept increasing commitments because of the expanding Cardiology service.

In the Cardiological sense we have commitments not only in Overton General Hospital but to the other hospitals in the group, to the Education Health Service Cardiac Clinics and to the Mass Radiography Unit. Increasing numbers of E.C.G.'s have to be reported (27,461 were taken last year), and we have an active C.C.U. and an expanding pacemaker service. Our catheter laboratory functions twice per week and we would like to increase this service because of the numbers awaiting cardio-dynamic investigation. Our cardiac

screening meetings with our surgical colleagues and our angio projection meetings take a further two sessions per week. It should be pointed out that the C.C.U., the pacemaking service and to a certain extent the investigative service are area rather than unit commitments, indeed the pacemaking service is a regional one.'

This request was accompanied by evidence to justify it and when the matter was discussed at the meeting of the Medical Division on the 16th April 1974 everyone seemed to be convinced of its validity:

Dr. Collis: I have little to add as I give full cover to the problem in my letter which was written by me after full discussion with Dr. Keltings and Dr. Stott (consultants in Dr. Collis's unit). It is hard to enlarge on but I would say that the Medical Registrar in Cardiology has more to do than any of the other Medical Registrars and I would stress the fact that it is an Area and even a Regional commitment.

Professor Alexander (Chairman): What should we do as a division?

Dr. Gregor: I think we should support it as we put it up a couple of years ago. It is a question of timing, we may be lucky this time.

Dr. Collis: We didn't put it up before.

Dr. Gregor: Yes we did I remember it coming to the Board of Management last year.

Dr. Collis: No we didn't put it up before.

Dr. Frome: Is there a moratorium on Registrar appointments?

Dr. Hudson: I would support the request though I'm not sure that we shouldn't ask for a rotational Senior Registrar. And I also think the letter should be changed to give more detail of the increase in numbers and the pacemaker service.

Dr. Collis: Yes I take the point on that.

Professor Alexander: I think this is constructive, would you consider putting up for a rotational Senior Registrar?

Another possibility is that Dr. Parrett in Chest Medicine has advertised for a Registrar to share between Overton and Wallace, and if the Overton part could be cardiac then the Registrar would get cardio-respiratory training. This would give you half a Registrar right away, Dr. Frome knows more about this than I do.

Dr. Collis: It would be useful to have this and it suggests that there is no Registrar moratorium.

Dr. Frome: No it doesn't, I'll explain the situation. Dr. Parrett had a Registrar and a Medical Assistant. The Medical Assistant retired and was replaced by a Registrar and to make the job more interesting he came here for half the week and has been working with me. The second Registrar post has now fallen vacant and I think the post would be more attractive if he also worked here. Each of them could work with you for two or three half days a week.

Professor Alexander: I think it should be five sessions.

Dr. Frome: They would have to cover Wallace though.

Professor Alexander: We would have to make it clear though that we would want five sessions.

Dr. Keltings: I would support Dr. Collis's request and I do not think that the compromise would make a full or sufficient contribution.

Professor Alexander: Shall we just put it up again?

Dr. Frome: Yes but if there is a moratorium then the application is a nonsense.

Professor Alexander: Okay we'll put the suggestion to Dr. Parrett for further discussion.

In this discussion it was clear that the division was going to support the request. Debate did not revolve around the question of whether an additional registrar was needed but how the division should go about securing funds for the post. The discussion took place in limbo because the division did not know if there was a moratorium on

Registrar posts. Apart from this the major positive suggestion was that further details of the increasing workload should be provided in support of the request (the memorandum was subsequently passed up to higher levels but no change was made in the information provided). Because of the doubts about the moratorium the possibility of sharing two posts in chest medicine at Wallace Hospital was debated, although Dr. Parrett, the chest physician, was not at the meeting. This seemed to suggest that there was sufficient capacity within the division to provide for the extra work, although obviously this was seen as less desirable than having a whole new registrar in cardiology. At the next meeting in May, however, it was learnt that the Registrar in Chest Medicine had been appointed without any discussion of whether he might spend time in cardiology:

Dr. Hudson: I am not happy about this, in the minute it was agreed that the suggestion be put to Dr. Parrett for further discussion and yet here we find that this has been ignored. I don't see the point in discussing things here if the discussions are then ignored. If it was to have been a rotational post in cardiology I would have thought that Dr. Collis at least should have been involved.

Dr. Frome: Well the post had been advertised before we discussed it and the applications were in and Dr. Parrett's first concern is with what happens at Wallace.

Dr. Hudson: Was this matter discussed with Dr. Parrett?

Professor Alexander: Yes I saw him about it.

Dr. Hudson: Well I'm still not happy with this. It seems to me that the protocol has been broken and that Professor Alexander, myself and Dr. Collis should have been consulted at least and possibly on the interview panel.

Because of this the person appointed had not been seen by the cardiologist, although doubtless an arrangement for rotation could still have been effected, and the division put its weight behind the application for the registrar in cardiology.

In the other divisions from which requests for additional junior staff came, consultants in Laboratory Medicine and Geriatrics wrote directly to the Committee of Divisional Chairmen without submitting them to their division. These divisions did not object to this practice and, as will be made clear in the following chapter, the Committee of Chairmen made no distinctions between requests which had been formally supported by the division and those which came directly from consultants. In more general terms discussions about increases in junior staff demonstrated the following features:

a. whether or not consultants took requests for additional junior staff to their division varied by specialty, for example, in general medicine they did, in geriatrics and laboratory medicine they did not;

b. the information presented in support of any case varied from consultant to consultant, the cardiologist was the only one to put forward a detailed case and yet other consultants within the Medical Division did not provide any information. There were no formal requirements about the way in which requests should be presented and nobody asked for additional information; and

c. the amount of information presented to a division had no apparent impact upon either the course of discussion or the outcome. All the requests were supported by the divisions concerned.

These cases suggest, in line with a proportion of the interview responses, that the divisions were used supportively rather than as critical screening devices. The divisions appeared to accept whatever consultants cared to place before them. In a sense consultants making requests called the tune, they might submit it to the division, they might by-pass the division, they might present a detailed case in a memorandum or they might just say what they wanted with no supporting evidence. Whether this was intentional or not, and a section of the interview responses suggests that it was, the result of the process was to maximise consultant autonomy and to impinge upon it as little as possible.

The other interesting feature about these discussions was that requests for junior staff were treated on a one-off basis by the divisions concerned. The Medical Division, in particular, agreed to a number of requests for additional junior staff and yet they made no attempt to consider the relative validity of these requests, even though at some level higher up the structure the relative priority of these and other requests would be considered. This again had the consequence of avoiding the problem of making decisions between consultants. However, in the case of requests for consultant staff and requests for equipment, divisions did not always avoid this problem. There were a number of the questions in the interview schedule which related to priorities.

The first question dealing with this was: Does your Division discuss staffing and equipment priorities? Twenty-three out of the forty-two consultants said that their division did deal with priorities but within this there were some discrepancies between divisions:

> The Divisions of Medicine, Obstetrics and Gynaecology and Infectious Diseases were unanimous that their divisions dealt with such priorities.
>
> The Divisions of Radiology, Geriatrics and Psychiatry were unanimous that they did not deal with priorities.
>
> The Divisions of Surgery, Paediatrics, Anaesthetics and Laboratory Medicine were divided.

During the fieldwork only the Medical Division was observed to make decisions about priorities. The next question was for those consultants who stated that their divisions did deal with priorities: How easy is it to put submissions in some order of priority? Ten consultants said that it was easy, 12 said it was difficult and 1 said that it was easier than it had been before. Perhaps significantly only one of the members of the Medical Division said that it was easy to place consultant requests in order of priority. A variety of reasons were given as to why these decisions were difficult. The chairman of the Medical Division at that time stated that voting was the only way of deciding priorities:

'The decision of course it would certainly not be easy for an individual to decide and therefore I think this is an area where putting it open to a referendum is in fact about the only way you really could do it without causing a great deal of rancour and schism between colleagues and this is something, of course, that is of extraordinary importance to avoid.'

While this may have solved the problem of individual consultants expressing adverse opinions about some of their colleagues' proposals, other consultants in the Medical Division were less optimistic about the impact of a vote upon the outcome of such decisions, for example:

'Well I don't think it is, I think there is a dual feeling here, I think the people who want to be fair and because so and so or such and such a unit got so much last time, perhaps they shouldn't have so much or the same claim this time and this again sounds very nice and democratic and desirable but in practice its ridiculous ...Much more important would be to have a well-documented, to have two or three people set aside to look at the particular things, rather than, its all done slightly hurriedly is it not? We each have our submissions and they all go forward and if its either politically or emotionally well-presented, whatever the word is, I think this carries the day but it may not, at the end of the day, be in the best interest.'

The argument here was that there was some attempt to spread the available money fairly between the consultants, not on the basis of need but on the basis of equal shares. Others within the Medical Division cited similar reasons for the difficulty of such decisions:

'No because quite often the priority has to be judged by the rest of the Division as it were from without, the only person that's able to judge it from within is the person that's making the demand, and essentially he is biased, but then he has the opportunity of putting his case verbally and in writing to them. Unfortunately some people can put their case much more forcefully than others and I think there's a little bit of unfairness in that quite often the better the case made, and it is in the making

of the case that the merit is judged rather than on the case alone, like a lawyer in court, one lawyer would get a criminal off, another one wouldn't although its the same criminal.'

'It is difficult, I remember last year we were given a list of major items that were being asked for and asked to grade them, so it was put to a vote, I suppose in some ways the person with the largest voice may prevail eventually, may swing opinion that way.'

Another physician said that all such decisions were based upon self-interest, you voted for what was closest to your own interests. On the other hand a physician and a surgeon argued that there was not necessarily any difference in merit between requests:

'I think very often the correct answer is that both are necessary and it depends on whether you're the patient with rheumatic disease or the patient with cardiac disease, which you feel is the more urgent of the two.'

'No, I don't think it's at all easy, I think everyone has a need for certain parts of equipment or certain staff and who's to say in fact that one has higher priority than another ...'

The point here is that it is the consultants within divisions who make or fail to make these decisions for the patients with rheumatic disease or cardiac disease. In the Medical Division, which did make such decisions, two main motivations seem to be at work. One argues that there is an attempt to equalise rewards between consultants and the other argues that decisions are not based upon objective criteria but upon the quality or force with which the case is put. Neither of these influences suggest the detailed, rational consideration of the divisional ideal.

Two of the other consultants who said these decisions were difficult mentioned economic criteria, and the problem not of making such decisions but of keeping to them:

'We do decide depending upon the expense, suppose one request by the Biochemistry costs £50 and the other department's costs £2000, naturally the £50 will be passed first ...'

'We're not a particularly efficient division. It's quite easy at a meeting to decide priorities but as for maintaining these decisions, that's a very different kettle of fish, people change their minds, they forget what has been said, they don't read the minutes, if they weren't at the meeting in question.'

All of this suggests that while priority decisions may have been made in some of the divisions they were not necessarily made in terms of what was most required.

The final question about priorities was: What about situations where you want something and somebody else wants something, how easy is it for you to argue your case? This question was designed to focus on the other side of the priority question and see if consultants found it difficult to question one another's proposals and argue for their own at the same time. Only 5 consultants said that they had been in this situation and they were all members of the Medical Division. Two of them thought it was easy, one of them genuinely so because he said that he had no difficulty in asking for what he wanted and expressing himself. The other one evaded the question by saying that he did not think that his request really excluded other requests. The 3 consultants who thought it was difficult gave similar reasons to one another:

'I find it very difficult to argue for it. This is a personal thing, this is a matter of one will make do perhaps, use alternative methods. I don't really approve of this system and therefore I can't get terribly enthusiastic about it. When one has to argue as though you were a political candidate or something of this kind.'

One of the others also mentioned the different perspectives he had in discussing his own proposal and two competing proposals:

'... I found myself on three sides as it were at the same time, desperately pushing my own concept but, because I have interests in a couple of other things, knowing of a couple of other concepts I wanted to push too, but not quite as hard as the first one, and of course when you do this you finish up by succeeding with the third one, which is the one you didn't really want pushed all that hard.'

These difficulties again give a clue to the way in which these consultants saw the decision-making process. All of them thought that you had to indulge in some kind of selling process as if 'you were a political candidate' although they felt that this was not the way in which decisions should be made. At the same time one of them was obviously very keen to get his own proposal accepted.

These are the major responses to the question of making priority decisions within divisions. It is obvious that there are a lot of different perspectives on this process and that in many cases these perspectives run directly counter to the way the system was envisaged by the Joint Working Party reports. In order to see how these perspectives affected the process of deciding priorities a number of decisions which involved priorities will be examined.

Requests for Consultant Staff

Requests for consultant staff are dealt with in a similar way to those for junior staff. Divisions decide they want an additional consultant and this then has to be agreed by the Committee of Divisional Chairmen. If it is accepted the request is then passed to the area level and may be considered by the Area Medical Committee in relation to other requests from within the area. Successful applications then have to gain approval in principle, and funding, from the Scottish Home and Health Department.

The division is therefore the first screening device through which requests for consultants are passed. Junior staff requests had been treated on a one-off basis by divisions which had more than one request over a period of time, but it is fairly clear that no request

is a one-off request. It has to compete with others at some level, whether they are requests from within the same hospital, the same district or the same area. The Medical Division was the only division to attempt to decide between requests for consultants although admittedly only one other division was faced with a potential choice between requests for consultants. This first arose when there was a request for a consultant in renal medicine shortly before the re-organisation of the Health Service. It was raised by Dr. Mells, a general physician with an interest in renal medicine, at the meeting of the Medical Division on the 6th November 1973:

Dr. Mells: I would like to ask that a request be put forward for a second consultant in renal disease, I would have written and distributed figures on this but I have been very busy. I would like to put forward the following arguments. First of all, there has been a great increase in workload. When I started this in 1968 there were a small number of dialysis and acute patients but in five years the number has increased and now we are responsible for the organisation of Home Dialysis in the region. There has also been an increase in acute renal failure and with the opening of the Intensive Therapy Unit we can give them the right treatment whereas they used to be transferred to Endrick Hospital. Secondly, there is the comparison with other renal units, I have central figures on staff numbers and we are at the foot of the list in terms of staff and well up in terms of our load.

Professor Alexander: I think you have already made your point. We want to help and as a first step I think you should prepare a memo.

Dr. Gregor: We need good figures for this kind of request.

Professor Alexander: We need another consultant it is a question of how we go about getting him.

Dr. Mells: Can we go ahead with this next week?

Dr. Gregor: I think it is a divisional matter and we should look at it in terms of divisional priorities.

Dr. Mells: It is a matter of some urgency and it seems that the Scottish Home and Health Department is prepared to provide extra people.

Professor Alexander: Will the division empower me to, er no, the division as a whole must discuss this and I will arrange an extraordinary meeting for that purpose.

No extraordinary meeting was called and the next meeting of the Medical Division took place on the 11th December. At this meeting Dr. Mells circulated a detailed memorandum of the change in workload in renal medicine but the general feeling was that this request should be considered in relation to other possible consultant additions. There was also a letter from the Chief Area Medical Officer (Dr. Ivar) who suggested that they should try to get the request through the Board of Management and the Regional Hospital Board before reorganisation in April 1974. The Medical Division discussed the matter again on the 15th January 1974:

Dr. Mells: Dr. Ivar stresses in his letter the urgency of putting this case for an additional renal consultant and I would be grateful if this could be expedited.

Professor Alexander: This is an important matter which the Medical Division should decide, are we going to support an additional renal consultant without looking at other priorities for extra staff? Dr. Mells presents quite a case, we have the largest commitment in Scotland. I'm not sure whether it would embarrass our other requirements. Should we look at it now?

Dr. Gilbert: It is difficult for me to suggest an alternative because I think we need an additional renal consultant, but endocrinology must be the poorest served specialty in the hospital. Dr. Canon (a Registrar) is very good but we really need a full-time endocrinologist. I would suggest that if we looked at the patient statistics we would find an equally strong case for endocrinology.

Dr. Mells: I would strongly support Dr. Gilbert's suggestion but I don't think the case for the renal consultant would

affect that. The renal case can be made out on a Regional basis, I don't think it would weaken his case.

Dr. Frome: I disagree, if you look at the workload of consultants in this hospital as compared with that of other Lennox hospitals we have the second lightest load by any measure you care to take. If we get the renal consultant, which will be hard, it will prejudice our chances in other areas.

Dr. Collis: I would like to see the figures which show this, what about Endrick Hospital and Riska Hospital, does that include split sessions between hospitals and honorary consultants?

Dr. Gregor: We have been through this before ...

Professor Alexander: Has anyone any objection to putting it up on a Regional basis?

Dr. Hudson: I don't have any objections, I have a question. Will this man be a general physician with an interest in renal disease? Because if so that will affect other claims because he will be another physician with general duties.

Dr. Frome: It will depend on his sessions.

Dr. Mells: I think initially he will only have a special interest and do it part-time, but as it expands he will require full-time duties.

Professor Alexander: How will it expand?

Dr. Mells: With the increase in home dialysis.

Dr. Gregor: We could hardly argue a Regional case if he had general duties.

Professor Alexander: That's a point, how about the man they're trying to get at Endrick Hospital (another centre with a renal unit) doing sessions here?

Dr. Mells: I put that to Professor Telfer (the head of the Endrick Unit).

Professor Alexander: He wouldn't like it.

Dr. Mells: No, but he did say that if we got a man then he could have sessions at the Endrick.

Professor Alexander: The fear is that this may rob us of other requests. Why don't we ask for four sessions, maybe Dr. Crispin at Riska Hospital (the third centre in Lennox with a renal unit) would share him?

Dr. Mells: He doesn't want one at the moment.

Professor Alexander: Well we must put it to the vote here.

Dr. Gilbert: I think we have to be selfish here and look at the hospital as a whole, the biggest groups are in endocrinology, which I have suggested, and nuclear medicine which Dr. Frome is interested in, we could probably get a man who would do both of these.

Professor Alexander: Should we have a meeting to discuss staffing priorities?

Dr. Mells: I thought a moment ago nobody had any objection to my request.

Again there was a delay primarily because the members of the Medical Division seemed unwilling to take the decision as to whether they should support the request. There appeared to be good reasons for thinking that agreement to the renal post might well jeopardise future requests, particularly because the post would include general medical duties, but they were unwilling to deny Dr. Mells his request. An extraordinary meeting was held on the 22nd January 1974 to sort the problem out:

Dr. Gregor: Well I think we have been looking at things like staffing piecemeal, we really have to look at all our priorities together. In the case of Dr. Mells' request I think we should put it forward as a Regional request and process it through normal channels. If he doesn't get it then it will not prejudice future demands.

Professor Alexander: Would you like to comment on that Dr. Mells?

Dr. Mells: I don't think it will prejudice future staffing particularly as it is a Regional commitment and it's done on the basis of a Regional workload.

Dr. Gregor: All I mean is that if it fails then it will not be treated as a special case in the future when other requests are considered.

Dr. Keltings: Although the problem is that if this request is not obtained then people will die because they are at the end of their biological tether and this is not the case with the other two.

Dr. Gregor: Yes, if we fail I'm not saying we should stop altogether just that this will not have to be achieved before we go for anything else.

Dr. Hudson: Yes I agree with this we have to put it up now. If we are to make priorities then it must be done on the basis of very careful planning. We must support this now on a Regional basis because of the home dialysis scene.

Dr. Gilbert: I agree on the recommendation of a Regional commitment although I feel something should be put in about the number of sessions.

The decision was interesting for a number of reasons. This was the first suggestion in any division that any consultant requests should be looked at in the light of other possible requests from within a division. Dr. Mells had presented a very full case for his request and it seemed that this would be accepted. However, they decided, rightly, that requests should not be treated on a one-off basis. The problem was that they were changing the rules of the game half way through the consideration of Dr. Mells' request and while some of the other consultants put up alternatives there was some ambivalence between fully discussing these alternatives and agreeing automatically to the request for the renal consultant. The major competition came from Dr. Gilbert and his claim for an endocrinologist but even he seemed unwilling to enter into the battle. He said at one point 'I would suggest that if we looked at the patient

statistics we would find an equally good case for endocrinology' and yet he made no attempt to bring forward such information. There seemed to be a genuine role conflict between doing what they knew the division should be concerned with, looking more broadly at priorities, and a reluctance to turn down a request from one of their number.

Apart from this there was the question of whether agreement to the request would prejudice other possible priorities. While it was agreed that the work was a Regional commitment it was also clearly stated that there was only enough work for 'half' a consultant. Because of this the acceptance of the request would undoubtedly prejudice future requests. One suggestion was that the post should be shared with one of the other renal units in the city but none of them wanted to share the post. However, the reaction to this was not to attempt to negotiate some sharing agreement but to accept the additional consultant. Half of the post was reasonable but the other half, on Dr. Mells' own admission, was supernumerary. While this solved the problem of role conflict and stopped them from impinging on a consultant's autonomy the decision appeared to be shaped more by these considerations than the need for a full-time renal consultant. The fact that the post was not possibly top priority and that it should possibly have been secondary to some of the other requests was recognised in statements by Dr. Gregor:

> 'I think that we have been looking at things like staffing piecemeal we really have to look at all our priorities together. In the case of Dr. Mells' request I think we should put it forward as a Regional request and process it through normal channels ... All I mean is that if it fails then it will not be treated as a special case in the future when other requests are considered ... If we fail I'm not saying that we should stop altogether, just that this will not have to be achieved before we go for anything else.'

In this case the fact that Dr. Mells had already made his request made it difficult for the division to reject it. However, they started the process afresh at the next meeting on the 12th February

1974. There was some time over at the end of the agenda and Professor Alexander, the chairman, asked if anyone would like to start the discussion. Two possibilities had been mentioned already - endocrinology and nuclear medicine and Dr. Gilbert, the champion of the former, opened the discussion:

Dr. Gilbert: I think at one of the meetings we talked about two possibilities, one of these was endocrinology. In the past we had two consecutive consultants who did this but now it is left to a non-consultant, Dr. Canon. If you look at the figures there are large numbers of both outpatients and inpatients. We are staggering alone in endocrinology, Dr. Canon does a lot and assists me but none of us have the endocrinology training necessary. We have an excellent team with myself, Dr. Ashton and Dr. Canon who, with a bit more training, would make an excellent consultant. Also we have vast numbers of outpatient attendances because we don't have a consultant in physical medicine. I would also suggest nuclear medicine and the possibility that it might be combined with endocrinology.

Dr. Frome: I agree with Dr. Gilbert except on physical medicine. At least we have some endocrine experience but there are no nuclear medicine specialists. We are now limping along doing thirty scans a week and the point is that there are no medical staff in the Scanning Room. Only I, through some study leave, have managed to get some knowledge of the specialty. The present demand of thirty scans is bound to increase and the quality is less good than it would be if we had someone medical there all the time. We do our best but it is in addition to our other work. It seems to me that if the service is to continue and expand modern medicine demands standards and we should have someone with formal training.

Professor Alexander: I feel it may be easier to attract someone when we have a new unit.

Dr. Frome: On the other hand I feel we should have someone here to help plan the unit.

Professor Alexander: Would you put endocrinology above nuclear?

Dr. Frome: I feel that nuclear is more important.

Dr. Hudson: I don't like the statement that we are staggering along in endocrinology. I know it wasn't said totally seriously but I think the situation is very serious. I think it would be easier to get an endocrinologist than a nuclear medicine specialist at the present time with the present state of training. I think the last point of Dr. Gilbert's, to combine them, is good and that would be an opportunity to make the scene at the regional level.

Dr. Marsden: I agree, if I have to rate them then it is endocrinology first and nuclear second, just.

Dr. Frome: After what Dr. Hudson has said I agree with him about a combined endocrinologist and nuclear medicine specialist.

Dr. Gilbert: I think physical medicine is important particularly with the new physiotherapy facilities but I would put it far below endocrinology.

Dr. Hudson: We also need a National Health Service clinical pharmacologist, we have university staff in this but we also need a full-time clinician.

Professor Alexander: How would you rate it?

Dr. Hudson: Above physical medicine.

Professor Alexander: And in relation to nuclear?

Dr. Hudson: Close but just below it.

Dr. Keltings: I think on balance endocrinology and then nuclear, but I would prefer both to go forward.

Dr. Marsden: I agree.

The consideration of the relative priority of requests from different consultants was revolutionary both in terms of the previous behaviour of the Medical Division and the approach of other divisions. While the decision to look ahead was laudable, the way in which this was done was a little haphazard. Although the main protagonists mentioned factors like outpatient and inpatient figures, for endocrinology, and scans, for nuclear medicine, there was no attempt to present the divi-

sion with systematic information, and the division certainly did not ask for this. As a result it was never clear what the basis of judgements like:

'If I have to rate them then it is endocrinology first and nuclear second, just.'

was. Both Dr. Gilbert and Dr. Frome tended to exaggerate the situation with the former talking about 'staggering along' and the latter about 'limping along', however, in talking to them about it afterwards it was clear that their feelings about arguing for their own case were different. Dr. Gilbert said:

'I have no difficulty in arguing for what I think is right.'

Whereas Dr. Frome was more circumspect:

'I really felt bad in pressing for nuclear, I just didn't know what to say one way or the other in order to appear to be fair but also to press for what I think is right.'

This is a classic statement of the problem of role conflict as it exists for the individual making a request but it was apparent that Dr. Gilbert had no such problem, consultants' reactions to the situation may therefore vary considerably. However, as other members of the division gradually declared their support for endocrinology it was easier for Dr. Gilbert to see what he thought was right as being the same as what the division thought was right.

The Medical Division discussed consultant priorities on two further occasions, once in relation to future consultant requirements and once in the replacement of a chest physician.

Future Consultant Requirements

This arose in response to a circular from the Area Health Board which asked hospitals for a list of retirements and future consultant requirements for the period 1976-80. The Committee of Divisional Chairmen referred the matter to the divisions on the 4th September 1974. The divisions dealt with it in remarkably different ways. The Medical Division held a ballot and arrived at the following list:

endocrinology, nuclear medicine, and physical medicine, in order of priority and in addition gastroenterology, cardiology, clinical pharmacology and allergy. This was the only division to attempt to put its requests in any kind of order although such a move was not possible for all of the other divisions. The Anaesthetics Division wanted four additional consultants but this assumed some homogeneity among consultants and ranking was not appropriate. However, in the Surgical Division the specialties within the division looked at their own situation and made no attempt to co-ordinate their requests, they merely asked for an ophthalmologist, a vascular surgeon and an orthopaedic surgeon but gave no idea as to their relative priority. Similarly in the Laboratory Division there were requests for a pathologist and a biochemist but again no indication was given as to the relative need for these posts.

So again there was considerable variation between the divisions as to how they chose to deal with this issue and whether they chose to rank priorities in those cases in which there was more than one request. Even in the Medical Division which had made some attempt at the assessment of priorities this had been done by ballot which, as will become clear below, is not necessarily a reliable method. This question arose again when the Medical Division discussed the replacement of a chest physician.

The Replacement of a Consultant Chest Physician

The consultant chest physician at Wallace Hospital, Dr. Parrett, was about to retire and the Area Health Board wrote to the Committee of Chairmen in September 1974 asking how the post should be advertised. This was referred to the Medical Division. In the Overton District there were two chest units in Wallace Hospital and Reeve Hospital and this had split the chest service. There were two consultant chest physicians at Reeve and they seemed to be content for Dr. Parrett's post to be changed to some other specialty. When the matter was discussed by the division in October the chairman, Professor Alexander, took this line as well, following on from a meeting in September when it was generally agreed that Dr. Parrett should not be replaced with another chest physician:

Professor Alexander: Do we want an endocrinologist to replace Dr. Parrett?

Dr. Gregor: I think it first has to be decided if Dr. Parrett is to be replaced in his present form.

Dr. Parrett: It has been said that chest medicine in the Overton group has had its faults but it has worked with the disadvantage of being split between Reeve and Wallace Hospitals. The Crofton Report (1) has recommended that there is a merging of chest medicine with general medicine as the former has tended to get neglected and I think that should happen. We are grateful for the facilities which doctors here have provided us with but I think we should have a major unit for cardio-respiratory problems as there are in other major hospitals.

Professor Alexander: Well this was considered at the last meeting with Dr. Gore, Dr. Pearce (chest physicians at Reeve Hospital) and Dr. Frome (a doctor with an interest in chest medicine at Overton) and it was decided that the post shouldn't be filled in its present form. We cannot really go back on that decision although there were a number of absentees.

Dr. Frome: Well I actually said that as a prima facie case it looked as if that was the case but I said that I would look for more information on the subject. The thing about chest medicine is that the Scottish Home and Health Department have a definite policy with the Crofton Report (1) which says that chest physicians should be replaced by general physicians with an interest in chest medicine. They make no recommendation to reduce the consultant establishment. It could be said that if we don't want it as a chest post the Endrick District could be very interested. There is no suggestion that the district or even the area can change the designation of a post, that has to go to the Scottish Home and Health Department, we can't scrap it off our own bat. The thing we should do is to say we want a general physician with an interest in chests. If we get them mixed up then we will almost certainly lose the post to the Endrick District.

Professor Alexander: The point that we could lose it is against the information I have. I am objective and I would be quite happy to see you get this, but where did you get your information?

Dr. Frome: From a member of the Crofton Committee.

Professor Alexander: Well Mr. Alwin (the District Administrator) says we can do it.

Dr. Frome: Well that was the view of a member of the committee.

Dr. Hudson: We might lose the chest post but would we get another one to replace it?

Professor Alexander: We can change it.

Dr. Collis: Why do you say it could go to the Endrick District?

Dr. Frome: They have a registrar and they are all set to go.

Dr. Gore: We have been lucky with the number of chest physicians we have had because of the split between the two hospitals and if you ask to replace it with another chest physician you may not get it at all. Another point is that the Senior Hospital Medical Officer establishment is about to come under review and we have two of them who could well be upgraded to consultant level.

Dr. Frome: This is stated in the Crofton Report (1).

Professor Alexander: Well Dr. Frome you're the only one who says we can't change it.

Dr. Frome: I can back it up with two members of the Central Hospital Staff's Committee.

Professor Alexander: This information appals me.

Dr. Hudson: I go along with Dr. Frome that the Crofton Report says there should be X number of consultants in chest, say 100, if there are 100 and we say we don't want the one we have then it could go to Endrick Hospital.

Professor Alexander: Well let's work in the belief that we can change it to what we want and then I'll check that out later.

Do we want the replacement to be a general physician with an interest in chests, or an endocrinologist or what? And it is up to me to ascertain if it can be done.

Up to this point they had been arguing purely about whether they could change the post or not, a fact which must have been ascertainable. As it was the discussion took place within a vacuum of knowledge about whether or not they could recommend such a change. The discussion then turned to what they should replace Dr. Parrett with:

Dr. Keltings: ... I think we should draw attention to the views of the other chest physicians.

Dr. Gore: I think there is no indication for replacing Dr. Parrett with a chest physician. Wallace Hospital has had to serve other areas apart from Lennox but with the reorganisation that will now cease and the clinic at Reeve manages most of the work for Lennox already.

Dr. Hudson: There is one point I would like to emphasise. I think it is terribly important to look after the welfare of Wallace Hospital. Anyone who is appointed should see that as his hospital rather than have it here and further reduce morale at Wallace with the attendant leaving of staff.

Professor Alexander: Is there a feeling it should be based there?

Dr. Gore: Yes.

Dr. Hudson: I think the morale problem is terribly important.

Professor Alexander: It would be difficult to have endocrinology there.

Dr. Collis: Or nuclear medicine.

Dr. Ashton: But this discussion should not be dominated by where the post should be put, we must determine it by present needs, if we don't do this it will have to be Physical Medicine.

Dr. Hudson: But it is terribly important if you have a district service that morale is kept up. Other specialty units in the city have moved to run-down hospitals, said they wanted supporting facilities and got them.

Professor Alexander: But I doubt if anyone in the next fifteen years could make a go of Wallace.

Dr. Hudson: I have to leave now but I would emphasise the morale problem.

Dr. Gregor: If the endocrinologist was appointed here then we could still use the beds at Wallace as we wanted to.

Professor Alexander: Dr. Collis?

Dr. Collis: My interest is in nuclear medicine rather than endocrinology and I think we should have it here.

Dr. Ashton: What is the situation at Wallace?

Dr. Parrett: Poor staff-wise.

Dr. Mells: Although I agree we need an endocrinologist and a nuclear medicine specialist my own feeling about Wallace, taking into account the facilities and the points made by Dr. Hudson, is that we make it rehabilitation or rheumatics, there are no facilities for those here.

Professor Alexander: This is something new and goes against our ballot.

Dr. Mells: It goes against an appointment at Overton but this is a Wallace post. If the post was here then we have our priorities ...

Professor Alexander: So in other words you are saying we should treat this as a Wallace post? We don't have a rheumatologist, what do people feel about that?

This was introducing a completely new suggestion into the discussion, again no evidence was produced to support it but nevertheless it immediately became part of the armoury of possible solutions. However, there were some who disagreed with this line of argument:

Dr. Ashton: I don't think this is sound reasoning. I think the problem of trying to form a primary unit at Wallace is that it might fall apart.

Dr. Gregor: I think that was what I was saying. We should treat

it as a vacancy within the district and then we as a division can use the beds.

Dr. Marsden: I don't think Dr. Parrett should be replaced with a chest physician or a rheumatologist. I think it should be endocrine or nuclear and I don't care which.

Dr. Stott: I think if it's endocrine then it has to be here, the patients would come from internal medicine patients that we would have here.

Professor Alexander: Dr. Baily.

Dr. Baily: I don't know much about this, I am a dermatologist but I do feel the want of a rheumatologist.

Professor Alexander: Dr. Keltings.

Dr. Keltings: I think that if you have people travelling back and forth then the hospital and the man lose out and that to make the post fixed at Wallace is not viable. The prime need is for an endocrinologist.

Dr. Gore: If you don't put people in Wallace then you might lose the beds completely, we should ask Dr. Gilbert if it would be possible to maintain an endocrine unit at Wallace.

Professor Alexander: I think if we had endocrine the main base would have to be here.

Dr. Canon: I run the endocrine clinic at present and we are getting 4 new and 30 return patients per week. I feel at the service level there is a need for an endocrinologist.

Professor Alexander: Could he be viable at Wallace?

Dr. Canon: I think it would be very much more preferable, I think whoever was appointed would prefer to be in Overton.

Dr. Ashton: The trend is away from Wallace in the midder and in other movements and I think it would be a bad idea for us to try and prop it up.

Professor Alexander: I think we have had our discussion and we should vote on the premise that the post will be retained in this district.

A vote by show of hands was then held and the voting was as follows:

General Physician with an interest in Chest Medicine	- 3 votes
Rheumatologist	- 3 votes
Endocrinologist	- 5 votes
Nuclear Medicine	- 0 votes
Physical Medicine	- 0 votes

Discussion then proceeded in the following way:

Dr. Keltings: I was going to suggest that we have a second vote and have an endocrinologist with an interest in nuclear medicine.

Professor Alexander: That would get too complex, let's vote on the second choice though. Dr. Baily you didn't vote that time, have you made up your mind?

Dr. Baily: I don't know much about this.

Professor Alexander: Well you're a member of the division, you have a vote.

Dr. Gregor: Surely we say endocrinology is the first choice and we now vote on the second choice.

Dr. Frome: Can we vote for what we voted for last time if it wasn't endocrinology?

Professor Alexander: Well I don't know, no I don't think so.

The voting for the second choice went:

General Physician with an interest in Chest Medicine	- 2 votes
Rheumatologist/physical Medicine	- 6 votes
Nuclear Medicine	- 4 votes

(The extra vote in this ballot is accounted for by Dr. Baily who did not vote in the first ballot, also he voted for his first choice, Rheumatologist/Physical Medicine, rather than his second choice like all the other members of the division.)

Professor Alexander: To summarise the debate, endocrinology is number one, rehumatology cum physical medicine is number two,

> I cannot see there is any way we can make it more democratic. But if it cannot be retained in this district unless it is a general physician with an interest in chest medicine then all this comes to nothing.

A number of points emerge from this discussion. First of all, the debate about whether or not the post should remain as a chest physician was conducted with very little evidence, it was based upon the opinions of those present. Presumably evidence as to the existing workload would have been relatively easy to obtain. Secondly, the alternatives which were discussed were once again debated without evidence to support them. Thirdly, the priorities for replacing the chest medicine post were different from those which had been decided in relation to future staff requirements, then, nuclear medicine had been the second priority, this time it was moved down to third priority.

There are a number of reasons for this inconsistency. The chest post belonged to Wallace Hospital and a number of consultants thought that any replacement should also be based at Wallace. The only possibilities with that condition were physical medicine and/or rheumatology because facilities for endocrinology or nuclear medicine were not available. While this possibility was mentioned the division did not decide whether it was talking about a Wallace post or a post for reallocation within the district. As a result some people voted on one basis and some on the other and for those voting on the basis that the post should be retained at Wallace the only options were physical medicine and rheumatology. Also, in the second ballot rheumatology and physical medicine were combined, while in the first ballot they had been separate options. This meant that the combined option could take the three votes which went to rheumatology in the first ballot. This happened despite the fact that the chairman had turned down a proposal to combine endocrinology and nuclear medicine because it would 'get too complex'.

The ballot to decide on which consultant posts they wanted in the future had been calculated according to the number of first choice

votes, whereas this ballot was conducted more along the lines of proportional representation. Not surprisingly different results are produced by different voting systems particularly if single options in the first choice are combined for the second choice and if people do not vote in the first ballot and vote for their first choice in the second ballot, as was the case with Dr. Baily, the dermatologist. Finally, the voting had been more complex because the general physician with an interest in chest medicine had been included in the ballot, whereas it had not been in the ballot concerned with future priorities, a number of consultants felt they had to vote for this option whereas previously they had supported the request for nuclear medicine. However, the greatest impact upon this different result was the change of voting procedure and it seemed a little strange that the priorities for consultants should be allowed to change with the particular voting system employed and this brings into question the use of a vote to make such decisions. The chairman seemed to see this as being important when he made the following statement:

'I cannot see there is any way we can make it more democratic.'

However, it appeared that this desire to be democratic had a number of effects upon the decision-making process. It meant that any suggestions for additional consultants were automatically included on the ballot list, as was the case with the rheumatologist. In a similar way Dr. Baily, the dermatologist, protested that he knew very little about the area concerned and yet he was told that he had a vote and that he had to use it. It was obvious that a number of members of the division felt that this was not necessarily the best way to make decisions as the following comment indicates:

'I'm not sure that democracy is a good thing for its own sake. I think it can dilute initiative because you can go to a divisional system and one person might have a proposal and it is combatted or argued against another proposal, now at that particular point it might not be thought by the majority to be the best system but I'm not sure what leads people to think that something is the best one to choose ... a democratic way need not necessarily or in the majority of cases be the best way. The problem is between the broad perspective and what

> the individual wants and very often it is the latter which wins out.'

Certainly there was very little discussion of information to enable decisions to be made and individual predilections rather than service needs played a part in how consultants voted, for example, when Dr. Collis said:

> 'My interest is in nuclear medicine rather than endocrinology.'

The final irony of all this was when the chairman said about the post in question:

> 'But if it cannot be retained in this district unless it is a general physician with an interest in chest medicine then all this comes to nothing.'

The vote had suggested that a general physician with an interest in chest medicine was not needed and yet if they were unable to obtain any other post they would have been prepared to accept the retention of the post rather than let it go to another hospital.

In a sense the alternatives which were discussed had become divorced from the consultants who had initially proposed them because they had become part of the 'furniture' in the discussion of future priorities. It therefore appeared that consultants were reasonably happy to press for what they as individuals wanted or were interested in and it was the configuration of these various interests which produced the outcome rather than any rational consideration of the relative needs of the different specialty proposals. Another issue in which priorities had to be decided was the higher medicine allocation and in this case the requests were very specifically tied to individuals.

The Higher Medicine Allocation

This is a financial allocation for equipment or possibly staffing from the Regional Hospital Boards under the old structure and the Health Boards under the new structure. The purpose of the allocation is described as follows:

'Higher Medicine Funds are for those developments which will be of real assistance to the teaching hospitals in implementing their essential functions as the leaders in medical thinking and in the development of new forms of care and treatment of patients.'

Each of the Boards of Management, and latterly the Districts, were asked to present their requests to a special committee which decided which requests were to be supported. The Committee of Divisional Chairmen received notification of this and the Chairmen were asked to raise the matter with their divisions and bring back any requests they had. In 1973-4 four divisions had requests and for three of those, the Surgical, Paediatric and Geriatric Divisions there were only single requests. The consultants just put these forward to their chairmen and they were automatically accepted and passed on to the Committee of Chairmen. By contrast four consultants in the Medical Division had equipment requests and the Division considered these on the 15th January 1974:

Dr. Ashton: There are four submissions from Dr. Hudson, Dr. Frome, Dr. Hale and Dr. Collis.

Professor Alexander: Let's see what they cost. Dr. Hudson - £3,000, Dr. Frome - £2,000, Dr. Hale - £12,000 and Dr. Collis - £6,700. Can you tell us what they are?

Dr. Hudson: Mine is a six-channel recorder for studying Oesophageal Mobility.

Dr. Hale: Mine is a Continuous Blood Flow Separator, it produces white cells in concentrated form and would be very useful for the treatment of, for example, leukaemia.

Dr. Frome: Mine really comes into the long-term plan for nuclear medicine which will include the whole body scanning technique. With our present equipment we can only do part of the body, this equipment moves us towards being able to do the whole body. It is not so much Higher Medicine as routine equipment.

Professor Alexander: It would be of interest to all users, I wonder if we could get it from another source if it is back-up for original equipment.

Dr. Collis: Mine is an Ultrasonoscope for echocardiography and includes a recorder. Echocardiography is now a widespread technique and it would be useful if we could have this equipment.

Professor Alexander: I find it difficult to rank these, would you like me to put them all up together?

Dr. Gregor: I think we should do it.

Dr. Ashton: I think we have to rank them, it is the whole point of the meeting.

Dr. Gregor: It will also be fought out at the Committee of Chairmen so we have to make some ranking.

Dr. Collis: Should we leave it to the critical observers, those who have not made a request, with the chairman and secretary to form an ad hoc sub-committee?

Dr. Keltings: Or we could leave it to the secretary and chairman.

Dr. Ashton: I think it would put the secretary and the chairman in an invidious position if they had to decide, we would be the judges on this occasion and the judged on the other occasions.

Professor Alexander: Well shall I send out a pro forma sheet with all the items written down and we will all rank them in private?

These requests were linked to individuals and the division again found it difficult to have an open discussion about the relative merits of the different proposals. In trying to find a way to make the decision a number of consultants put forward and reacted to suggestions which indicated that they did perceive a role conflict. One of them suggested that all the consultants who did not have requests should make the ranking decision so that they would not be biased. Another suggested that the chairman and secretary should undertake it but the secretary said that they would be in an invidious position, being the judges on this occasion and the judged in the future. This was a classic statement of the role conflict in the division.

The solution was the same as that employed for the consultant priorities, a postal ballot. This method defused the situation by making secret the support which consultants gave to the different proposals, thereby avoiding the role conflict. At the same time, however, it curtailed discussion of the relative merits of the different requests, in a situation where the aims of the Higher Medicine Allocation were very specifically laid down. Again very little information was presented about the various pieces of equipment, although for the purposes of the committee at the Regional or Area level a very detailed case of what the equipment would be used for has to be provided. It would have been preferable if the division had been presented with these formal submissions but again it would have involved consultants openly declaring their support for other consultants, or openly opposing them, and they seemed to be concerned to avoid this.

The following year there were again four requests from members of the Medical Division for the Higher Medicine Allocation. On this occasion there was no discussion of the requests by the division, a postal ballot was held instead. This had become the way of dealing with this particular category of consultant requests.

The other type of equipment which was discussed by the divisional system was Medical Moveable Equipment for the routine care of patients. The requests for this came from individual consultants through their divisions to the Committee of Divisional Chairmen which had to decide which requests to support out of a limited budget. None of the divisions made any attempt to screen the requests or place them in some order of priority. Divisions automatically gave their support to all requests and the attitude of some of them was that this automatic support improved the chances of obtaining the request, the following quote from the chairman of the Surgical Division indicates this:

Mr. Scott: Mr. Wren has asked that we make a request for a mechanical form of suture stapling. The initial outlay is £1,000 and then each cassette of staples costs around £5

> which means about £15 for each patient. This will be put forward. Are there any other requests? Mr. Pitney wants something but he hasn't given me the details yet. Requests can be made from an individual or a group but we have much more chance of getting things if they are divisional requests rather than if they are made individually.

If such support enhanced the chances of success it was certainly not because of the screening process through which the division put all such requests. There was also a small amount of support between divisions for pieces of equipment. A discussion in the Division of Obstetrics and Gynaecology, which was routinely attended by a paediatrician, went as follows:

Dr. Pollen: What about the baby heaters?

Dr. Leven: We missed out on those last year and so we should really push for them.

Dr. Pollen: Dr. Langton in paediatrics is asking for an Ivac and we should support that.

Dr. Camp (paediatrician): If you put forward for the heaters then we will support that request.

The Committee of Divisional Chairmen therefore had the task of mediating between requests both within and between divisions. The divisions showed no inclination to mediate between the requests of individual consultants as a first stage in the decision-making process, again it appeared that they did not want to be in the invidious position of being the 'judges and the judged'.

The other area of divisional discussion which had implications for consultant autonomy was patient care evaluation and rules about consultant practice. These issues were rarely discussed by divisions but there were a number of debates which touched upon this area.

Patient Care Evaluation and Clinical Practice

There was a general question on the interview schedule which asked:

Has the divisional system had any effects upon the way you organise your clinical work? Only 6 out of the 42 consultants interviewed said that it had and two of these were chairmen who said that they had less time in which to do their work. Among the remainder, 2 physicians mentioned the sharing of beds in the Coronary Care Unit and the Intensive Therapy Unit, a geriatrician said that work between hospitals was more integrated and a surgeon said that he knew more about staffing in the specialty than he did before. In general consultants seemed reluctant to allow the divisional system to interfere with the way in which they practised - this was particularly clear in the following discussion.

The Medical Records Officer in the Overton District, Mr. Lambert, had developed a system whereby consultants received a quarterly print-out of their own diagnostic and treatment statistics. However, the reaction of clinicians to these was not enthusiastic. On one occasion the Surgical Division discussed the use of the print-out with Mr. Lambert. He explained its possible uses in examining various methods of treatment and length of stay. Their general attitude to this was expressed by the chairman, Mr. Scott:

> 'If you read the recent Blue Bulletin it says a number of unfortunate things. They report on the comparison of the performance of surgeons for hernia in different hospitals. There is a possibility in this of an edict on length of stay. In that, people would be compared and that would have a very unfortunate outcome.'

While any totally inflexible edict on length of stay might indeed be dangerous this was no reason in itself for not examining practice within the Surgical Division. It was clear that the consultants had no wish to compare one another's practice. The Medical Records Officer already had doubts about the use to which the print-out was put and had discussed this with the Medical Records Review Committee. On the 6th February 1974 he wrote to the Committee of Chairmen asking that the print-out be discontinued because it was expensive and consultants were not using it for any purpose. The Committee of Chairmen discussed it on the 6th March:

Dr. Henley: I have a letter from Mr. Lambert. The whole thing is news to me, have you any comments?

Dr. MacAulay: I have always thought that this duplicated the Scottish Home and Health Department print-out and I thought that provided we could get it if we want it, then I don't think it should go out to people who don't want it.

Professor Alexander: How many of us consult it?

Dr. Murdoch: I don't use it.

Professor Alexander: I think it should be sent out and I think it may be a defect on our part.

Dr. MacAulay: I could use something simpler.

Dr. Falk (Medical Superintendent): Well this committee was asked what it wanted in terms of change a couple of years ago and it has the advantage over the national print-out that you can get it when you want it rather than every year or so. I think it is a service to consultants but why isn't it used? I think we corrected a lot of the criticisms last time around, for example, having the diagnosis printed in rather than a code number. It is the old story, do people want to know what they are doing? The divisions should be trying to improve their performance and I think community medicine should play a part in this, although it shouldn't interfere.

Mr. Scott: Well we are all sympathetic and I agree that it would be a good thing but quite honestly I am clinically stretched and I would have to take the figures home to look at them, quite honestly with the numbers of consultants we have we are clinically stretched.

Professor Alexander: I think Dr. Falk's view should be respected and I don't think we should precipitously make a decision. Recently a consultant in community medicine has been appointed to the district and this information could be of use to him. We should give him a chance to look at these figures, he is a full-blown consultant in community medicine and will be able to digest them. It would be wrong to remove them at this

point and they could be useful to him later on, and we can always bring out the axe.

Dr. Falk: If people like Dr. MacAulay have problems they should raise them at the Medical Records Review Committee ... I think Mr. Lambert would be happy to point out and highlight anomalies and differences that appear to be statistically significant.

Professor Alexander: I think the best person to look at anomalies is the clinician.

It was agreed to allow the print-out to continue for six months. Two community medicine specialists were appointed and Mr. Lambert wrote to one of them asking him if he would do something about the statistics which were being produced. Dr. Thomas replied:

'I presume that the object of producing these print-outs was to improve patient care ... The mass of information as presented in the diagnostic list would seem not to meet this aim ... It seems to me therefore that the continued production of the diagnostic list would be of no value as a routine measure ... The clinicians themselves are obviously unhappy with, indeed not interested in, the print-outs as produced, but they are the ones who should perhaps be asked, possibly through divisions, the information they would like, if any, and how they would like it presented.'

This letter was discussed by the Medical Records Review Committee and subsequently Mr. Lambert wrote the following note to the Committee of Chairmen:

'I enclose a letter from Dr. Thomas which was discussed ... yesterday and you will note that Dr. Thomas is recommending that the clinicians are the ones who should perhaps determine the information they would like and how it should be presented.

A previous opportunity was given to the clinicians to determine the presentation but no constructive suggestions were received. The Committee would ask the Divisional Chairmen to agree that this quarterly print-out be discontinued.'

The Chairmen agreed that the print-out was not of much use to them and recommended that it should be issued on a six monthly or yearly basis rather than every quarter.

Neither the clinicians nor the community medicine specialists wanted to take the lead in this, both thought the other should determine changes in the print-out which might facilitate some assessment of their work. While blame for this outcome might be equally shared it was clear that the doctors were not exactly enthusiastic about comparing and evaluating one another's practice. The only other discussions relating to clinical practice were brief and not concerned with evaluation. One was in the Medical Division and related to kidney donors and the other was in the Surgical Division and was about surgical appliances. The kidney donor issue was raised in February 1974:

Dr. Keltings: I was alerted to this need when we might have had a kidney donor a while ago and I don't think we know enough about personal action and responsibility at the local level. I have a list of the instructions from 1970 and I think it is imperative the relatives know that death is inevitable and that all is being done to save them. I suggest that in the event of this arising the patients should be moved to the Intensive Therapy Unit in good time so that relatives can be approached without a rush. I would like us to consider telling juniors that this should be the procedure.

Professor Alexander: Do you suggest that any potential donor should be put in the Intensive Therapy Unit?

Dr. Keltings: Yes, then there would be more time to discuss the matter with relatives and to administer assistive respiration even though they know the situation is hopeless.

Professor Alexander: But the sort of patient who is likely to be a good donor will generally be young and probably have had an accident and they are likely to have been in the Intensive Therapy Unit anyway. Also if we put it down in writing then the Intensive Therapy Unit might become known as the Frankenstein Unit or something, where they take out the organs, that could be a danger.

Dr. Collis: I think they are so few and far between that notoriety is unlikely to develop.

Dr. Keltings: But there are patients who are not in that category ...

Dr. Hudson: I think we have discussed this enough and I think it would only do harm if it were written down and might commit us. I think we should leave discussion here.

In the official minutes it was stated that:

'The matter should be left to the individual judgement of the Consultant Physician responsible for each case.'

This expressed a clear concern with individual responsibility and autonomy in dealing with cases. However, some of the consultants were prepared to entertain the introduction of such a ruling on practice with regard to potential donors. What is signficant is that the decision of the division was responsive more to the status quo and to allowing consultants to make up their own minds rather than to any general ruling which might control what they did. In this way their autonomy was safeguarded.

The discussion in the Surgical Division was about surgical appliances and a proposal that firms supplying appliances should take it in turn to staff the appliance store in the hospital:

Mr. Wren: What concerns me is that we might not be able to use the firms we want to.

Mr. Pitney: Do you specify a firm when you prescribe a surgical appliance?

Mr. Wren: Yes, I always do.

Mr. Sander: So do I.

Mr. Pitney: Who do you recommend?

Mr. Wren: Well, for surgical corsets I recommend Menzies.

Mr. Sander: Do you? So do I.

Mr. Wren: But I'm a bit worried about their shoes.

Mr. Sander: Yes, I think other people are better on shoes.

Mr. Pitney: But isn't it like the pharmacy where the pharmacist decides which drug firm to use?

Mr. Sander: Not at all, it's nice to be able to ring up the firm and say I'm not happy with this, come and fix it.

Mr. Pitney: But I don't know the first thing about surgical appliances.

While this is not a central area of surgical practice this discussion indicated that the surgeons knew very little about one another's practice habits in this particular case.

While these examples are rather specific, apart from the case of patient care evaluation, divisions seemed to be very unwilling to make decisions which might in any way direct what consultants should do. A member of the Medical Division mentioned this when he was interviewed:

> '... we still don't feel free to criticise each other's ordinary performance and ordinary organisation of their duties in any detail at all. I don't know if we ever will do, because obviously it's a little bit, er, what you'd really finish up with in these circumstances is a kind of East European type standing up and confessing your failure to follow the party line ...'

Even had they been willing to indulge in such criticism the incident relating to surgical appliances suggested that consultants knew very little about one another's practice. In that case, even the basis for an examination of practice or contrasting practices was lacking.

Conclusion: Overton Hospital

This section has been concerned with whether or not, or to what extent, consultant autonomy and its maintenance plays a part in the operation of the divisional system in Overton Hospital. It was argued theoretically that there is a role conflict in divisions between the representation of individual consultant interests and making decisions on the basis of what is best for the specialty

as a whole. It was then argued that the concern, at the individual level, with consultant autonomy meant that the solution to the role conflict would favour outcomes which did not impinge upon the professional value of individual autonomy.

Two perspectives on the work of divisions have been discussed, consultant responses to questions about the way divisions deal with issues and accounts of the way in which divisions dealt with specific decisions.

In analysing the process of divisions it is clear that the same issues were dealt with in rather different ways by the divisions in Overton Hospital. The physicians used the Medical Division for all their requests, as a matter of course, before they were passed to the Committee of Divisional Chairmen. Other divisions did not enforce this, in geriatrics consultants sometimes by-passed the division and wrote direct to the Committee of Divisional Chairmen, in radiology the division only met twice during the eighteen months of fieldwork and the chairman made most of the decisions about what the division wanted. The Laboratory Division was rather different because it comprised a number of departments and the heads of these often discussed matters directly with the chairman of the division without reference to the division as a whole. In this way divisions had different standards for dealing with proposals as to whether or not they passed through the division.

Secondly, within divisions, and particularly among those where presentation of requests was a routine, there were variations in the manner of presentation. Some consultants presented a lot of supportive information which might enable other members of their division to evaluate their proposals, others presented very little information.

Apart from medicine, obstetrics and gynaecology, paediatrics and surgery, whether or not a consultant used the division or wrote direct to the Committee of Chairmen seemed to be dependent upon the consultant rather than the division. In the same way how much supportive information was presented was also up to the consultant rather than

any standard determined by the division. Consultants retained a large measure of autonomy in deciding how they used the structure. Divisions imposed few standards on the format for the presentation of requests.

In addition, these variations made little difference to the screening process of the various divisions. Irrespective of mode of presentation and supportive information, for the most part divisions accepted or supported consultant proposals. This was largely confirmed by the interview responses. A sizeable proportion of the consultants saw divisions as being used supportively rather than critically when dealing with consultant requests.

The divisions therefore avoided impinging upon consultant autonomy. Proposals were accepted with little consideration of how they related to the general development of the specialty concerned. What consultants wanted became what specialties wanted and in this way the role conflict between these two elements was solved by giving primacy to the expectation that individuals should represent their own requests and interests.

The question of priority decisions was particularly interesting. Priorities inevitably involve some form of discrimination between alternatives and for divisions generating more than one request for, say, consultant or junior staff within a certain period, priorities between them would be decided further up the medical advisory, or the administrative, structure. The Medical Division was the only division to attempt to tackle the priority of its various submissions. Admittedly most of the other divisions with the exception of Surgery and the Laboratories had not encountered this problem, but apart from medicine, divisions avoided any question of priority and treated requests on a piecemeal basis. This had the result of avoiding the choice between proposals from different consultants and thereby any transgression of their judgement and independence. In the Medical Division it was recognised that choices between their proposals were being made further up the Medical Advisory Structure, and they decided that they would rather determine their priorities than someone who

was removed from their situation. This was a big step forward in terms of the Joint Working Party proposals but they did not find the process of deciding between consultant requests nearly so easy. If priority decisions were to be made on the basis of merit or some grand specialty design, presumably information which enables such a comparison to be made has to be presented. In the case of the Higher Medicine allocation information presented in support of the submissions was limited, if uniform, and for consultant staffing information was severely limited. In both cases ballots were used to decide between the alternatives. This avoided the problem of individuals being openly associated with the decision as supporters or opponents of different consultants and their proposals. From the interviews a number of consultants in the Medical Division said that in voting for proposals they were concerned that benefits should be shared equally by consultants over a period of time. The ballot enabled this to take place whereas an open consideration of proposals on their merits would have made this difficult to achieve. The aim of securing an equal share of benefits to all consultants is also consistent with the notion that they did not want to interfere with one another's autonomy.

Finally, in relation to patient care evaluation and the consideration of policies for dealing with particular clinical problems it was clear that consultants did not always know a lot about one another's practice, and, even if they did, were concerned not to interfere with it or set down definite rules or procedures. They preferred to let each consultant chart his or her own course.

ALLAN HOSPITAL

The divisional system had not been introduced in Allan Hospital and, as outlined in Chapter 6, the main medical organisation in the hospital was the Medical Staff Association. If doctors used this as the basis of the Medical Advisory Structure then this was the forum through which

requests for staff, equipment and the like would pass. As will become clear below, issues which were discussed in divisions at Overton Hospital were often taken straight to the administration rather than through the Medical Advisory Structure in Allan. Before examining the operation of the Medical Staff Association the attitude of consultants to the relationship between the Association and individual consultants will be discussed. It is, however, more difficult to separate out problems relating to individual autonomy from problems relating to specialty. In Overton it was possible to ask about the level of the division whereas in Allan some people would be adjudicating on members of their own specialty while for others the same people would be not only consultants but members of another specialty as well. However, the Staff Association, as the lowest formal level in the Medical Advisory Structure, is the only body in the hospital which is supposed to screen proposals from consultants or specialties before they are passed on to the District Medical Committee or the administration.

Twenty-seven consultants were interviewed and the following questions focussed on the relationship between individual consultants and the Medical Staff Association. The first question was a general one: Do you think the Medical Staff Association is a good place to consider ideas and proposals from individual consultants and specialties? The broad response was as follows:

Yes	12
No	8
Depends	7

Of the seven consultants who answered 'depends', four said 'yes, if it affects the hospital, no, if it is a unit matter', one said 'yes for general discussions but no for arriving at decisions' and one said 'yes if it is well chaired, but the chairman has to let people have their say and also control what they have to say and generally he does the former and not the latter'. The remaining two said it depended upon the issue. Members of the Staff Association were therefore split as to whether the Medical Staff Association was a

good screening mechanism. Consultants were then asked about the advantages and disadvantages of taking matters to the Medical Staff Association.

Six consultants said there were no advantages at all. Among those who thought there were advantages, six saw it as being used supportively rather than critically, for example:

'To get the support of the whole staff.'

'Others might see the pitfalls in proposals, and improve them.'

Among the remainder a variety of advantages were put forward, for example:

'You can discuss matters common to all staff and divisions.'

'Nobody can say I wasn't consulted.'

'To get a broader consensus.'

'People can air their views.'

'It's useful if we get bees in our bonnets.'

'Things can be channelled if they are not relevant to the Staff Association.'

The question about disadvantages of taking matters to the Staff Association produced a lot more answers, with some consultants identifying more than one disadvantage. There were three main types of disadvantage:

1. Structural Disadvantages: 9 consultants, for example, too large, too diffuse, too many specialties.
2. Disadvantages in what it is expected to do: 4 consultants, for example, 'it is asked to make decisions which are economic rather than medical'.
3. Disadvantages in the way it operates: 23 consultants, for example, 'it cannot decide on things', 'there is too much self-interest', 'it's just a talking shop', 'people

are not informed', 'nobody takes any notice of you unless you have been in the hospital for a long time', 'it's badly chaired'.

Fairly obviously the structural disadvantages play a large part in determining how the Medical Staff Association operates. The major complaint appears to be that it is very bad at making decisions, and if it does actually make a decision this is also done badly because people are not informed or some people are more influential than others.

In the light of these disadvantages the answers to the next two questions were not surprising. The first of these was: Could you tell me about any proposals or ideas you have raised with the Staff Association? and nine consultants said they had never raised anything at the Staff Association. The second was: Are there any matters you have deliberately chosen not to take to the Staff Association?, fifteen consultants said they had avoided taking issues to the Staff Association. Most of these said they would rather take problems to their specialty colleagues and/or direct to the administration or higher levels of the Medical Advisory Structure.

Consultants were then asked about the reverse situation: What about occasions when other consultants make suggestions or proposals, do you find it easy to comment and decide what should be done?, the response was as follows:

Yes	7
No	18
Depends	2

In elaborating on their answers consultants made it clear that one of the problems involved in this was knowledge of other specialties. Even among the seven who said it was easy to comment, two mentioned specific specialties, an anaesthetist said he would comment on surgical specialties and a physician said he would comment on specialties allied to medicine. Most of those answering said it was lack of knowledge but in some of the answers there was also an indication

that the behaviour of any consultant was in some sense sacrosanct, for example:

> 'The world of operating theatres now bears no relationship to the world of operating theatres when I qualified in the 1950's. It's a different world, things have tightened up, it was unbelievably slack before and it's highly technical. The use and personal habits, manners and efficiency of these units has nothing to do with those who are not using them.'

This last sentence implies some concern with individual consultant autonomy irrespective of lack of specialty knowledge. Others were just facing a lack of information:

> 'No, you see if you take the Coronary Care Unit, if that subject was brought up at the Staff Association I would find it very difficult to comment on whether the provision of a Coronary Care Unit would be a good or a bad thing or even a necessary thing within this hospital. So there might be things I would say "yes" and not really know if I was giving the right answer.'

Two of the consultants who answered 'no' said they would comment if they were asked or if the specialty or consultant concerned wanted support or assistance. Of the two who answered 'depends', one said that she would comment on interdisciplinary matters and the other that he would comment on matters that were not particular or peculiar to a specialty.

The next question was of a more general nature: <u>What are the most important functions of the Staff Association</u>? and this produced a variety of answers. The major responses were the following:

Discussing Body/Talk Shop/People can air their views.	12
Dissemination of information.	8
Liaison between consultants and specialties.	4
'Co-ordination of things which affect everyone - but the Staff Association doesn't do this.'	2

The remainder were individual responses, such as 'cuts down internicene strife', 'to see fair play', 'general things like religious services on the wards'. The general opinion was that the Staff Association was good for letting off steam and learning about new developments but there was little or no mention of making decisions about individual consultant proposals. There was, however, a Staff Association Executive and a final question which is relevant to this section related to that: What about the Staff Association Executive, what does that do?, in answer to this three consultants said they had no idea! The following were the main answers:

Recommends decisions to the Staff Association because the Association is too big and irrelevancies are brought up.	9
Runs over and decides the agenda.	4
Shortens the Staff Association meetings.	4
Occasionally makes decisions independently of the Staff Association.	4
Decides urgent matters.	3
Cuts out squabbling.	2
Does nothing because the items it discusses are discussed again by the Staff Association.	1
Sorts out the problems but cannot make independent decisions.	1

The largest single group was that which said that the Executive was a way of avoiding the inefficiency of the Staff Association, the following is a typical statement of this:

'I think the idea was that sometimes the discussion becomes so diffuse with so many slightly varying voices that it's possible to reach no decisions at all. In other words, my view is that if it's democracy then it becomes apolitical because you can't really get anything done and the idea behind the Executive was to thrash out some of the thornier problems and present proposals or solutions which the Staff

> Association could then decide, in other words, it was to get one step along the road.'

Although this viewpoint was not unanimous because one of the consultants said that the Executive resulted in items being discussed twice instead of once. Certainly for some issues discussion went on at length in both meetings even though the full meeting of the Staff Association was always held immediately after the Executive meeting. This was one of a number of indications that the Association as a whole was very unwilling to allow the Executive to take independent action. However, the general view was that it had a streamlining effect upon the workings of the Medical Staff Association.

In this section consultant opinions about the Staff Association, particularly with reference to individual autonomy, have been presented. The overall impression is that the members did not think of the Association as being a particularly efficient decision-making body. Only twelve consultants unreservedly thought it was a good place to discuss proposals from individual consultants and specialties. As a consequence nine consultants had never taken anything to the Association and fifteen consultants had deliberately taken matters elsewhere. The main benefits attributed to it were its support for individual proposals and the fact that it allowed consultants to get together and air their views. The members saw its major defects as being its size, its diffuseness in terms of the number of specialties present and its resulting inability to make decisions. In probing more deeply into how easy it was for them to comment upon one another's proposals, only seven of them said that it was. However, the major barrier to doing this was more in terms of lack of knowledge of what went on in other specialties than in terms of individual autonomy. Although it is difficult to separate out these two strands in a committee composed of consultants from different specialties.

From these interviews consultants did not present the Medical Staff Association as a body which could undertake or was undertaking the functions of either specialty divisions or a Committee of Divisional

Chairmen. There was of course some 'sub-Medical Staff Association' activity, some members stated that they took matters direct to the administrators and the physicians did have a hospital division. However, in the latter each consultant's right of veto made the maintenance of individual autonomy a prime concern. Another perspective on the way in which the Staff Association operates can be gained from analysing issues which might have implicated individual autonomy.

With a view to comparing Allan with Overton similar types of issue will be examined, particularly individual requests for additional staff and equipment and questions of clinical practice.

Requests for Additional Junior Staff

Prior to the Medical Staff Association becoming the bottom level of the Medical Advisory Structure, consultants with requests for additional junior staff had always written direct to the Medical Superintendent. The same pattern continued after the reorganisation except that the requests were channelled to the District Medical Officer. The vetting of requests in terms of whether a specialty required them or not was a function which consultants either did not think the Staff Association should perform or did not want the Staff Association to perform. As a result any discussion of junior staff by the Staff Association was in general rather than specific terms. One issue which provides an insight into their approach to the problem arose when it was learnt that the whole of Scotland was to receive a 3% increase in junior staffing for the financial year 1974-75. The Staff Association discussed this in November 1974:

Dr. Cally: A 3% increase in junior staff has been granted nationally and there is stated the pious hope that the teaching hospitals will keep down their increase so that the peripheral hospitals can have more than 3%.

Dr. Maldern (Community Physician representing the District Medical Officer): Well, I have a list with one or two which I think are high priority.

Dr. Lyon: Individual divisions should decide on their own wants and if the priority between divisions has to be decided then this should be done by the Executive of the Staff Association with the co-option of other specialties not already on it. The danger I see is that someone outside the hospital will be making the decision and they don't have a clear idea of the hospital situation whereas we do.

Dr. Cally: But we all look at life through our own tubes, I don't feel the shortage of anaesthetics staff.

Dr. Maldern: I have an area list from all the districts and I presume they will be sent down to the districts for their views.

Dr. Cally: At the end of the day it is difficult because some people are not going to be able to get what they want.

Dr. Aldis: But we have to be brave enough to do it.

Dr. Lyon: I agree it is important that we make this kind of decision.

Dr. Cally: We are too small in number to make this decision now but I think it will come to us from somewhere.

This discussion made it clear that if the Staff Association was going to be involved it would only be concerned with the relative priority of requests from different specialties, rather than with the priority of requests within a specialty or the validity of a single specialty request within that specialty. Below that level it was suggested that divisions should decide upon their own wants and yet there were only a few specialties which made any claims at all to having a division. The speaker was an anaesthetist and he belonged to an Area Dvision of Anaesthetics but for the majority of the specialties there was no such organisation.

The remainder of the discussion is interesting because it indicates an ambivalence about dealing with specialty requests, however, this will be discussed in the next chapter.

In relation to requests for junior staff the Medical Staff Association showed no interest in deciding whether individual requests were valid in themselves. In this sense the Medical Staff Association was not a substitute for specialty divisions.

Requests for Additional Consultant Staff

The pattern was very similar for requests for additional consultant staff. There were fewer requests for such staff in Allan than there were in Overton and consultants wrote direct to the District Medical Officer rather than broaching the subject with the Medical Staff Association. In the Aldershire Health Board as a whole the situation was slightly more complex because of the imminent opening of a new hospital. Plans for consultant staffing in this new hospital were being made by the Chief Area Medical Officer. However, this was kept separate from requests which had come up from individual consultants and specialties. The feeling of consultants about deciding on consultant staffing requests can be gauged from the following discussion by the Area Medical Committee. This was raised by Dr. Baird, Area Community Medicine Specialist on Manpower Planning, in January 1975:

Dr. Baird: I think the Chief Area Medical Officer has plans for twelve extra consultants in the next year and so I think he will press the Scottish Home and Health Department on this.

Dr. Struan: Does this twelve include the staffing of the new Laggan Hospital?

Dr. Baird: No.

Dr. Lyon: Dr. Baird says they are looking at additional consultant appointments, is it conceivable that the Hospital Subcommittee (comprising the hospital members of the Area Medical Committee) could look at the list?

Dr. Tilt: I think the Chief Area Medical Officer has the final word on this.

Mr. Struan: It is the existing consultants who would put forward the cases and it would be coming to them for a decision, perhaps it would be best if it went through an intermediate

step, through Community Medicine for an unbiased viewpoint.

Dr. Lyon: Mine is really a selfish viewpoint as I hope they don't appoint surgeons without appointing anaesthetists.

This arose again at the next meeting of the Area Medical Committee in February 1975:

Dr. Baird: There is no question that staffing in Aldershire is the worst in Scotland. To tackle this we have a number of crude suggestions to start with which we will use before we get onto more sophisticated methods and arguments. The first is that Medical Assistant and Senior Hospital Medical Officer posts should be considered for upgrading when they fall vacant and that those single-handed consultants should be doubled. We have five consultants up for consideration already but we would like your priorities for the next twelve.

Mr. Braden: You say all staffing is bad but thoracic surgery isn't even mentioned on your list and that is even worse.

Mr. Struan: I would like the hospital sub-committee to discuss this, I think the thing is that these posts have to be competed for and each specialty should gather information to put forward.

Dr. Tilt: I think you will have to co-opt people so that all the specialties are represented.

In this case requests for consultants were going to be discussed by the Area Medical Committee or its Hospital Sub-committee and yet they had not been discussed at either the District or the hospital levels. Also at this stage it was apparent that the hospital doctors saw these requests as being specialty requests rather than individual requests. The implications of this will be more appropriately covered in the next chapter. Suffice it to say that the Medical Staff Association did not act as a screening mechanism for individual consultant requests.

Requests for Medical Moveable Equipment

There were no requests for the Higher Medicine Allocation in Allan

Hospital but there were the routine requests for medical moveable equipment. Prior to reorganisation the Medical Staff Association had nothing to do with deciding between the requests. Consultants had sent them to the pharmacist and he had presented the full list to the Medical Superintendent who in turn decided which pieces of equipment should be purchased. The first part of this procedure continued in the same way after reorganisation, consultants sent in a list of what they wanted. In the year 1974-5, however, the pharmacist passed them on to Mr. Meacher, the Finance Officer, who sent them to the Medical Staff Association Executive asking for a quick decision. Because the pharmacist was involved in the process the Executive held a meeting with the Prescribing Committee and decided on the priorities between the various requests. The Executive then discussed this way of doing it in January 1975 partly because the remainder of the Staff Association was unaware that this had happened:

Dr. Cally: There was a meeting of the Prescribing Committee and the Executive on medical moveable equipment. This time it was a fait accompli but we should ask the Staff Association if this is an acceptable way of doing it. I don't think it can be criticised this time as Mr. Meacher had to get the list in.

Dr. Gow: In this sort of thing there has to be some point at which items are questioned beyond the level of instigation. You could easily imagine someone dreaming something up and nobody being nasty enough to question it, but I hope none of us would fail to say that something was daft if we thought it was.

Dr. Aldis: Isn't it the Executive's job to do this?

Dr. Gow: Yes.

Dr. Cally: I think we should have a meeting on all things like medical moveable equipment a lot earlier in the year as we have had to rush this through, but I think we should put the general principle to the Staff Association.

This was put on the agenda for the next meeting when it was again discussed by the Executive and then by the full Association. The discussion then focussed more on the specialty aspects of this decision and this will be looked at in more detail in the next chapter.

There was no discussion of medical moveable equipment on a formal basis below the level of the Medical Staff Association. In this case the Executive and the Prescribing Committee were having to make decisions involving comparisons between requests from the same specialty and from different specialties, but there was no attempt on the part of consultants or specialties with more than one request to allocate priorities to them. In the discussion above there is also some realisation of the problem of turning down other consultants' proposals when Dr. Gow refers to the need for questioning beyond the level of instigation. In relation to medical moveable equipment where there was a limited budget and more requests than there was money to buy them, some of the requests had to be refused and so some form of questioning had to take place. Unfortunately, the researcher was unable to attend the meetings at which this happened so there is no information on how the decisions were made.

The final area of consideration in this context is patient care evaluation and clinical practice.

Patient Care Evaluation and Clinical Practice

There was no discussion of patient care evaluation in the Medical Staff Association even on a general basis. The only germane matter to be considered was consultant responsibility in areas of work which cut across a number of specialties. The two items involved, the Intensive Therapy Unit and the care of cardiac arrests, give some indication of the approach of the Association to matters of clinical practice.

Ever since its formation there had been discussion about the Intensive Therapy Unit and who was responsible for patients admitted to it. At the end of 1973 the issues involved came to a head at a

meeting of the Staff Association Executive:

Dr. Rollo (Medical Superintendent): There is a letter here from the nursing staff on the I.T.U. detailing a number of cases in which junior doctors have neglected to come to patients when they were called to do so and when there was an emergency. In particular a case involving Dr. Andrews who refused to see a patient when he was asked to come, saying that it was not his patient. He appeared later in the unit and still refused to see the patient even though his condition was serious.

Mr. Earn: That's disgusting and unbelievable.

Dr. Gow: I though it was a value of the medical profession that a doctor would attend a patient whether he was the patient's doctor or not.

Mr. Fillan: The situation is a little confused though, in that sometimes a seriously ill patient is having treatment from a number of consultants and it is difficult in such cases to say which doctor is responsible.

This was left to full discussion by the whole Staff Association immediately following the meeting of the Executive:

Dr. Cally: Well this concerns who is responsible for patients in the I.T.U..

Mr. Marsh: This worries me because it is not always clear who the patient belongs to. If a patient has severe injuries he may be undergoing treatment from a number of consultants. It is not clear who is responsible in that situation.

Dr. Rollo: Well the background to this is that the nurses have made a number of complaints about trying to get hold of juniors and the juniors have failed to come.

Dr. Cally: Well give us their names and we can do something about it.

Dr. Rollo: I'm not sure that names should be repeated.

Dr. Currie: Well I have a case here which you should hear about. There was a chest patient who urgently needed attention and

the junior failed to come and when he eventually turned up hours later he treated the case in a very lackadaisical fashion and refused to come back and see the patient because he said he thought he could do nothing more.

Dr. Fruin: That's bloody awful.

Mr. Earn: I know that cases do switch consultants. I may be treating the most serious aspects of a case but then after a while the patient's orthopaedic problems need to be attended to and the case is handed over to Mr. Grange, but in any case any doctor should see an emergency.

Mr. Voil: The problem is, who is responsible?

Dr. Currie: No, that's not the problem. The problem is who is looking after the hour by hour care of the patient? We anaesthetists are there a lot of the time and we see the problem.

Dr. Lyon: Yes, we find that we may be looking after a patient for two days when he is not our patient and nobody comes to see him.

Mr. Earn: Ideally those involved should meet once every twelve hours and discuss progress and what should be done.

Dr. Fruin: Well, let me tell you about a particular incident.

Dr. Lyon: Yes, you tell them about that one.

Dr. Fruin: Mr. Earn asked me to go and see a patient of his and his blood pressure was right up and his pulse was off the map.

Dr. Lyon: No, it wasn't, it was 160.

Dr. Fruin: Well O.K. so I gave the patient a dose of X and I met Dr. Lyon in the corridor as I came out and he said 'What the hell are you doing here?'.

Dr. Lyon: Precisely.

Dr. Fruin: That's what he said to me.

Dr. Lyon: Right and that's what I mean. There is a complete lack of co-ordination and communication.

Dr. Cally: I suggest we change the rules so that the sister can call a consultant direct so that if she calls the junior and he doesn't come then she can call the consultant and he can deal with the patient and the junior.

Dr. Carrock: Isn't the solution to this to give the junior a good bollocking?

They decided eventually to form a sub-committee, on which the main specialties would be represented, to look at the problem. The matter came back to the Executive in February 1974:

Dr. Glen: We need someone to talk to this when it comes up at the full meeting. Who was at the discussion?

Dr. Gow: There was myself, Mr. Earn and Mr. Fillan.

Dr. Cally: What did you do?

Dr. Gow: Well we listened to certain cases from the nursing staff where the system was obviously not working and we decided that the nurse should always ask the resident 'Does your chief know the patient is here?'.

Mr. Earn: Yes it is vital that the chief knows.

Dr. Cally: Well, to an outsider, it appears to me that the problem here is from the move over from nursing care to medical care and the fact that the nurse is making the choice of medical referral and phoning up other doctors when in fact it should be a medical decision.

Dr. Gow: Agreed.

Dr. Cally: What about having someone who is in charge of the I.T.U.?

Dr. Gow: No, I don't think that would work and it would be a hell of a job for the person who did it.

Mr. Earn: I agree, I think that all that needs to be done is for the nurse to make sure that the senior staff know that the patient is there. You should look on the I.T.U. as an extension of your ward really and make a round there too.

Dr. Gow: Yes, it's like having a patient in sick bay.

The matter was not discussed again until the meeting of the Staff Association Executive in April 1974:

Dr. Gow: The sub-committee has met twice and tried to establish a series of rules for the I.T.U. and the main regulation which came up was that the consultant concerned should be informed immediately his patient goes into the I.T.U..

Dr. Glen: There was some opposition to this and it was changed from 'immediately' to 'as soon as reasonably possible'. A number of people are still unhappy with this but the committee has spent a long time discussing it and from now on all matters will go to that committee rather than the Staff Association or Dr. Currie who is in administrative charge of the I.T.U..

The new rule was subsequently circulated to all consultants.

A similar problem of consultant responsibility arose over an item entitled 'Responsibility of Anaesthetists for Cardiac Arrests' which was discussed by the Staff Association in December 1973:

Dr. Lyon: I object to the title of this item because it implies that the anaesthetists have the responsibility for these cases and they do not.

Dr. Rollo: I put this item on the agenda and I did not mean to put that slant on it but I won't change it.

Dr. Lyon: Well, I want my objection put in the minutes.

Dr. Rollo: The issue arose through the switchboard operator. She said that last week there was a cardiac arrest and there were apparently four anaesthetists on call and she couldn't get hold of any of them and it worried her greatly.

Dr. Lyon: Well, I don't think anaesthetists have the sole responsibility for cardiac arrests. If we are called and we are not doing anything else then we will come but we have no duty to stop anything we are doing in order to deal with cardiac arrests. The Staff Association discussed this situation a long time ago and decided that it was not the anaesthetists' responsibility.

Dr. Glen: There is a letter here from the consultant-in-charge of anaesthetics in Aldershire and he says there were four anaesthetists on call that day, but effectively there were three because one was standing in for another who was on study leave.

Dr. Currie: If you look back through the minutes this was discussed in 1970 and it was decided that the best thing to do was to have a cardiac arrest team, but it was decided that the staff available meant that such a team could not be formed.

Dr. Lyon: Precisely, if it was said that the whole team could not be formed then it must also be clear that any part of that proposed team could not operate effectively, and we are being asked to act as that team even when the whole team could not be formed.

Mr. Fillan: I think we should accept that the anaesthetists will not always be available and that they cannot be solely responsible.

Dr. Rollo: So the switchboard will call them and if they cannot come then they will call someone else.

Mr. Earn: There is not that much time to play with but then it's a fairly simple process in the early stages. However, we do run a short course every six months or so but the attendance from the junior staff is very poor.

Dr. Fruin: Well, I will make my junior staff go.

Dr. Rollo: Put that in the minutes.

Mr. Earn: Well, we have discussed the problem before of how you make junior staff do things they don't want to do and there are no sanctions we can operate.

Dr. Rollo: That's right we approached the Postgraduate Dean and he said that even if we refused to sign their certification then he would sign it.

Dr. Fruin: Well, I will make my juniors attend.

The discussion finished and there with no clear answer to the problem of dealing with cardiac arrests.

In both these cases, despite the fact that other groups in the hospital were experiencing difficulties, there was no willingness to define consultant responsibility in relation to either the Intensive Therapy Unit or cardiac arrests. Rather everything was left much as it was before and there was even a suggestion that the problem with the Intensive Care Unit was being caused by the nursing staff:

> '... it appears to me that the problem here is with the move over from nursing care to medical care and the fact that the nurse is making the choice of medical referral and phoning up other doctors when in fact it should be a medical decision.'

But the problem was that the medical staff were not prepared to co-ordinate themselves such that they could make the decision or such that the nurse would know what to do, added to this nursing staff were not allowed to telephone consultants direct if junior staff did not do what they wanted them to do. In both cases there was no attempt to devise a system which would make sure that these crises did not arise, although undoubtedly any system would involve making some consultant or consultants responsible for the situation. They were not prepared to do this and so a premium was put upon individual autonomy at the expense of the organisational necessities of dealing with emergencies.

Conclusion: Allan Hospital

This section has looked at the Medical Staff Association at Allan Hospital. Interview responses and case study material have been examined in order to assess the extent to which a concern for individual consultant autonomy affects the process of decision-making.

It was clear that the Medical Staff Association in no way acted as a substitute for specialty divisions. Consultants tended to avoid using the Staff Association for many of the issues which may have entailed an element of individual autonomy. Instead they preferred to contact the administration, community medicine specialists or higher levels of the Medical Advisory Structure direct. The main reasons for this avoidance appear to be the size, diffuseness and

multi-specialty nature of the Association. Because of these factors consultants thought that the Association found it very difficult to make decisions. There was an Executive Committee and although this played a part in deciding upon priorities for medical moveable equipment its general role was limited.

The Staff Association therefore had few opportunities to demonstrate that it was able to put broader approaches and perspectives before a concern to leave consultants largely to their own devices, or agree to what they wanted. In those cases which did arise, and in discussions at higher levels in the structure, it appeared that specialty problems were more prominent and had a greater influence upon processes of decision-making. This will be discussed more fully in the next chapter. However, in the two cases relating to medical practice the Association was unwilling to direct what consultants should do, preferring to leave them to decide what they wanted to do individually.

OVERTON AND ALLAN: THE MEDICAL ADVISORY STRUCTURE AND CONSULTANT AUTONOMY

This chapter has examined the way in which Medical Advisory Structures deal with matters internal to the profession at the level of the individual consultant. The general aim has been to assess the extent to which decision-making is affected by the profession's concern with the maintenance of individual autonomy.

The divisional system was never intended to interfere deliberately with clinical freedom - the freedom of consultants to treat patients in the way they want to - and this in itself was a recognition of the importance of this value to the profession. However, divisions and lower levels of the Medical Advisory Structure are expected to deal with matters internal to the profession, that is, issues which have implications for professional practice, or are extensions of that practice as, for example, in patient care evaluation:

> 'We consider that the development of systematic critical evaluation of clinical work should be one of the most important functions of a division ... In some hospitals the practice has

> developed of holding regular and fairly frequent meetings attended by all members of a discipline. At these meetings, cases are presented and current practices are examined critically. While we do not wish to depart from the principle that each consultant is personally responsible for his own patients, we see great value in the results of clinical work being examined on a group basis ...' ((2), para. 36)

And also in the planned use of resources, for example, requests for additional staff and extra equipment.

As a way of thinking about divisions it was stated in Chapter 2 that the proposed operation of the structure involves consultants in two expectations: (a) presenting their own requests and proposals and trying to get them accepted and (b) deciding what is best for the specialty as a whole or whether claims raised by consultants are valid in a broader sense. It was argued that in some cases these expectations would conflict with one another and that consultants would be facing a role conflict. It was suggested that expectation (a) might be favoured as a solution to this conflict because of the professional value of individual autonomy, and that, if this was the case, the structure would not operate in the way the Joint Working Party reports anticipated and recommended.

If this was true and the maintenance of individual autonomy was a key factor in determining the way in which decisions were made then it would be expected that proposals presented to the division would be agreed to more or less automatically and that such proposals would be given equal support by the division. It would also be expected that if divisions considered aspects of clinical practice and patient care evaluation, they would avoid answers or solutions which meant that consultants <u>had</u> to change the way in which they practised.

The two hospitals were very different in the basic operation of their respective Medical Advisory Structure. Overton had a divisional system while Allan had decided that the Medical Staff Association would act as the hospital level of the Medical Advisory Structure.

In Overton most divisions routinely dealt with matters internal to the profession, while at Allan the predominant pattern was for consultants to avoid using the Staff Association for discussion of their requests and proposals. These were eventually discussed at the area level, but again members of the Area Medical Committee were not completely sure about their role in deciding between requests.

Despite these differences, in analytical terms there was not such a gulf between the two hospitals. In Overton there were divisions in which it was not compulsory for consultants to present their requests, some wrote direct to the Committee of Divisional Chairmen. Furthermore, even in those divisions where it was accepted practice the mode of presentation and the amount of information provided varied from consultant to consultant. With few exceptions consultant requests at Overton were agreed to. The exceptions were in the Medical Division in relation to priorities for additional consultant staff and the Higher Medicine allocation and these will be examined in a little more detail below. In Allan, with few exceptions, requests were agreed to by default, consultants could use the structure if they wanted to and generally they chose to avoid it, the exception here was medical moveable equipment. Ignoring these cases for the moment, in terms of (a) whether or not proposals had to be submitted through the structure, (b) the uniformity of decision-making in relation to those which were submitted, and (c) the way in which matters of clinical practice and patient care evaluation were handled or avoided, the structures tended to maximise the expectation concerning the individual presentation of requests. They avoided the critical examination of proposals and issues in which individual autonomy might have been threatened. While it could be argued that all requests and proposals were valid it is still the case that issues of clinical practice and patient care evaluation were not tackled, they were avoided. In addition, the process by which divisions decided to support proposals or requests does not encourage one to accept that view. Supportive evidence was rarely presented and in all cases requests were agreed to with limited discussion.

The way in which the system tends to operate in relation to individual consultants is therefore, in terms of outcome, consistent with the theory. The remaining question is therefore whether this outcome resulted directly from the reluctance of consultants to impinge upon one another's autonomy. In Overton it is known that divisions gave more or less automatic agreement to most of the proposals but in doing that discussions were fairly brief and it was not possible in the majority of cases to identify a reason in the actual discussion which either justified acceptance or indicated why they were accepted more or less automatically. Similarly in Allan it is known that the Staff Association did not insist that all consultant proposals should be considered by the Association, but it is more difficult to say why that was the case and why consultants chose not to take matters to the Association.

In Overton this is where the Medical Division's decisions on priorities are instructive. On the surface the decision to allocate priorities between consultant requests goes against what has been said above. However, the way in which they did this, using a vote or a postal ballot, and the way in which consultants said they made their decisions between the options, does not. It is evidence that a concern for individual autonomy was stopping the structure from operating in the way the Joint Working Party reports anticipated, and instead serving professional values. The postal ballot concealed the decision and curtailed discussion such that once this method had been decided upon it was used as a matter of course on the next occasion when a similar decision was required. Also consultants in the Medical Division said that they and the division tried to equalise benefits to consultants so that in time they all received an equal share. While this may have been supportive of notions of individual autonomy it was not seen as being necessarily a good way of allocating resources. In addition a substantial number of consultants saw divisions as being used supportively rather than critically. This suggests that a concern for individual autonomy and notions of the company of equals did play some part in influencing decisions. By making priorities they looked as though they were taking the broader expectation of deciding what was best for the

specialty, but the way in which this was done ruled out any critical consideration of proposals.

The position at Allan is more difficult to interpret. This is partly because discussion in the Staff Association was limited, not in terms of length but in content relevant to this chapter and partly because of the impact of specialty considerations as well as those of individual autonomy. However, looking back to the development of the structure in Allan, the decision not to form divisions seemed to stem in part from a concern with individual autonomy, and in the case of the only hospital division to be formed, in Medicine, its very existence was predicated on the fact that the division would not decide anything which any of the participants disagreed with.

To generalise, a concern for individual autonomy seemed to deter Allan consultants from forming divisions, or profoundly affected the basis on which they were formed, while in Overton this concern did not prevent the formation of divisions, but it did influence the way in which they operated. The factors which stopped Allan consultants adopting the Joint Working Party structure, prevented the structure from critically considering consultant proposals in Overton.

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Chapter 8. Medical Advisory Structures and Specialisation

Introduction

In the last chapter the operation of the Medical Advisory Structures in the two hospitals was examined in relation to consultant autonomy. In this chapter the main concern is with the potential obstacles to the operation of the structure which were outlined in Chapter 3. When a Medical Advisory Structure has mediated between individuals and their specialty colleagues there will be some issues which need to be taken further and examined in a hospital context and relative to other specialties. This is provided for in the Committee of Divisional Chairmen, or in the case of Allan, the Medical Staff Association. At the divisional level discussions were between individuals, at the Committee of Chairmen level they are mainly between specialties through their representatives.

Three characteristics of specialisation were identified in Chapter 3. Firstly, knowledge of other specialties is limited, with some exceptions for those which work closely together. Secondly, specialties are autonomous. Thirdly, there are status differences between specialties. It was argued that each chairman on the Committee of Chairmen is faced with a role conflict between representing his or her own specialty's interests and deciding what is best for the hospital or service as a whole.

It was further suggested that each of these specialty characteristics might influence the way in which chairmen resolved the conflict. In the case of lack of inter-specialty knowledge chairmen would be unable to comment upon proposals or requests from other specialties, therefore they would tend to agree with proposals from other chairmen and feel unable to make suggestions about how other specialties should work. For specialty autonomy, chairmen might feel unwilling to comment upon business from other specialties because they would be impinging upon their atunomy, and again proposals or requests would tend to be agreed with. Finally, status differences between specialties might have an impact in those cases where choices have to be made between specialties. The decision might be made on the

basis of arguments between specialties with those with more status having their interests served. If these influences occur then they all suggest that the role conflict will tend to be solved by putting specialty representation first rather than making decisions on the basis of broader considerations.

The way in which such decisions are made is important because the Committee of Chairmen or its equivalent makes some decisions for the hospital and some recommendations to higher levels of the structure. If specialty requests are agreed to more or less automatically, or if some specialties consistently get their own way to the exclusion of others there is little point in having a structure at all.

The issues which will be examined in this chapter are similar to those of the last chapter. The influence of specialty characteristics will be greatest for those decisions which directly affect the practice of medicine and the major focus will be upon those.

The chapter will examine Overton and Allan separately and in the conclusion the two will be compared and the implications for the structure discussed. Again, two sources of data will be employed, responses from interviews conducted with consultants and extracts from meetings.

OVERTON HOSPITAL

At Overton the vast majority of the discussions between specialties occurred at the Committee of Divisional Chairmen. Before looking at some of the issues which arose, the interview data will provide a broad picture of the way in which consultants saw the Committee, the role of chairman and the way in which decisions were made.

For this purpose consultants were divided into two groups, the existing chairmen of the divisions and those who had been chairmen in the past, there were 15 of these, and the remainder of the

sample, 27, who had no personal experience of the Committee of Divisional Chairmen. Two of the latter group said that they felt unable to comment upon the Committee of Divisional Chairmen and so the responses below are from 25 consultants with no personal experience of the Committee of Divisional Chairmen. These two groups were asked slightly different questions about the committee and their responses will be dealt with separately.

Before looking at the responses of these two groups there was one question which was asked of all respondents which is relevant here: Within your own division what do you think are the main features of the Chairman's job? Some consultants suggested more than one feature and the following are the major groupings they identified:

Represent divisional requests to the administration and the Committee of Chairmen.	29
Screen the business, chair meetings, correlate ideas.	15
Communication man for the division.	11
Judicious arbiter in areas of controversy.	6
Administrative chores.	6
An example of enthusiasm to colleagues.	4
Fight on behalf of his colleagues.	3
Consult with department heads if a quick answer is required. (All members of the Laboratory Division)	3
Delegate administrative work in the division.	3
Submerge his own views to the views of the division.	1
Don't know.	1

There was a reasonable degree of unanimity that the main feature of the chairman's job was to represent divisional requests to the administration and the Committee of Divisional Chairmen. The next group of questions asked the 'non-chairmen' about various aspects of the work of the Committee of Divisional Chairmen.

Consultant Opinions About the Committee of Divisional Chairmen

This section reports on the responses of 25 consultants and the first question was a general one: What are the main functions of the Com-

mittee of Chairmen?, several consultants suggested more than one function and the following were the major groups:

Solve problems and decide priorities between specialties.	8
Hospital decision-making and advisory body.	8
Represent the hospital on higher bodies.	4
Discuss problems raised by the divisions.	2
Report back to individuals on discussions in the committee.	2
A replacement for the Medical Superintendent.	1
Don't know.	3

These are fairly standard responses although there was certainly not a unanimous view of the purpose of the committee.

The next question was designed to see to what extent chairmen were expected by their divisions to represent their own interests on the committee: How strongly do you think your chairman should push your case when he/she brings up something your division has decided? Twenty-one consultants said the chairman should push very strongly, and the remaining 4 said that it depended upon the issue, for example:

> 'I suppose it depends upon how important a decision it is that we have made. I don't think an issue should be made of every decision ... Our division is only one among many in the hospital and if we make a decision that is going to affect the working of other divisions, if the other divisions won't wear it, unless it's a matter of the most vital importance to the running of our division, I don't see that one division can impose its will on the rest.'

This was a very moderate view compared with those who thought the chairman should push their case very strongly, for example:

> 'If we consider it a desirable addition of staff or equipment or building then it's up to our chairman of division to push it and push it as hard as he can. Because by the very nature of things, a man with drive will get what he wants, whereas somebody who just states they want it and are

not prepared to back it up will not get it. That's the committee system and the democratic system in which we work I'm afraid. So, in other words, presenting a case powerfully is all important.'

'... if he doesn't push it, it's not likely anyone else will push it, it's a question of everyone having to push their own little bit, and somebody else has to decide who's the one that's the important one. If he's not going to be a fairly forceful kind of character and get things done for the division, then he's not much good as a chairman, if he tends to lag behind the others. Because some of the other chaps have got strong sort of personalities, who will do all the pushing.'

'Well, the answer is that you should see them in an overall plan, but what happens is, as the world works, he who shouts loudest gets most and if you don't do this, as geriatrics has done, and is still doing, you end up with nothing.'

An E.N.T. surgeon thought that this was particularly the case for the Surgical Division because it covered a number of specialties:

'But I think he should push strongly for and particularly our division because we've got to remember that we are the only Surgical Division. There are a number of other divisions, in fact there are too many other divisions representing far smaller groups. We are just one Surgical Division and I'm talking about on the medical side there are far too many ... So I think we've got to push, we've almost got to press our case, he's got to press our case very strongly because he's one against many. It comes down to a slice of the cake.'

However, three out of the twenty-one consultants did add a rider about requests from other divisions, for example:

'Oh, I think he should push it as strongly as possible. There are matters such as the creation of new consultant

posts, if there are, say, one in psychiatry, one in paediatrics and one in surgery, but the Board say they will only give money for two, then it's a matter of priorities and then we can state our case for the psychiatric one. Although I don't think we should push our case and disregard other needs, I would think we always have to take a balanced view of the units of the hospital as a whole and not merely push our case.'

A large majority of consultants therefore expected their chairman to go all out to gain agreement from the Committee of Divisional Chairmen for what they wanted. At the same time many of them gave the impression that pressure was a major way of getting what you wanted. Their view of the system was not one in which careful consideration of well-presented evidence was the norm but one in which 'he who shouts loudest gets most'.

The next question asked about inter-specialty knowledge: Do you think the other chairmen know enough about your specialty to make the right decisions about problems your chairman raises? The response was:

Yes	5
Not necessarily	7
No	13

Of those who thought the other chairmen did know enough about their specialty, three were pathologists, and they said that they had contact with most specialties, one was a general physician who thought that there should be a court of appeal if a specialty was not happy with the result and the other was a general surgeon who said that they all had the same problems of shortage of space and money.

The thirteen who thought other chairmen did not know enough about their specialty used two main arguments. One group said that they were all in the same boat, for example:

'No, I don't think they do know much about my specialty, but to be fair, I don't know much about the other specialties either.'

While this may have been true it is not clear that this would make for informed decision-making. The other group suggested that because of lack of knowledge, their chairman would be listened to:

'I doubt that, not the Chairman's committee by itself because I think that problems in psychiatry are not easily understood by those outside psychiatry, probably not.'

'All they can do presumably, if they're honest chaps, is to sort of, is to take what's said or explained to them about the specialty they don't know much about themselves. They've got no expert knowledge of the specialty and if it's got to be a decision of all the chairmen then you rely on the fellow who's putting forward the case for that particular specialty, to sort of put it clearly and honestly to them and hope that the other chaps will be reasonably honest to them and will be able to accept the chap's word for it.'

'I think they need guidance, I don't think off-hand. But surely that's what our own chairman would be there for, they would need to be guided.'

'I would hope that they were made aware through our chairman and he was adequately aware.'

In most of these answers many consultants seemed to think that other chairmen were dependent upon the chairman concerned giving them the necessary information on which they could base their decision.

Among the seven who answered 'not necessarily', four said that it depended upon the specialty:

'... I don't think they necessarily can. Some of them are in a better position to know than others, for example, the present chairman of the Committee of Divisional Chairmen is a biochemist and by the nature of his experience in a service that serves the whole hospital, he has an idea of what goes on everywhere, a good position. But suppose you were to take someone, say an Ear, Nose and Throat specialist, such a person might have great areas of ignorance, just the same way as I am totally

ignorant of anything that goes on in obstetrics.'

'I'm not terribly au fait with the physicians' problems or the dermatologists, with the surgeons, probably yes because we're working with them all the time.'

The other three in this category used more personal explanations:

'Well, I think this must vary a lot and depends on the personality of your own chairman possibly ...'

'I think this depends upon whether they individually take the trouble to find out. Many of them I know do take the trouble to find out ... and they should be in a position to make an unbiased decision in relation to any priority which isn't involving their own division. I don't think one can ever be unbiased in discussing a priority which does involve one's own division.'

'... it's not just a matter of knowing about the specialty, it's also the business of knowing about the man who's making the request, whether he's been a reasonable man in the past or whether he's been unreasonable ... I think the decision is probably made there ... whether you know much about it or not ... If you think well that guy just wants everything that comes out, it's not so much knowing the equipment as knowing the individual who's asking for it.'

Overall, therefore, 20 out of the 25 consultants had doubts about the extent to which chairmen of other specialties knew enough about their specialties to make the right decisions about problems their chairmen brought up.

The first question in this section asked about the basic functions of the Committee of Chairmen, 8 saw it as being to solve problems and decide priorities between specialties, 8 as making decisions for the hospital and 4 as representing the hospital on and to higher bodies. To obtain some idea of the extent to which members of divisions expected their chairmen to press for their own interests, consultants were asked how strongly their chairman should push their case at the

committee. Twenty-one said he should push their case very strongly and many thought that pressure exerted on the committee was more important than the rationality of their case. The general view was that if chairmen did not push for a division's viewpoint nobody else would do it for them. Within this, a minority stated that the chairman should not be totally dogmatic but should have an eye to the needs of other specialties. In terms of the suggested role conflict it therefore appears that there is a strong expectation on the part of divisional members that the chairmen will go all out to get what they want.

Going on from this, 20 consultants had doubts about the extent to which other chairmen knew enough about their specialty to make the right decisions about problems which their own chairman might raise. This supports the assertion that lack of inter-specialty knowledge might affect the decision-making process particularly as a number of respondents said that other chairmen were reliant upon the information provided by the chairman making the request or raising the problem. However, it would be unlikely that a chairman would present information which did not support a divisional request and the other chairmen would be in a bad position to assess the validity of that information. Furthermore, if specialty autonomy was a value held by chairmen then they would also be reluctant to question the information that was presented.

While this is the view of doctors with no personal experience of the committee it suggests that the committee is seen as a body at which chairmen should press for their own divisional interests and in which other chairmen are not always in a position to judge the validity of those interests.

Opinions of Present and Past Members of the Committee of Divisional Chairmen

Fifteen consultants were or had been chairmen of divisions. They were asked a series of questions about their position on and the operation of the committee. The first one was "How do you see your position on the Committee of Chairmen?, and several of them gave more than one answer:

Pushing one's own division.	9
Making decisions for the whole hospital.	4
A more broadly based spectrum than the Board of Management and a replacement for it.	2
Forum for the various interests in the hospital to get together.	1
Forward planning.	1
Everybody is equal and they speak when they have something to say.	1

A majority of the chairmen felt that they were on the committee to push their own division, although there was obviously some tension between this view and the view that they should make decisions for the hospital as a whole. One of the chairmen expressed it in the following way:

> '... I saw it more importantly as making decisions for the whole hospital and secondarily, pushing our own division. I felt that one's own division ought to come second to the general. That's how I felt about it but I don't say I always behaved like that. It was quite the same on the Board of Management, I always pushed my own unit but I knew I really shouldn't'.

Three of those who said they were on the committee to make decisions for the whole hospital also said they were intent upon pushing for their own division as well.

The next question asked chairmen about the expectations of their divisional colleagues: <u>If you are raising a matter at the Chairmen's Committee at the request of your division, how do you think your division expects you to present that request</u>?. The response was:

To get what they want.	10
To represent the view decided by the division.	2
They trust the chairman to put the best case.	1
They expect co-operation from other divisions.	1
To report back on what happens to the request.	1

Most of the chairmen thought that their division wanted them to go all out to get what the division wanted. However, three others men-

tioned the problem of representing views other than their own (the ones who answered 'to represent the views decided by the division' and 'they trust the chairman to put the best case'), for example:

'I think that the division expect that when we make a decision in our division, say to ask for an extra member of staff or something like that, that, whatever my personal view might be, when I go to the committee I'll adopt the standpoint that the division as a whole has come too. We try not to vote or anything like that but have a consensus of agreement on points like that. And it's never happened and I suppose it would rarely happen that the division would want something that would be opposite from me. But I would take the view that it would be, one would have to make it clear if one was representing a view that was different from the division, that it was a personal point of view and not the view of the division. I think it would be quite reasonable to behave in that sort of way.'

In view of this expectation on the part of the division chairmen were asked: <u>When you have a divisional request to put to the committee what kind of approach do you take</u>? This question produced a number of very individual statements. Several chairmen said they just presented the facts. The chairman of the Radiology Division said that he did not regard anything as a divisional request but just something which the hospital needed. Another chairman said that 'you just try to persuade them and you cannot throw your weight around'. The other main remarks were as follows:

'... I have to balance, protecting the Overton unit and also being reasonable insofar as the rest of the hospital is concerned.'

'I think that what I did if I wanted something doing, I asked for it and went on asking for it, unless it was obviously manifestly impossible. Sometimes we had to modify it a bit, but I felt that it was evidence of how much you needed the thing, how long you were prepared to go on asking for it.'

'I take the approach that this is for the benefit of patient care and that anything that we're asking for is essential from that angle.'

'I think you've got to take it on the smooth running of the hospital in the future. I think you've got to present it, shall we say, in reverse to what you really think it is. In other words, you've got to present it - this is a hospital facility that they will be deprived of if we don't promote it.'

'Well, the chairman's job is altering now compared with what it was two or three years ago when we had the Board of Management. When you had the Board I think your job was to carry the torch for your division into the big Board and make sure that you were not just representing your own division, you were representing everybody. Now, the chairman, he's for his own division really, not nothing but, but I mean his own division first. Whereas previously, your own division you were pushing but it was the whole hospital you were putting then. So that now I think the job mainly is the correlation of everything in the division and promoting your own interests first, the hospital interests second I think.'

In these responses some of the chairmen recognised a tension between what they or their division wanted and the fact that they knew they should be making decisions on the basis of the service provided by the hospital as a whole. The last two extracts above explicitly state that they are in the business of promoting their own interests as first priority and that they use more broadly based arguments as a form of propaganda. In the last extract the chairman concerned thought that the structure itself encouraged this, because all the specialties were represented and there was no reason for any chairman to look at issues in a broader context, as there had been on the Board of Management where fewer specialties were represented.

The next question was directed towards the problem of inter-specialty knowledge: Do you think the other chairmen know enough about your specialty to make the right decisions about problems in your division? The overall response was:

Yes	7
No	7
Depends	1

Of the 7 who answered 'yes', 4 made unqualified statements whereas the other 3 suggested that this was dependent upon their advice being taken:

'Yes, I think they do and I think they pay a good deal of attention to what one has to say, I think your point of view is listened to. It depends on the particular specialty, some of them, they require a considerable amount of filling in, others, like general medicine, have a pretty good notion of what paediatrics is about.'

Among those who answered 'no', all of them said that the other chairmen needed to be guided by them:

'I found they accepted what I said almost inevitably, almost invariably. If I had plenty of evidence then they would accept that I knew more about it than anyone else.'

'I am pretty confident that the other chairmen would listen to us and be guided by us. Just as I would be if it was infectious diseases or biochemistry. I mean, who am I to say. And the same thing goes I'm sure, unless there was some unreasonable stupidity, they would back you up.'

'... I have a gloomy feeling that it is an uphill job to be pushing the psychiatric case in some of these committees where your colleagues from the Surgical, Medical and Laboratory Divisions are really quite unequipped to give advice or deal with any of the sort of problems that I am used to dealing with in the mental hospital, it is a different world.'

'No, I don't think they do, I think they would require to be guided fairly strongly. But, on the other hand, if I was to fail as chairman to adequately inform them or convince them on my own specialty, then I would see this as a failure in ourselves ...'

The chairman who answered 'depends' used similar reasoning:

'Well, in some cases they are unaware of these, but it is up

to each chairman to identify these areas where he thinks he should tell the other chairmen what it's all about and I've always found them really able to listen to one's point of view, and work it all out properly.'

For all three responses there were therefore consultants who thought that other chairmen had to be guided in terms of specific knowledge of their specialty. The final question in this section asked chairmen about the reverse side of the coin: How easy is it for you to decide and comment upon matters raised by other divisions? The response was:

Easy	5
Difficult	3
Depends	5
Does not arise	2

Three of the five chairmen who said it was 'easy' did not qualify this in any way, however, the other two who gave this response said it was easy because there was no question of interfering with another specialty:

'Quite easy usually ... When they raised a special point it was almost always agreed with. The only thing that might stop it might be money or something like that.'

'Most of the time you know pretty well what's going on, but there are occasions when you're not competent to make decisions about other specialties. I don't think there's any question of interfering with other specialties, I think there'd be chaos if you did. You don't expect them to interfere with yours and you don't interfere with theirs.'

This last reference was clearly to the autonomy of specialties and the fact that it was unlikely to be impinged upon.

The 3 chairmen who said it was 'difficult' also referred to the problem of interference with other specialties, as one of them put it:

'Well again I rather adopt the attitude that, which I think they probably adopt towards me, I have to listen to what they have to say and if it is something which they obviously think is for the best then one is inclined to support them on this because I don't think that one can interfere, so to speak, in the running of another division about which you may not know very much at all.'

Among the 5 who answered 'depends' all of them said that it was dependent upon the specific issue as to how much they were able to comment, for example:

'Many a time I did, other times I didn't, because it was completely outside our knowledge and experience and there's no point in my commenting.'

The two chairmen who answered that it 'does not arise' had both been chairmen of the Committee of Chairmen, although their reasons for saying this were rather different:

'When I was chairman very few people really seemed to bother very much, and it was only a matter of two or three divisions which seemed to, or divisional chairmen, who loomed large in any discussion.'

'Well, as a rule they tell me before the meeting, it's wise if you have a project that you want given attention, not just to shove it on the agenda but to come and tell the chairman what it's about. If you tell the chairman what it's about then he has the chance of asking them more questions and beyond that going and asking other people more questions.'

The first chairman was suggesting that there was very little to comment upon in terms of a relatively small number of proposals from other divisions. The second chairman thought that he was in a better position to comment because he had time to investigate a little before the meeting at which the proposal arose.

Apart from these two and the four chairmen who did not qualify their statement that it was easy to comment, the other nine chairmen

appeared to experience some difficulty, either because they lacked knowledge of other specialties, or they did not want to interfere with their business.

The overall impression of the chairmen's views of the Committee of Divisional Chairmen is that a majority of them thought they were on the committee to push their own division and that they thought their specialty colleagues wanted them to do this as well. In terms of their approach to the committee with requests from their division, most of them tried to present them as hospital necessities and a minority of them said that they were promoting their own interests first and the hospital's interests second.

Eleven out of the 15 chairmen had doubts about the extent to which other chairmen knew enough about their specialty to make the right decisions about problems they might raise, they said that they had to give the other chairmen guidance and that this was generally accepted. Finally, in relation to commenting upon proposals raised by other divisions, chairmen did not find this particularly easy, three did, but among the remainder there were doubts about whether they had the knowledge to do so and in addition they did not like the idea of interfering with other specialties. These responses are very similar to those of the non-chairmen which were reported earlier in the chapter.

Divisions and their chairmen appear to put a premium upon the representation of specialty interests on the Committee of Chairmen, rather than upon a broader concern with making decisions for the hospital. In this sense there is quite a lot of pressure on the chairmen to press for what their divisions want. At the same time the general feeling was that chairmen of other divisions did not know enough about other specialties to be able to comment sensibly, although there were exceptions to this. In a similar way chairmen were reluctant to comment upon matters raised by other specialties, because they did not know enough or because they were wary of impinging upon the autonomy of other specialties.

The interview data therefore suggest that the Committee of Chairmen may not be a very effective screening device for deciding upon the validity of one-off proposals or requests from divisions. However, the next step is to examine the way in which the committee in Overton actually dealt with such requests.

Decision-making and the Committee of Divisional Chairmen in Overton Hospital

Many of the decisions made by divisions also have to be considered by the Committee of Divisional Chairmen. In some cases the Committee of Divisional Chairmen makes the final decisions, for example, in deciding how to spend available money on medical moveable equipment, in others the committee has to decide whether or not the proposal should receive the support of the hospital in order for it to be considered at a higher level, for example, requests for additional consultant staff. There are of course other decisions which are referred down to the committee, for example, by the Area Medical Committee, but the concern here is mainly with specialty initiated decisions. Some of the issues which will be discussed have been partially covered in the last chapter which examined the process at the divisional level. The focus here is upon the extent to which the Committee of Divisional Chairmen acts as a screening mechanism for specialty requests and proposals and considers them in the light of the service as a whole at the hospital level. If the committee does not do these things then attention will be paid to the reasons for this with particular reference to the impact of lack of inter-specialty knowledge, specialty autonomy and specialty status differences.

Specialty Requests for Additional Junior Staff

The expected pattern for these requests would be for a division to decide that it needed an additional junior member of staff and for it then to be referred to the Committee of Divisional Chairmen. The committee would assess the validity of the request in terms of its own merits and relative to requests for additional junior staff from other specialties. However, in most cases the discussion of such requests by the committee was rather limited.

The Medical Division had agreed to the request of the dermatologist, Dr. Ure, for an additional registrar. The chairman of the Medical Division, Dr. Gregor, was also, at that time, the chairman of the Committee of Divisional Chairmen, and he raised the matter under 'Any Other Business':

Dr. Gregor: Dr. Revel the present registrar in dermatology is a G.P. doing three sessions a week. Dr. Ure has suggested that Dr. Revel should be appointed to the G.P. grade and that a registrar should be appointed. Are we agreed on this?

Everyone: Agreed.

This involved an increase in staff of one registrar, but no information was presented in support of the request and it was agreed to without discussion. Another request raised by Dr. Gregor in April 1974 was treated in a similar way. The Medical Division had decided that it wanted two additional House Officers and a letter was written by the secretary of the division to the committee:

Dr. Gregor: With the opening of the Coronary Care Unit and the Intensive Therapy Unit it is felt that junior staffing in the Medical Division may now be inadequate. We feel that we need two extra house officers to cope with this.

Mr. Sander: This will mean a training programme will have to be introduced.

Dr. Gregor: Yes certainly. Are we agreed?

Everyone: Agreed.

No information was given in support of the request, there was merely a statement of the feeling of the Medical Division. The only concern expressed by the committee was that there should be a training programme, rather than whether the posts should be established in the first place, or whether they were more important than other requests for junior staff from other divisions.

In slight contrast to these requests was one for a cytology screener in the Pathology Department. However, this had not been considered

by the Laboratory Division, the administrative head of the Department of Pathology had written direct to the committee. In addition the chairman of the Laboratory Division was unable to attend and his place was taken by the bacteriologist, Dr. Pepper. The request was discussed in June 1973, before reorganisation, and the meeting was attended by the Medical Superintendent, Dr. Falk:

Dr. Gregor: I want to welcome Dr. Pepper in place of Dr. Henley, you are in the Laboratory Division. Do you have any comments on this request for a cytology screener?

Dr. Pepper: Well I know nothing about pathology apart from what I did in the army. However, I am generally dubious about the quality of training that cytologists have. I'm all for having extra cytology staff as long as they are adequately trained.

Dr. Gregor: Well I think we would all take that point. But do we want an extra one?

Dr. Falk (Medical Superintendent): Well we do have a backlog which needs to be caught up on. The gynaecologists and the general practitioners are complaining, so we really need one and it cannot be done on a part-time basis.

Dr. Gregor: Well it's agreed then.

It was obvious that the Laboratory Division had not discussed the matter beforehand from the response of Dr. Pepper who made no case for the post and said that he was unable to comment because he had no experience of pathology. The only evidence was presented by the Medical Superintendent but no figures indicating the extent of the backlog or an increase in workload had been presented by the Pathology Department. There was therefore no information to help the chairmen make their decision, and if a member of the division concerned felt unable to comment it is hardly surprising that none of the other chairmen commented. To some extent there seemed to be a lack of inter-specialty knowledge in this case. At the same time the chairman, Dr. Gregor, did ask whether an extra cytologist was needed and he developed upon this a little more in November 1973 in relation to a request for general practitioner sessions in psycho-geriatrics.

This matter came up under 'Any Other Business' in the form of a letter from the professor of geriatrics, rather than through the Geriatric Division:

Mr. Alwin: There is a letter from Professor Wall asking for the consideration of the establishment of two G.P. sessions in psycho-geriatrics at Wallace Hospital, and geriatrics at Overton.

Dr. Gregor: Dr. Malcolm, you're chairman of the Geriatric Division, would you like to comment?

Dr. Malcolm: Well he wants to bring in married women with experience as this seems to be national policy now to make use of these people.

Dr. Gregor: I can appreciate that but is there a need for them?

Dr. Henley: I have always accepted Professor Wall's word, I'm getting old.

Dr. Gregor: O.K. we'll agree then. But there is a problem of priorities. We are at present recommending things on a piecemeal basis. We should be looking at relative priorities, that should be our ideal.

Again in this case the matter had not been discussed by the division concerned and no evidence was presented in support of the request. Also interesting was Dr. Gregor's comment that they were considering requests on a piecemeal basis and that they should be concerned with the relative merits of different requests. This might have marked a definite change in the work of the committee. However, at that stage Dr. Gregor had to retire as chairman of the Medicial Division and hence as Chairman of the Committee of Chairmen. He was replaced in the former position by Professor Alexander, and Dr. Henley of the Laboratory Division became Chairman of the Committee of Chairmen. From then on there was still no attempt to consider junior staff requests in a broader context, although there were variations in the way requests came to the committee.

The request for a registrar in cardiology, which was considered by the Medical Division (this was reported in the last chapter) came to the Committee of Chairmen in June 1974. Each chairman received a copy of the memorandum which the division had discussed, giving details of changing workload, although, even then, there was not much discussion of the figures:

Dr. Henley: This is the request for the registrar in cardiology. I think there is quite a strong case for this.

Dr. Gregor: This has come to this committee before and was supported and went to the Board of Management but was turned down by the Regional Board.

Dr. Henley: So we are just submitting it through new channels.

Everyone: Agreed.

The main reason for acceptance was therefore that the committee had accepted the request beforehand, yet it had been turned down by the Regional Board. It might have been anticipated that the committee would have wanted to know why it had been turned down by the Regional Board for this might have changed their ideas about the request. It had been turned down because there was a policy of not designating junior posts as being in specific specialties and rather ironically the request was turned down again, by the Area Board and for the same reason. Another interesting point is that Dr. Gregor was attending this meeting because Professor Alexander could not attend and Dr. Gregor had been concerned in the past that the committee should not consider requests on a piecemeal basis and yet he failed to raise this about a request from his own division. While this is understandable because of his responsibility to represent the decision of the Medical Division it indicates the role conflict involved in trying to be objective about individual items and the way in which they are handled.

In contrast to this request which had been through the Medical Division, another request from a consultant in geriatrics came in the form of a letter to the District Administrative Officer, Mr. Alwin,

and again it had not been considered by the Geriatric Division:

'... regarding the position of the two general practitioners currently staffing Bason Hospital. This small hospital functions as a Rehabilitation Unit for elderly patients, with a brisk turnover. At present two local general practitioners are employed on a sessional basis, one for three per week and the other for two. The division of work has resulted in each of these doctors being responsible for one complete floor of the hospital, this means that in actual fact both are doing the same amount of work. It is not desirable, nor indeed possible that one of these doctors should curtail his work on the basis of working less, for indeed the turnover is increasing all the time. I would ask that the Board should consider increasing the sessional basis of employment to three sessions each, thus remedying the difference in parity.'

This was discussed by the Committee of Chairmen, who received a copy of this letter, on the 1st May 1974:

Mr. Alwin: In the days of the Regional Board all medical staff establishment matters had to go there and I think that still applies to the new Area Board, although we pay in the case of G.P. sessions. If you agree we send it to the area.

Dr. Henley: Well Dr. Hayward makes the request and I take it Dr. Malcolm approves, therefore we accept the request.

This request had also not been discussed by the relevant division and Dr. Henley did not even ask the chairman of the Geriatrics Division to voice his support, he just assumed it would be supported. While Dr. Malcolm would have made some declaration in favour of the request, this was one further step away from a detailed consideration of proposals. The case might have been perfectly justified but the process of decision-making did not make this apparent.

A request for a Senior House Officer from Professor Wall was dealt with in a similar fashion. Again he wrote direct to the committee,

the matter had not been considered by his division, the letter had not been circulated and it was discussed under 'Any Other Business':

Mr. Alwin: There is a letter from Professor Wall requesting an additional Senior House Officer on the staff at Overton with duties at Reeve Hospital. This is because there is an arrangement with the Medical and Surgical Units at Reeve that one of the geriatrics staff cover the beds at night. The person doing this was in a temporary university post and if the arrangement is to continue he has to be replaced.

Dr. Malcolm: I fully support that.

Mr. Sander: I back that up but I wonder about the wording of the letter that you read out. It suggests that he provides all the cover for the surgical wards, but it is only one night in three for him.

Professor Alexander: The medical ward at Reeve belongs to the Medical Division, it is not mine. A while ago I had a letter from Professor Wall saying that he would like the geriatric residents to come into our rotation scheme. We agreed but it would have meant that our residents would have had to do two months in geriatrics and if we were to cover Reeve as well we would have had to ask them to do six weeks in Reeve, and if that were so we wouldn't get any residents, so he agreed to provide cover for Reeve at night. I hope this is successful otherwise the arrangement will not continue.

Dr. Leven: I think we should obviously support this.

Professor Alexander: It is the domino theory. They might lose the geriatric beds in Reeve, we must back this up all we can.

The request was therefore supported. A number of points arise from this. First of all, the request had not been through the division concerned and in addition it was brought before the chairmen under 'Any Other Business' so none of them had had a chance to read the letter which justified the claim. However, this did not stop them considering it and supporting it. Secondly, the request stemmed from the fact that the geriatrician concerned had wanted junior staff

in his specialty to participate in the rotation scheme organised by the Medical Division, thereby giving junior staff in geriatrics and medicine broader experience. A full exchange would have meant that residents in medicine would have had to spend time in Reeve Hospital where the geriatricians had beds. The physicians would not agree to such a full exchange because they might have found it more difficult to attract students to become residents in Overton if they also had to spend time in Reeve Hospital, which was deemed to be less attractive. Rather than let the arrangement crumble because of this complication Professor Wall arranged for a member of staff on a temporary university appointment to cover at Reeve for one night in three. Because the post had finished the member of staff was leaving and the Senior House Officer post was required to replace the temporary member of staff. The request was undoubtedly foreseen and as a routine commitment it only involved one night in three and the need for this had arisen because of the refusal of the Medical Division to extend its links with Reeve Hospital. While it was a good strategy on the part of the geriatrician to give temporary staff routine commitments and then when they leave ask for a full-time hospital member of staff to replace them, the consideration given to the request was cursory.

Overall no requests brought to the Committee of Divisional Chairmen for additional junior staff were turned down, they all received equal support. In addition, the committee did not seem to be concerned to tell divisions or consultants how or in what form they should present requests. Some requests came through the division while in other cases the consultant concerned wrote directly to the committee. Some requests were accompanied by information as to the needs for the post, for example, increases in workload, comparison with other hospitals. Others had no information at all. Sometimes information was circulated with the agenda for the next meeting and chairmen knew that the matter was going to come up, while on other occasions the requests came up under 'Any Other Business' and chairmen had no idea they were going to arise. On the face of it this suggests that the Committee of Divisional Chairmen did not want to lay down rules as to how specialty divisions, or individual consultants, should

present their requests. Despite this, or possibly because of it, the route by which requests reached the committee and the amount of information presented had little or no impact upon the way the chairmen dealt with them. They all received support with very little discussion. This outcome is consistent with the arguments that chairmen would not know enough about other specialties to make judgements and would therefore agree with what other chairmen wanted, thereby avoiding the broader expectation of making decisions for the hospital as a whole. It is also consistent with the other contention that a concern for specialty autonomy would deter chairmen from commenting adversely upon requests from other specialties.

However, it is difficult from the issues which have been discussed above to decide if either or both of these was responsible for the way in which requests were handled. Discussions were rarely long enough for the reasons for acceptance to become apparent. There was one other case which involved the upgrading of a junior member of staff and this throws more light upon the attitude of chairmen towards other specialties.

The post of Junior Hospital Medical Officer (J.H.M.O.) was phased out by the Scottish Home and Health Department in the mid-1960's and the holders of such posts were generally redesignated as Medical Assistants. One of the last J.H.M.O.'s in Scotland worked in Overton Hospital in psychiatry. In February 1974 she wrote to the old Board of Management stating her experience and asking if she could be upgraded to Medical Assistant. She also stated in her letter:

> 'My consultant colleagues ... have no objection to my request. Dr. Galbraith (Chairman of the Psychiatry Division) is at present on holiday and I will be asking him later on his return.'

The Board of Management referred the matter to the Committee of Divisional Chairmen and it was discussed in March 1974:

Dr. Henley: This was put in my hands the day before the last meeting and I wanted to consult Dr. Galbraith on this.

Dr. Falk (Medical Superintendent): When it came in I consulted with the Regional Hospital Board and the understanding is that most of these posts have disappeared and have been regraded as Medical Assistants. The Regional Board was favourable and I think we should ask why this has not happened before. She stands to gain financially but I wouldn't have thought her duties would have changed.

Long, long silence.

Dr. Falk: I think it is an assimilation rather than an upgrading, this has been the pattern in the past. Did she choose to remain a J.H.M.O.?

Dr. Galbraith: If she had the chance I don't think she did. We are in our unit, er, our division, opposed to the idea of having a Medical Assistant. It goes without saying why she has remained in her present position. She is doing senior house officer/registrar duties and we could not fit her in as a Medical Assistant, although you say she could continue doing the same work ... I have advised her for the last ten years to go but she has not.

Dr. MacFarlane: Does she have the D.P.M.?

Dr. Galbraith: No, it is not compulsory for advancement.

Dr. Falk: I think the Medical Assistant is a personal grade.

Mr. Alwin: When the J.H.M.O. grade was abolished each Board of Management was asked to submit recommendations and her name did not go forward.

Dr. Falk: She says in her letter that her colleagues have no objection to her request.

Dr. Galbraith: They have no objection but they do not support it.

Dr. MacFarlane: I don't think we should disagree with what our psychiatric colleagues think.

Professor Alexander: I think it would create a precedent if we go against the Psychiatric Division, it could happen to any of us, if we bring something up then others could reject it.

Dr. Leven: I agree.

Dr. Henley: Do we agree that she remain in her present grade then?

Everyone: Agreed.

Over the next eight or nine months there were a number of informal developments including the offer of a Medical Assistantship at a mental hospital within the district, but Dr. Coker demurred because she wanted to continue working in Overton Hospital. The matter was finally settled at the meeting of the Committee of Chairmen on the 8th January 1975. By this time Dr. Galbraith had been replaced by Dr. Little as chairman of the Psychiatric Division, and Dr. Little was from another hospital within the district.

Dr. Hill (District Medical Officer): You will remember Dr. Coker raised this and it was suggested through other channels that she should be regraded as a Medical Assistant. It has gone through the Health Board and the Scottish Home and Health Department and for her to be regraded the matter has to go through a certain procedure. J.H.M.O.'s had to be regraded as Medical Assistants if the post was of unlimited tenure. The regradings began in 1964 and it must have been the view of the Board of Management then that this post was of limited tenure, but there can be no doubt, ten years later, that it is of unlimited tenure.

Dr. Little: It is not my view but the division will think that this is a bad decision so I would be glad if you would instruct me that this has to be so.

Dr. Henley: Yes this has nothing to do with the views of the people she works with.

Dr. Hill: It still has to be recommended by the staff of the hospital.

Dr. Henley: Well we've been through that already and nobody will go against psychiatry. Do we decide now contrary to the earlier informal decision after local discussion with the psychiatrists, do we decide to initiate the procedure to have her regraded? I don't see what else we can do.

Dr. Little: If we ask for advice we may have to take it. I think it would be better if we just went ahead. It is out of our hands I can say that the national level decision allows no discussion of this.

Particularly interesting in this case were the comments in the initial discussion. The chairmen were faced with what was arguably a straightforward administrative manoeuvre as recommended by the Medical Superintendent. However, they were unwilling to go against the view of the chairman of the Psychiatric Division, not because of anything which the discussion revealed but for a more basic reason:

'... it would create a precedent if we go against the Psychiatric Division, it could happen to any of us, if we bring something up then others could reject it,'

and this was something which the chairmen were anxious to avoid. They therefore decided against the upgrading not because of the information presented but because they wanted to avoid any precedent which implied that it was alright to impinge upon another specialty's autonomy. It was a concern with this that encouraged them to avoid the broader decision-making expectation. Although it is different from straightforward requests for staff, this issue brings out the likely reason for the instant approval of junior staffing requests. The reason why it was stated in this instance and not in the others is because a justification had to be given for rejecting the upgrading of the J.H.M.O. because there was a strong case of doing so.

This was apparent in the discussion nine months later when the upgrading was agreed to. However, even then it was clear that the new chairman of the Psychiatric Division experienced one aspect of the role conflict when he said:

'It is not my view but the division will think that this is a bad decision so I would be glad if you would instruct me that this has to be so ... It is out of our hands I can say that the national level decision allows no discussion of this.'

Fairly obviously Dr. Little was not going to achieve what his division

wanted. His problem was a role conflict between (a) representing the Division of Psychiatry and opposing any change in the post and (b) making a decision on objective lines within a broad administrative framework. In this case he had to accept the latter but he wanted it to appear to his division that he could not have done otherwise.

Specialty Requests for Additional Consultant Staff

Requests for additional consultant staff were dealt with in a similar way. If a specialty wanted an extra consultant then the Committee of Divisional Chairmen had to support it before the Board of Management would recommend it to the Regional Board (under the old structure) or before it would be considered by the Medical Advisory Structure at the area level in relation to requests from other hospitals and districts.

The first of these was a request from the Paediatric Division for a consultant in child and adolescent psychiatry. Dr. MacAulay the chairman of the division had written to the Regional Board and they had replied that it should be considered initially by the Committee of Divisional Chairmen. It was discussed in May 1973:

Dr. MacAulay: We have wanted one for some time and it has been suggested that we should share him with Daleside Mental Hospital and build up a Child Psychiatry Unit in Overton in the future. I hope that you will give this your blessing for when it goes before the Board of Management.

Dr. Gregor: What is the difference or dividing line between child and adolescent psychiatry?

Dr. MacAulay: It is confusing we would like to get someone who is qualified in both, you had better ask Dr. Galbraith.

Dr. Galbraith: Well, er, I, um, it's difficult to draw a dividing line there is some overlap of interest between adult psychiatry and adolescent psychiatry and the same goes for adolescent and child psychiatry.

Dr. Gregor: Which division would he be attached to?

Dr. MacAulay: Both?

Dr. Galbraith: Yes, both.

Dr. Gregor, Well, do we agree to this?

Everyone: Agreed.

This was passed on to the Board of Management and the chairmen's decision was accepted. There had been no information presented to the committee, and the consideration at the Committee of Chairmen was rather limited. The discussion which did occur suggested that they did not know much about the subject.

Another request was that for the consultant in renal medicine which was covered in the last chapter. A memorandum setting out the following points was sent to the chairmen before the meeting at which it was considered:

a. The medical staffing of the renal unit at Overton was considerably less than that of the other units providing comparable services and having comparable home dialysis commitments.

b. Renal disease was the only major specialty at Overton Hospital in which the work was not shared by two or more consultants.

c. There was reason to believe that the Scottish Home and Health Department would support the establishment of a second consultant at Overton as it had already approved in principle two additional consultants in renal disease in the region.

The chairmen discussed it in February 1974 and before the start of the meeting the chairman said:

Dr. Henley: Professor Alexander has to leave us at three o'clock, is there anything you want to say on the rest of the agenda before you go? I think the request for a renal consultant is a formality.

Professor Alexander: No.

When the item was reached Professor Alexander had left and the chairman said:

Dr. Henley: This is a request from the Medical Division and the Medical and Nursing Committee of the Board of Management have agreed if we concur. This is home dialysis and a regional commitment and we are asked to rubber stamp it.

Everyone: Agreed.

When this was reported in the official minutes, the following was stated:

'The committee, after full consideration and having heard Professor Alexander unanimously agreed that the recommendation by the Medical and Nursing Committee be supported.'

One wonders how long they spend on an item when it is reported that there is a less than full consideration!

This case was slightly different. The Medical and Nursing Committee of the Board of Management had said they would agree if the Committee of Chairmen agreed because there was some urgency in sending the request up to the Regional Board before the Health Board took over. There was therefore some pressure on the Committee of Divisional Chairmen. Admittedly a body of information was presented in support of the request but there was no discussion of this, it was treated as a formality.

Another request, from the Surgical Division, was for an additional consultant in ophthalmology. It had been considered by the division and the following information which had accompanied the request was also passed on to the Committee of Chairmen:

a. Changes in the numbers waiting for admission over the previous year.

b. Changes in the number of inpatient discharges over the previous year.

c. Changes in the number of new outpatients over the previous year.

All of the figures showed a considerable increase. The post was requested to replace a retiring Medical Assistant and the Surgical Division thought that the request was understated. The Committee of Chairmen accepted the request without discussing the figures, although they were available to them.

Divisions were also asked to estimate their future consultant requirements for the period 1976-80. This arose in a circular from the Health Board in September 1974 and the Committee of Chairmen referred it to the divisions. The results were reported in October 1974:

Dr. Henley: Dr. Hill, have you received the lists?

Dr. Hill (District Medical Officer): I have had nothing from the Surgical Division.

Mr. Sander: We are having our meeting on Friday.

Dr. Hill: In anaesthetics they want four more consultants but most of the rest are negative. In the labs there is one additional consultant in pathology at Overton and a biochemist. The Medical Division is more tortuous if I can break down the various submissions. Endocrinology, nuclear medicine and physical medicine are put in order of priority and they also mention gastroenterology, cardiology, clinical pharmacology and allergy, but there is a unanimous request for the first three.

Dr. Henley: Do you want to elaborate Professor Alexander?

Professor Alexander: No, I'll just leave it with the poll. It is interesting that when you leave it to what people think you get a reasonable list.

Dr. Hebble: Can I ask Dr. Hill if he got a reply from radiology and if he didn't if he treated it as negative?

Dr. Hill: No, I haven't had a reply.

Dr. Hebble: Well, our requirement was typed out, we want one more and I will make sure it gets to you.

In this case there was no particular need for the committee to discuss whether the submissions from the various specialties were appropriate or valid, they were merely projections into the future. However, it was interesting to note again that all the specialties had gone about this exercise in rather different ways. The Medical Division had gone through some form of voting procedure. The Surgical Division had split into its sub-specialty parts to decide on the increases it wanted. The chairman of the Radiology Division had made the decision by himself. However, whatever the specialty method of dealing with the requests they were all accepted as equally valid by the Committee of Chairmen and passed on up to the Health Board.

One final request for a consultant was the replacement of Dr. Parrett, the chest physician, at Wallace Hospital. This was partially covered in the last chapter. The matter had been referred to the Medical Division by the Committee of Chairmen and the division had decided eventually that he should be replaced by a consultant endocrinologist. This decisions had to be returned to the chairmen for reconsideration and it was more complex than some of the one-off requests for additional staff because it involved a change of function and location. The chairmen discussed it in November 1974 and Dr. Ashton represented the Medical Division because Professor Alexander was unable to attend:

Mr. Alwin: There is a letter from Dr. Hill saying that the Medical Division recommend that Dr. Parrett's post is filled with an endocrinologist, there is also a copy of the letter from the division which says that rheumatology with physical medicine is second priority but this is subject to the provision that the post will stay in the Overton District. He says there was a minority view that the staff at Wallace should not be run down ...

Dr. Leven: While we are discussing this Dr. Sutton at Wallace retires in another year. I think a general statement should be made about the future of Wallace as this is having a deleterious effect particularly upon the nursing staff.

Dr. Malcolm: I would support Dr. Leven, I have beds there.

Dr. Leven: Somebody must be in a position to do this.

Dr. Henley: We can decide, I don't think the District Medical Committee will differ from what we say.

Dr. Leven: You don't think the area should be involved?

Dr. Henley: We, in the first instance, deal with policy.

Mr. Sander: Did the Medical Division consider the repercussions of this? If it was an endocrinologist then that could put paid to the chest and the medical units at Wallace. Is there any suggestion that any physician would work there?

Dr. Ashton: I think the Medical Division thought we should strengthen the weak points in the team. The future of Wallace is a separate issue. On the chest beds, Dr. Gore, Dr. Pearce and Dr. Frome said that there are too many at the moment, only Dr. Frome had any doubt about that.

Dr. Leven: The other thing is that in the future Wallace may be wanted for decanting. I don't think we are competent to decide the future of Wallace.

Dr. Henley: You mean that we should ask the area what they think and say that we are in the process of discussing it?

Dr. Elton: Is it inconceivable that the endocrinologist could use Wallace as a base?

Dr. Ashton: No, it's not possible, all the facilities needed are here.

Dr. Elton: I suppose ... that this is just a redistribution of beds within the Medical Division and I don't know if anyone else should be involved.

Dr. Leven: The problem is that if these beds aren't used then they have to be closed.

Dr. Hebble: Dr. Parrett gives tutorials in general medicine to the junior staff at Wallace, I think this should go on with someone from the Medical Division.

Dr. Henley: The Medical Division will have to think about that but it might be an idea to invite the junior staff here as there is so much going on.

Dr. Elton: I think it is the problem of the absentee landlord that is worrying.

Dr. Henley: Well, shall we include in the letter that the Medical Division should work closely with Wallace Hospital, including training and we will leave that to the Medical Division to worry about?

This decision from the Medical Division received a lot more detailed attention than any of the other decisions relating to consultant posts. The main reason for this was that their decision had obvious repercussions, not only for their specialty, but for Wallace Hospital and the district as a whole.

This clearly brought out the conflict between the aims of a particular specialty and the problems which these aims might give rise to on a broader level. Dr. Ashton summed up the viewpoint of the physicians when he said 'I think the Medical Division thought we should strengthen the weak points in the team. The future of Wallace is a separate issue'. Whereas some of the other chairmen, in particular Dr. Leven who worked in Wallace Hospital, were concerned about the effect upon the hospital, the effect upon teaching and the use of Wallace for decanting beds from Overton while parts of it were renovated. Dr. Leven even suggested that the possible repercussions were so great that the Committee of Divisional Chairmen was not competent to decide on all the issues. Despite these factors, the view of the committee appeared to coincide with the comment by Dr. Elton 'that this is just a redistribution of beds within the Medical Division and I don't know if anyone else should be involved', because the committee decided to accept the Medical Division's proposal and leave that division to worry about the problems that had been raised. Again there seemed to be no willingness to go against something which a specialty had decided on its own, even though there were cogent reasons for disagreeing in this case.

Overall, the way in which requests for additional consultant staff were handled by the Committee of Divisional Chairmen was much the same as the way in which they had dealt with requests for junior staff. While in general more information was presented in support of these requests there were some for which this was not the case, for example, the request for a consultant in child and adolescent psychiatry. However, despite the presentation of information, requests were agreed to with very little discussion, practically as a matter of course. The one exception was the last case but even there the request was agreed to primarily because they did not want to impinge upon the Medical Division's use of its resources even if it did affect other aspects of the service.

The way in which these decisions were handled is again consistent with the argument that either specialty autonomy deters chairmen from inpinging upon other specialties, or inter-specialty knowledge makes it difficult for them to do so. In the last case respect for medicine's autonomy appeared to play a part in the agreement with the Medical Division's request. However, it should be remembered that in the interviews chairmen expressed some doubts as to whether members of other specialties knew enough about their own specialties to be able to comment and whether they knew enough about other specialties to be able to comment.

Because all of the requests were treated as one-off cases, rather than competitors, which they would be when they were considered at the area level, specialties were equally successful in obtaining support for what they wanted. In these cases specialty status difference played no part in the way decisions were made. However, there were other cases in which decisions had to be made between requests from different specialties. If some specialties were better able to get what they wanted then this should become evident in such decisions.

Priority Decisions and Medical Equipment

Priority decisions had to be made by the Committee of Divisional Chairmen in relation to requests for medical moveable equipment and

submissions for the Higher Medicine allocation. Before examining these cases it will be useful to look at the responses to two questions on the interview schedule which asked chairmen about priority decisions. The first one was: What about situations where the Committee of Chairmen has to put requests in some order of priority, how easy is it to do this?, the response was:

Easy	5
Difficult	9
Have not been involved in such decisions yet	1

Most of those who said that these decisions were difficult said that the two necessities were to get as much information as possible and to look to the good of the hospital, but that these two points were not always possible because information was not always presented and their direct involvement in many decisions biased their viewpoint.

The next question was: Do you think it would be better if someone other than the Committee of Chairmen made these decisions? and despite the difficulties some of them had in making the decisions none of them thought that the decisions should be made by anyone else.

The opinion of the non-chairmen was very similar. They were asked: Do you think the Committee of Chairmen is the right place to make decisions about priorities between divisions? and the response was:

Yes	19
No	2
Depends	2
Too early to say	2

The response was clear cut but among those who thought the chairmen's committee was the right place, a majority answered 'yes' because they could not think of an alternative body which could make the decisions. The following comment was typical:

'Well I can't see any other place for it to be decided. It's the best that can be made of a rather imperfect situation. I can't think of any way of improving this. You see, in my way of thinking, you have a situation where there are a

whole list of priorities being fed to a central committee and at the end of the day only a certain number of the priorities can be considered and passed, and ultimately I think it comes down to personality, it depends how forceful a personality the person on the committee has, whether in fact his proposal is, carries any weight. And that's why I think the chairman of the division must have this ability to push the proposals at the Chairmen's Committee.'

The two who answered 'no' gave similar reasons, as one of them said:

'It's a bit invidious really because you're getting people at the same sort of level from the different specialties and perhaps none of the people involved is sufficiently detached to look at it in an adequate fashion, so that I think again one would have reservations.'

The two consultants who answered 'depends' were concerned with whether other chairmen would know enough to make such decisions and also whether they would support other specialties in opposition to their own:

'It's not quite so easy, I think perhaps it would be better seen as a specialty priority rather than a hospital priority, because this is the difference, you may not convince all the other disciplines who are all cracking round about their own things, I think perhaps you've got to go to the area who's got an overall picture for the region as a whole and realises that this is a priority, I think you may get more support quicker.'

'Imagine a situation where you have an argument between medicine and surgery over a particular thing where, who's to adjudicate in this case, dermatologists, psychiatrists, laboratory medicine people? I don't think they necessarily can.'

Of the two who thought it was too early to say one was a physician who had serious reservations based upon the experience of the Medical Division in trying to secure extra beds from other specialties:

'Well, if you'd asked me if I thought the Committee of Chairmen should be the ultimate authority, and I think this becomes a responsibility which should be offered to the Committee of Chairmen, but if it doesn't solve the problem there should be a higher authority which solves it, very much so. If you're talking about the allocation of beds, in the foreseeable future this will not be a useful function of the Chairmen's Committee ... I think they're still living in the unit system. It comes into conversation, my unit, my beds, our unit, our beds. But this is wrong in a situation where there is someone who has no beds, where people or patients are having to undergo considerable hardship. This is quite wrong for someone to go on saying "Yes we would like to help" and the Committee of Chairmen can sit around all day and the end result we've seen is, it doesn't work. So somebody has got to, to go back to the old Medical Superintendent, my view is that he should have come in and said this is what's happening. This could cause a bit of trouble initially but if clinicians are better able to do their job I think it's justified. The divisional system is being used insofar as it's non-controversial.'

Overall both chairmen and ordinary members of divisions thought that the Committee of Chairmen was the right place to make decisions about inter-specialty priorities although a majority of the chairmen thought that such decisions were difficult to make. The only doubts which were expressed related to whether sufficient information was available to make such decisions and whether the chairmen could act in an unbiased way and look to the good of the hospital, particularly when their divisions expected them to get what they wanted. Even among those who thought that the committee was the right place to make priority decisions a substantial number said that this was because there was no alternative, rather than because of positive virtues of the Committee of Chairmen.

This chapter will now look at the way in which such priority decisions were dealt with.

Medical Moveable Equipment

It is customary for hospitals to have available a certain amount of money for expenditure on medical moveable equipment. Requests for this equipment come from individual consultants and prior to the introduction of the divisional system decisions about which requests should be purchased were made by the Medical Superintendent in Overton Hospital. By 1972 this function had been taken over by the Committee of Chairmen. However, they decided that the full committee was rather cumbersome and in the first year they appointed a sub-committee. They went through the same process in April 1973:

Dr. Gregor: I suggest that the sub-committee we chose last year should be the same again this year. This was myself, as chairman of this committee, one representative from Wallace Hospital, that was Dr. Leven, one representative from Reeve Hospital, that was Dr. Murdoch, Dr. Henley from the Laboratory Division to look after the service specialties and the Medical Superintendent. I think we were quite fair last year and I don't think anyone's nose was put out of joint.

Dr. MacAulay: Shouldn't we change one member each year to give each specialty a bash?

Dr. Gregor: Well, I don't think it was biased in any way, and there is not much room for change if we keep one member from each of Wallace and Reeve Hospitals.

The chairman's idea in forming the committee in this way was to provide hospital representation and a representative from the laboratories because of their special position. The chairman happened to be a physician and he was on the committee because of his chairmanship. While this seemed to be a relatively fair way of constituting the sub-committee, Dr. MacAulay of the Paediatric Division obviously thought that the success or failure of requests was in some part dependent upon the specialty membership of the sub-committee. Whether or not this was the case it is hard to say because the researcher was not allowed to attend the meetings at which these priorities were decided.

However, the way in which the sub-committee was formed in subsequent years was of interest. At the start of the financial year 1974-5 the Committee of Chairmen again looked at the money available for medical moveable equipment and Dr. Henley, chairman of the Laboratory Division was now chairman of the Committee of Chairmen:

Mr. Alwin: We now have the revenue allocation for the coming financial year and it is £12,600,000. We have allocated £25,000 for medical equipment for hospitals. In determining the priority of requests last year there was a sub-committee of this committee consisting of the Medical Superintendent, Dr. Gregor - the chairman of this committee, Dr. Leven - from Wallace, Dr. Murdoch from Reeve and Dr. Henley from the laboratories.

Dr. Henley: The sub-committee seemed to work quite well, we spent two and a half hours on it and there were no complaints, I suggest a similar sub-committee.

Mr. Alwin: Dr. Gregor and Dr. Murdoch are off this committee now.

Dr. Henley: Well, it would be myself as chairman of this committee and for the laboratories, Dr. Leven for Wallace, Dr. Elton taking over from Dr. Murdoch from Reeve and the District Medical Officer, Dr. Hill. That means there is one less. Medicine was on it last time, I don't know whether it should be general medicine again with Professor Alexander or perhaps we should have Mr. Sander for the surgeons, I'd be happy to see it rotate between those two. Well shall we have myself, Dr. Leven, Dr. Elton, Mr. Sander and Dr. Hill then?

General murmurs of agreement.

At this point it seemed as though the idea behind the sub-committee had been changed, and the previous chairman was seen as being on the sub-committee as a physician rather than as the chairman of the committee. Technically the sub-committee was complete in its initial conception because Dr. Henley was doubling up as representing the service specialties and as chairman of the committee. However, he seemed to think that the extra place should be filled by a physician

or a surgeon, probably the specialties with the highest status in the hospital. At this point Professor Alexander arrived, having been at another meeting:

Dr. Henley: We finished the business early Professor Alexander, we were discussing the sub-committee for medical moveable equipment. That was the committee I just read out, we put the surgeons on it. Are you happy with that?

Professor Alexander: What do you expect me to do, explode?

Dr. Henley: Well Dr. Gregor was on it last year and we thought it might be an idea to have a general surgeon on it this year.

Professor Alexander: What exactly is this for?

Dr. Henley: Medical moveable equipment.

Professor Alexander: It's not higher medicine?

Dr. Henley: No, it's second division, are you happy with that?

Professor Alexander: Well you have made the decision already.

Dr. Henley: We could change it, nothing is fixed.

Professor Alexander: No, it's fine as it is.

Dr. Henley: Well there's one physician on it, Dr. Elton from infectious diseases at Reeve.

This exchange was quite remarkable. Partly because the sub-committee had taken on a definite specialty representation aspect and the specialties which were mentioned in this context were medicine and surgery. While it would have been difficult for Professor Alexander to accept the offer of a place on the sub-committee because he would have appeared to be favouring his own specialty, it was stated that Dr. Elton was a physician and he was on the committee so all would be well. It appeared that medicine and surgery had advantages in terms of sub-committee membership because none of the other specialties were mentioned in this context, nobody suggested that it might be an idea for the paediatrician to be on the sub-committee. There was further support for this interpretation in what happened subsequently. First of all, Professor Alexander reported back to the Medical Division:

Professor Alexander: The third point was the setting up of a sub-committee to look at the allocation of money for medical moveable equipment ... There is no representative from the Medical Division on this sub-committee which is bad. I had had to lecture and by the time I got there the matter had been decided. Apparently last year there was no surgeon on the sub-committee and so this year they have put on the surgical chairman. I was told that Dr. Elton is a physician and he can keep an eye on things but he's not even in our division. However, Dr. Henley has said that he will be coming to discuss with me ways in which the money might be split up.

This report by Professor Alexander highlights a number of points. Firstly, he had the opportunity to be on the sub-committee but turned it down and yet he did not tell his division this for obvious reasons. In the context of the Committee of Chairmen his acceptance of a place on the sub-committee would have made it look as if he was favouring his own specialty. In the context of his division his failure to accept the offer would look as if he was not doing his job properly, so he was juggling with the two expectations of the role conflict entailed in being chairman. Secondly, he obviously thought a physician should be on the committee and did not think that a physician from outside the Medical Division could be of any advantage. Thirdly, Dr. Henley had said privately that he would consult with Professor Alexander outside the sub-committee framework and this again suggests that medicine has a privileged position. One more episode substantiated this view. The sub-committee reported to the Committee of Chairmen in June 1974:

Dr. Henley: This sub-committee met last week. Dr. Elton was unable to come and he sent notes of what he thought were particular priorities so we had to replace him and Dr. Gilbert came as the physician instead of Dr. Elton.

Dr. Gilbert was a member of the Medical Division and although Dr. Elton was an infectious diseases physician he was not on the sub-committee because of that, but because he worked at Reeve Hospital.

Technically Dr. Elton should have been replaced by a representative of Reeve Hospital. Again medicine seemed to have a favourable position.

There was a further allocation of money for medical moveable equipment later in the year. This was reported to the Surgical Division in September 1974:

Mr. Sander: This time the District Medical Officer, myself, Dr. Gilbert, Dr. Elton and Dr. Leven looked at the items and allocated the money. Dr. Henley was not available for the meeting. Most of the money went to biochemistry because they got little or nothing at the start of the year.

By now Dr. Gilbert seemed to have become a permanent fixture or at least number one substitute on the sub-committee. This time Dr. Henley, a member because he was from a service specialty and also because he was chairman of the Committee of Chairmen, could not attend and there was no indication that he should be replaced by a physician according to the constitution of the sub-committee.

It should be remembered that the researcher was not permitted to attend the meetings of these sub-committees and therefore it is impossible to say whether the physicians or the surgeons used their position to the advantage of their specialty. All that can be said is that in terms of the way the sub-committee was constituted medicine and surgery had an advantageous position relative to other specialties. Biases in terms of status within the profession were directly translated into membership of quite an important sub-committee. It is also important to note that this was something of a two-way process. Members of the Committee of Chairmen, particularly the chairman, Dr. Henley, appeared to think that these specialties should have these advantages, and this was expressed in a form of deference. At the same time the physicians seemed to think that they should have a special position. The other decisions which involved priorities were for the higher medicine allocation.

Higher Medicine Priorities

Higher medicine funds were provided once a year by the Regional Hospital Board prior to reorganisation and the Health Board subsequent to reorganisation. The aims of the fund are clearly stated:

> 'Higher Medicine Funds are for those developments which will be of real assistance to the teaching hospitals in implementing their essential functions as the leaders in medical thinking and in the development of new forms of care and treatment of patients.'

Each division had to collate requests from its members and the way in which the Medical Division did this was reported in the last chapter. The divisions were then asked to bring their requests back to the Committee of Chairmen.

The following requests were discussed by the chairmen in February 1974:

Medical Division (in order of priority)	
1. Continuous Blood Flow Separator.	£12,000
2. Ultrasonoscope for Echo-cardiography, including a recorder.	£ 6,700
3. Body Scanning Equipment.	£ 2,000
4. Six Channel Recorder for Studying Oesophageal Mobility.	£ 3,000
Surgical Division	
Secretarial Assistance for Study of Crohn's Disease.	£ 1,500
Paediatric Division	
Fiberscope.	£ 3,500
Geriatric Division	
Recorder for Hemiplegic Gait Studies.	£ 1,500

The chairmen had to put them in priority order for review and final decision by a committee at the Regional level.

Dr. Henley: This is really long overdue and cannot be delayed any longer. Many people have not asked for anything, the main requests are from the Medical Division and apart from that there

are only three items. The Medical Division have put their requests in order of priority and we have to get this off our hands today. It is always difficult to judge priorities between divisions. Professor Alexander is a member of the Higher Medicine Committee, maybe he could answer any questions. It is a pity the Fiberscope at £3,500 is so expensive, Dr. MacAulay.

Dr. MacAulay: Yes it is.

Dr. Henley: I think Dr. MacAulay would like top priority. Dr. Malcolm, the Recorder for Hemiplegic Gait studies seems to have less priority.

Dr. Malcolm: I should point out that this is part of an inter-regional and inter-disciplinary project with the Bioengineering Department at the university. It is more of a national study and has been going for four months. It is the smallest item at £1,000.

Dr. Henley: There is some advantage in putting things up with different prices. Mr. Ritson you are standing in for Mr. Sander today, would you like to comment on his request?

Mr. Ritson: This is very much an Overton Project, it has been running for six years and he has been doing it with the senior registrars. I have a two-page document here from Mr. Sander, they are looking at all cases of Crohn's Disease in the region and it is a comprehensive study. So far there have been seven or eight papers and three or four publications and I think Mr. Sander thinks they could get more information if the study was ongoing until 1975. He wants secretarial help and computer time to compile a register and it is for £500 a year for three years.

Dr. Leven: The amount is certainly modest.

Professor Alexander: I wonder if the amount is enough?

Mr. Ritson: It is all here with two secretarial sessions a week.

Professor Alexander: I think that one of the weaknesses is that you are asking for too little. The committee may well say if

you cannot get two sessions locally well so what, I think you may have priced yourself out.

Dr. Henley: Can you double the estimate?

Dr. MacAulay: Is there no other way of finding the money?

Mr. Alwin: I wouldn't have thought there would be much difficulty.

Professor Alexander: If you get it from the Board you could get cracking right away. I think Mr. Sander's work is admirable.

Dr. Henley: Mr. Alwin says the Overton Board will do it. Let us come back to the other things. Would Professor Alexander agree that the three lower medical priorities go below paediatrics and geriatrics?

Professor Alexander: Dr. Collis is very keen on the Ultrasonoscope, the second medical priority. I don't want that to be excluded.

Dr. Hebble: For a smaller expenditure Dr. Collis could have got an adaptor for the equipment we already have in radiology, for £1,000-£1,500 and we have some spare sessions.

Dr. Henley: Does Dr. Collis know this?

Dr. Hebble: Dr. Bryan his Senior Registrar discussed this with me.

Dr. Henley: This ultrasonoscope would be in your department?

Dr. Hebble: It would have to be, it couldn't be moved about too much. Perhaps we should leave it and if it is not successful take up the question of the adaptor.

Professor Alexander: Dr. Collis might feel constrained by not having the sole use.

Dr. Henley: Could the Fiberscope be used for anything apart from paediatrics?

Dr. MacAulay: It could be and I have discussed the possibility with Dr. Hudson from the Medical Division.

Dr. Henley: What do we do? Do we decide now? The Regional Committee will not necessarily accept our priorities.

Professor Alexander: I think I feel warmed to Dr. MacAulay's request, it is important to keep investing in the Paediatric Department. Have you attached a project scheme for the use of the Fiberscope?

Dr. MacAulay: Yes, certain ideas, I filled up the form.

Professor Alexander: Have you specified exactly what the interests are?

Dr. MacAulay: No.

Professor Alexander: Well it's important that you do, the committee is not interested in machines but in the forward march of medical advance.

Dr. Henley: Could Dr. MacAulay amplify on this and give extra information on its usage to Mr. Alwin? Professor Alexander has commented favourably on this list, shall we just pass the list on as it is?

Mr. Alwin: Last year we did that and they sent them back and asked us to rank them.

Dr. Leven: I would think Dr. Hale first, then paediatrics, then geriatrics and then the other three medical requests.

Professor Alexander: Dr. Malcolm, you know we have some television equipment and I was wondering if that could be, well to my mind it's not being adequately used, could you use that?

Dr. Malcolm: It is possible, I haven't gone into it much.

Professor Alexander: Well we have £3,000 worth of equipment and here is a tailor-made project. There would be whoops of joy if you could use it. I think we should determine if you could use it, I think we have the equipment there already.

Dr. Malcolm: Yes this is possible, although I haven't looked at all the aspects of it yet.

Professor Alexander: Well it's there, it's working and it works.

Dr. Henley: Well we could give this the lowest priority. The only thing is that you may want the equipment portable otherwise you will have to bring the patients here.

Dr. Malcolm: Yes.

Professor Alexander: Some parts are portable and are in the clinical teaching centre, you could start tomorrow.

Dr. Henley: Well we have paediatrics and the Medical Division. We could put them all equal but we need to have them one and two, which should we put first?

Dr. MacFarlane: Hasn't the Blood Flow Separator a much wider use than the Leukaemia Unit?

Professor Alexander: Oh yes it could be used in genersl surgery and paediatrics and it would certainly put the place ahead, but I don't want you to think I'm pressing this.

Dr. Leven: I think it should be first.

Dr. MacAulay: I have always thought it should be first.

Dr. Henley: O.K. we'll put the order Dr. Hale, then paediatrics, then the other three Medical Division requests and then geriatrics.

At a general level it was obvious that the chairmen did not find this an easy decision to make, and at certain points in the discussion the chairman was all for passing the requests up to the region unranked rather than attempt to put them in order of priority. Also very little time was spent trying to assess the extent to which the various submissions would fulfil the aims of the Higher Medicine allocation, which might have been one way of making the decision. Although chairmen tried to make their own projects attractive in other ways apart from their contribution to medical thinking and new forms of care and treatment. The geriatric request was 'inter-disciplinary' and 'inter-regional', while the surgical request was 'very much an Overton project' and the Continuous Blood Flow Separator 'would certainly put the place ahead'. Rather less specifically the decision was particularly difficult because medicine had ranked its requests. Who was to say whether the lower priorities in medicine were more or less important than single requests from other specialties? There were three main influences in the approach to the

ranking and the derivation of the final list. First of all, there was the idea that all the specialties should receive equal treatment and that the three lower medical priorities should go below the first priorities of all the divisions. This was stated at various points, Dr. Henley said 'would Professor Alexander agree that the three lower medical priorities go below paediatrics and geriatrics', and a little later Dr. Leven said 'I would think Dr. Hale first, then paediatrics, then geriatrics and then the other three medical requests'. There was therefore a feeling that medicine should not gain because it had more than one request. This appears to be the influence of a concern with specialty autonomy and equality. Secondly, within this view the chairmen, apart from the chairman of the Medical Division, were most deferential towards the Medical Division's requests and rather more critical of some of the others. The chairman of the committee said near the beginning of the discussion 'the recorder for hemiplegic gait studies seems to have less priority', without discussing the relative priority of the first choices of the specialties (quite apart from the Medical Division's second, third and fourth choices). The chairman seemed to think that the medical request should automatically be first, this was true of Dr. Leven's statement above and also the paediatric chairmen said 'I have always thought it (the Continuous Blood Flow Separator) should be first'. The chairmen appeared to expect medicine to come out on top. It was obviously an issue which had great salience for all specialties with requests and yet even within this context they still seemed to treat medicine as the most important. Medicine's success stemmed in large part from the deference of the other specialties.

The third influence was the fact that the chairman of the Medical Division, Professor Alexander, wanted to get first priority, but in addition he wanted to get the best priority possible for the other Medical Division requests. This was illustrated when it was suggested that the lower medical priorities should go below paediatrics and geriatrics and he said 'Dr. Collis is very keen on the Ultrasonoscope ... I don't want that to be excluded'. Because the other chairmen

seemed to think that no specialty second choice should come before the first choice of any specialty, he had to find some way of reducing the competition. He had already obtained money for the Surgical Division by suggesting that the Board of Management should provide it. He then suggested that the paediatric request had been ill-prepared by saying that the Regional committee 'is not interested in machines but in the forward march of medical advance'. The last competitor was geriatrics and he managed to persuade them that some existing equipment would be suitable when it was not clear if it was portable or if it would meet the requirements of the study. Indeed, if it had been suitable why was the geriatric request still left on the bottom of the list to be submitted to the Regional Committee? However, it did mean that the three lower Medical Division request were put above the request from the Geriatric Division. Professor Alexander was more willing to press existing equipment on Dr. Malcolm than he had been to accept that a cheaper ultrasonoscope could have been used in conjunction with existing radiological equipment. As with medical moveable equipment other specialties seemed to be willing to grant more to the general physicians, the general physicians expected to get more, and they did.

The following year the proposals were dealt with in a slightly different way. Again the physicians had four proposals which they had voted in order of priority. There was a request from the Laboratory Division. The Surgical Division also discussed a proposal for a teaching attachment on the 10th January 1975 but they did not have the information available at that meeting to formulate a firm proposal. Despite the fact that the Committee of Chairmen had decided that the matter would be dealt with by the whole committee, and that the chairman of the Surgical Division had told Dr. Henley that his division would be submitting a request, an ad hoc sub-committee was formed and the priorities were decided without the surgical request. This was reported in the minutes of the Committee of Chairmen:

> '... Dr. Henley reported that he and the District Medical Officer had met the chairman of the Medical Division to consider applications which had been submitted. The following priorities were determined:-

1. Echocardiogram (Dr. Collis)
2. Digital Computer (Professor Alexander)
3. X-Ray Image Intensifier (Dr. Hudson)
4. Ultratome and Accessories (Dr. Bander, Laboratory Division)
5. Gamma Camera (Dr. Frome)

Dr. Henley referred to the low priority which had been accorded to the Gamma Camera requested by Dr. Frome and indicated that there was a strong minority in favour of according this a higher priority. In that connection Dr. Henley read a letter that he had received from Dr. Frome drawing attention to the fact that, nothwithstanding the high cost such cameras had been provided in other large hospitals in Lennox. The letter stressed that this equipment was for the use of the whole hospital and not just for the Medical Division and asked leave to have the matter considered by the committee. While Dr. Hebble expressed support from the X-ray Department attention was drawn to the fact that low priority had been allocated by the Medical Division.

After full discussion in which the view was expressed that it might be more appropriate to seek the necessary funds for a Gamma Camera as a special allocation rather than to include it in the Higher Medicine submissions the committee agreed that Dr. Frome's request remain on the Higher Medicine list with the priority accorded it by the Medical Division but that consideration be given to submitting a request for a specific allocation for this equipment in the next financial year. Mr. Sander expressed concern at the timing of the meeting to decide priorities and indicated that the Surgical Division would be making a submission which would now require to be dealt with outwith the above list ...'

Mr. Sander reported on his dissatisfaction at the next meeting of the Surgical Division on the 14th February 1975:

Mr. Sander: The position was that at the last executive meeting we were asked for requests and I notified the District Medical Officer and Dr. Henley that we were finding out the price of

> ours. But at the last meeting of the Committee of Chairmen claims were lodged by the Medical and Laboratory Divisions and they have been put in order of priority without consultation and without our item included in the considerations. I lodged a complaint but since then our request has been mysteriously authorised but not through Higher Medicine ... The lowest priority was assigned to a Gamma Camera and I think that had this list been before the whole Committee of Chairmen, then the Gamma Camera, which would have benefited quite a few units, would have got more support from other chairmen and would have been given higher priority.

This was rather different from the previous year. Although the outcome was very similar with the first medical priority becoming the first priority for the hospital, in addition the second and third medical priorities also became the second and third hospital priorities. In this case notions of specialty equality did not intervene in deciding the order. However, it was rather strange that the procedure had been changed without telling the chairmen although this was possibly understandable in view of the length of time the decision had taken the previous year. Rather more difficult to understand was the fact that the decision was taken before the surgical submission had been received and that subsequently the surgical request was agreed to outside the Higher Medicine Allocation. The question of the Gamma Camera was interesting as well. This was one piece of equipment which was of potential use to other departments, it was not something which could be considered purely as a Medical Division submission. Like the replacement of Dr. Parrett discussed above, the Gamma Camera had repercussions for other specialties. Presumably the decision on priorities had been made by a sub-committee and could therefore be changed by the committee as a whole.

Although the chairmen expressed doubts about the final priority list they were unwilling to change the priority ranking which had been decided by the Medical Division, despite the broader context in which the priorities were being considered. Instead it was suggested that money might be obtained in a different way for this equipment, in the same way that money was found elsewhere for the surgical request.

This suggests that the chairmen would rather change the parameters of the decision by using money for other purposes (and they had done so with the surgical project the previous year) than make decisions about priorities between certain requests or go against the recommendations of a specialty. It is unlikely to be coincidence that in both years a Medical Division request was given top priority and a Surgical Division request was obtained by moving it outside the decision and using money from other sources.

The decisions about medical moveable equipment and the Higher Medicine allocation both required the chairmen to decide upon the relative priority of requests from different specialties. The chairmen found them difficult decisions to make as witnessed by the referral of decisions to sub-committees and the time taken to decide on the Higher Medicine submissions the first time they were considered. In terms of medical moveable equipment the physicians, and to a lesser extent the surgeons, were granted structural advantages by being given positions on the sub-committee making the decision, purely because they were from those specialties. To this extent the other chairmen seemed to think these two specialties should have that right and the physicians at least seemed to expect that right. Whether their membership of the sub-committee was advantageous to medicine and surgery it is hard to say, but certainly they had opportunities for advantage which other specialties lacked.

In Higher Medicine the researcher was able to observe the decisions being made. In this there was some concern that all the specialties should have an equal chance insofar as chairmen were in favour of a priority ranking in which the first or only priority of all specialties was higher than the second priority of any specialty. Within this, however, there seemed to be general agreement that medicine should be first and the chairman of the Medical Division achieved higher priority for all his requests than the request from the Geriatric Division. In the second year even the notion of specialty equality disappeared and the first three priorities from the Medical Division were put above the only priority from the Laboratory Division.

In both these cases the advantages which were apparent favoured general medicine and to a lesser extent general surgery. This suggests that relative status of different specialties does have an influence upon certain decisions when priorities cannot be avoided.

Patient Care Evaluation and the Control of Clinical Practice

It was clear in the last chapter that the Committee of Divisional Chairmen was not keen to lead the way in using statistics produced by the Medical Records Department for the purpose of Patient Care Evaluation. The committee thought that the community medicine specialists should be concerned with the way in which this was done and the community medicine specialists thought the clinicians should do it. As a result nothing was done. There was no attempt to advise specialties in the use of the statistics or the evaluation of their clinical practice.

There was only one issue which related to clinical practice within specialties. This was raised by the Senior Nursing Officer at the Nursing School in a letter to the Medical Division in December 1973:

> 'I would very much like the views of the Medical Division on the First Aid Administration of Oxygen within the hospital. Would the members consider that nurses in training should administer oxygen in an emergency in a ward, pending the arrival of the medical staff.'

Dr. Gregor handed this over to Dr. Frome, the chest physician and he replied to the Senior Nursing Officer later in the month:

> 'Oxygen is a therapeutic substance like any other, and it can be fatal in a significant proportion of patients. Its unskilled prescribing is, therefore, dangerous and it should be given on the instructions of a medical practitioner.'

Mr. Laver, the Chief Nursing Officer and future District Nursing Officer took this up and wrote to the Committee of Chairmen in January 1974:

'I concur with Dr. Frome's statement that oxygen or any other therapeutic substance should only be administered by a nurse when it has been prescribed by a doctor. However, what is not clear is the position of the nurse in emergency circumstances when medical advice is not readily available; where for instance a patient has collapsed and oxygen might be considered essential for resuscitation purposes. I should be pleased if the chairmen would indicate whether in their opinion there are any circumstances in which a nurse should administer oxygen on her own initiative where it has not previously been prescribed by a doctor.'

The Committee of Chairmen discussed it in February 1974:

Dr. MacFarlane: I think that what Dr. Frome is getting at is that if there is a chronic bronchitic then a large dose of oxygen will kill them, he may feel the risk outweighs the advantages.

Mr. Ritson: Dr. Frome is very non-specific. He doesn't answer the question of the emergency situation which is what Mr. Laver wants to know.

They decided that nurses should only use oxygen in emergencies on the understanding that a doctor should immediately be informed. However, it came up again in March:

Dr. Henley: This was not satisfactorily disposed of at the last meeting. The minute reflected what we decided but since then I have realised a lot of refinements to our discussion. Dr. Frome had stated an opinion in his letter but that was not shared by a lot of the members. I came across Dr. Frome being interrogated by Dr. Hebble and I joined in and he amplified on what he said. I tried to get some middle of the road on this and spoke to Dr. Gregor, Dr. Ashton, Dr. Gilbert and Dr. Pearce and they all seemed to think that Dr. Frome's view was extreme and that it needed to be watered down. There are also points of difference on the use of 100%, 30% and 24% oxygen. I think that the clinical discussion was a mistake for this committee and that it should have been sent to the individual

divisions. The question has several answers depending upon where it is implemented. Where we draw the line between emergencies and non-emergencies completely defeats me. Professor Alexander concurs with me in thinking that the individual units should make it clear what they want done. I get the impression that there is a good case for letting the nurses administer 24% oxygen and then call the medical staff immediately. Do you want to discuss it further? I think we need to be more precise than we were last time.

Dr. Hebble: I would just say that I do not think this is the place to give instruction to medical units, for example, with respect to concentration, I would feel unhappy if I received instructions from this committee. I don't think it is a question of deciding but rather giving an answer to the Nursing School, I think the answer should be somewhere along the lines you have suggested.

Professor Alexander: I think it is wrong to hamstring nurses so that they can do nothing in a state of emergency. If they feel that a patient needs oxygen then they can give it with a Venturi Mask with less than full strength oxygen, then there would be no danger even to a bronchitic. We ought to satisfy and encourage nurses that they can do something, and thereby foster individuality and responsibility.

Dr. Henley: If we look at the previous minute we could add a sentence on the Venturi Mask and 24% oxygen.

They therefore decided to make a general recommendation as to the concentration of oxygen and the use of a Venturi Mask but they left the precise details to the individual units and divisions. From the point of view of the Nursing School this was not particularly useful. Nurses in training spent relatively short periods of time in the various units in the hospital and from a teaching point of view it was undesirable that each unit should have a different policy regarding the emergency use of oxygen. Certainly there was some difficulty in differentiating emergencies from non-emergencies but the chairmen seemed unhappy about making a general ruling because it would entail telling specialties what to do:

'I think that the clinical discussion was a mistake for this committee and that it should have been sent to the individual divisions.'

'Professor Alexander concurs with me in thinking that the individual units should make it clear what they want done.'

'... I do not think that this is the place to give instruction to the medical units, for example, with respect to concentration, I would feel unhappy if I received instructions from this committee.'

Once again the chairmen appeared to be unwilling to impinge upon the autonomy of the individual specialties to decide what they wanted to do.

Conclusion: Overton Hospital

The first half of this chapter has examined the way in which the Committee of Divisional Chairmen in Overton Hospital dealt with specialty or divisional requests which are internal to the profession. The results of interviews with consultants and chairmen have been reported. Particular decisions have been analysed and the main issues covered were requests for junior and consultant staff, medical moveable equipment, the Higher Medicine Fund and aspects of medical practice.

It was argued in Chapter 3 that the position of chairman involves a role conflict between representing divisional requests and opinions and making decisions on the basis of hospital or broader service criteria. It was suggested that three characteristics of specialisation might influence the solution of this role conflict: lack of inter-specialty knowledge, the professional value of specialty autonomy and status differences between specialties. This section has tried to analyse the extent to which these factors did influence decision-making in the areas listed above.

The interview data support some aspects of this argument. Twenty-nine of the forty-two consultants interviewed thought the main feature of the chairman's job was to represent divisional requests to the

Committee of Divisional Chairmen and the administration. Twenty-one of the twenty-five non-chairmen thought their chairmen should push their case strongly when they brought something up which they had decided. There was therefore a good deal of pressure on the chairmen to represent their own specialty interests. This was reflected in the fact that ten of the fifteen present and past chairmen thought their division expected them to get what they wanted and nine of them thought their own position on the committee was to push their own division (three of these also said that they were on the committee to make decisions for the whole hospital as well). Within this, however, a number of chairmen said that they tried to present divisional requests in terms of the needs of the hospital, although this was not always strictly the case.

It therefore appeared that many of the chairmen were aware of the contrasting expectation of representing specialty interests and looking at issues from the viewpoint of the hospital, and that many of them tended to give more weight to the former than the latter. In addition, both ordinary members and chairmen doubted the extent to which chairmen in other specialties could come to the right decisions about their problems because of lack of inter-specialty knowledge. A minority also said that this would be inappropriate because it would involve interference with another specialty's business.

The interview data therefore suggested that there was some perception of role conflict, but for chairmen, the specialty representation expectation was more in their minds than the broader expectation which the Joint Working Party reports anticipated for the committee (1,2,3). They also had doubts about the extent of inter-specialty knowledge and the problem of impinging upon the autonomy of other specialties.

In terms of the operation of the system, the Committee of Divisional Chairmen did not impose any structure upon the way in which it wanted requests to be processed and presented by divisions. It was prepared to deal with all requests or proposals whether they had been discussed by the division concerned, or just submitted by a consultant, whether

they were accompanied by a pre-circulated memorandum containing detailed arguments and supportive figures, or just came up under 'Any Other Business' in the form of a brief note read out at the meeting. In general the committee was loathe to tell specialties how to deal with requests and in what form they should be presented to the committee. The autonomy of specialties was thereby left intact.

There was also some ambivalence about the way in which requests should be dealt with. Ultimately the priority between requests for staffing and equipment has to be decided by someone. For all staffing requests priorities have to be decided at the area level, before they are submitted to the Scottish Home and Health Department. At the area level choices have to be made between requests from the districts in the area. Comparisons at that level have to be made between specialties both within and between districts. In Lennox the Area Medical Committee appointed a sub-committee of the five chairmen of the District Medical Committees to do this, and Dr. Henley was on this sub-committee. He therefore had to take part in this decision with no knowledge from the Committee of Divisional Chairmen as to which of the requests for junior of consultant staff were most important to the district. No doubt he made some assessments but these were his own rather than the committee's and they were combatted from the other districts.

The previous chairman recognised the need for a more detailed consideration of such requests by the Committee of Divisional Chairmen when he said, just after yet another request had been automatically agreed to, 'there is a problem of priorities. We are at present recommending things on a piecemeal basis. We should be looking at relative priorities, that should be our ideal.' But the committee showed no enthusiasm for this idea. Throughout the period of research they therefore dealt with staffing requests on a piecemeal basis. All requests were agreed to more or less automatically and irrespective of their lineage, in terms of whether the division had considered them and whether supportive information was presented. This is consistent with the potential influence of both lack of

inter-specialty knowledge and a mutual desire to protect specialty autonomy. Which was more influential?

In the interviews, both chairmen and non-chairmen had doubts about the extent of inter-specialty knowledge among chairmen. Many of them made the point that because of this the committee was dependent upon the chairman concerned for guidance. However, in the vast majority of staffing requests guidance was rarely given or asked for. This suggests a concern with specialty autonomy and a desire to refrain from questioning a specialty's wishes in any way. There was also a large element of self-preservation in this as the case of the J.H.M.O. indicated. A reason had to be given for not taking a fairly straightforward administrative step, and it was not because of the evidence but because '... it would create a precedent if we go against the Psychiatric Division, it could happen to any of us, if we bring something up then others could reject it.' This suggested a paramount concern for the preservation of specialty autonomy. Subsequently the decision was changed but only after the presentation of insurmountable evidence from the area and the Scottish Home and Health Department.

While priority decisions were avoided in staffing this was not possible in relation to medical moveable equipment and the Higher Medicine Fund. In the former, the money was provided on a district level and the buck stopped there - they had to do it. In the case of Higher Medicine, the final decision was made at the regional and latterly the area level, and the committee at that level insisted upon a priority ranking. The Committee of Divisional Chairmen did this with some reluctance. In both these cases it was not possible for all specialty requests to be given equal support, choices had to be made between them. For medical moveable equipment a sub-committee was used to make the decisions and the physicians had a favoured position with respect to its membership. The process of the sub-committee was not observed but in terms of composition of the sub-committee the physicians and to a lesser extent the surgeons had opportunities for influence which other specialties lacked. This was partly because the other specialties expected them to have

greater influence and also the physicians seemed to expect this.

For Higher Medicine, the process of decision-making was observed. In one year the whole committee considered the submissions, and the chairman of the Medical Division pressurised the committee more than the other chairmen with requests, and the other chairmen seemed to think, right from the start, that medicine should have highest priority. The Surgical Division request was financed from routine funds. The following year the decision was made by a 'surprise' sub-committee. The physicians again came out best, and once more the surgical request was funded from alternative sources. Therefore when choices had to be made and priority decisions could not be avoided in the allocation of resources, the relative status of specialties did have an impact upon the process, with medicine, and to a lesser extent surgery, benefiting to the exclusion of the other specialties.

It was suggested in Chapter 3 that the interest groups which the divisional system creates might act in the same way as political pressure groups - particularly in competing for scarce resources. In the case of medical moveable equipment and Higher Medicine resources were being competed for and medicine and, to a lesser extent, surgery either did best or had most opportunity for influence. In both cases the decisions were made within committees rather than through lobbying individuals not involved. It appeared that this occurred through their higher status and the regard for them within the profession as much as direct lobbying on their part. In the Higher Medicine allocation the physician's first choice became the hospital's first choice without pressure and mainly through Scott's 'deference boon' (4) and Friedrich's 'law of anticipated reactions' (5). These concepts also seemed to explain the favourable position of both medicine and surgery on the sub-committees to determine the priorities for medical moveable equipment. In both cases, however, the physicians wanted more than that granted to them out of deference, so in Higher Medicine even thought the first medical priority had become the first hospital priority, the chairman wanted the other medical priorities to be above some of the single requests from

other specialties - and he was partially successful in arguing for this.

Finally, discussion of specialty medical practice was very limited, the chairmen were unwilling to give orders to specialties as to how they should undertake their clinical practice. The theoretical role conflict implied by the purpose of the Committee of Divisional Chairmen was therefore solved in a number of ways, none of which embodied the expectation of making decisions on the basis of hospital or service level considerations. First of all, priority decisions between specialties were avoided if at all possible. The influence here seemed to be a reluctance to compare specialty requests due to a concern with specialty autonomy and, from the interview data, lack of specialty knowledge. Secondly, in the treatment of requests on a piecemeal basis agreement was always forthcoming, again a concern with specialty autonomy seemed to deter chairmen from questioning requests or asking for justification. Thirdly, in those cases in which priority decisions could not be avoided and a decision had to be made between specialties, the relative status of specialties appeared to have a greater impact upon the process than the consideration of proposals in the light of their purpose or broader service considerations. In this process medicine and surgery seemed to benefit.

ALLAN HOSPITAL

Allan Hospital did not have a Committee of Divisional Chairmen and decisions relating to specialties did not necessarily occur at the hospital level in the Medical Staff Association. As with Overton Hospital the interest is with the way in which specialty requests and proposals are handled and the extent to which lack of inter-specialty knowledge, a concern with specialty autonomy, and specialty status differences have an impact upon this.

Before looking at specific cases there are some interview data which throw light upon the way consultants see specialties within the

Medical Staff Association (the responses are once more from the 27 consultants who were interviewed). The first of these asked, Do you think that the Medical Staff Association plays a useful part in solving problems in your specialty? The response was:

Yes	5
No	20
Don't know	1
Maybe	1

A number of those answering 'No' said that the Staff Association was only used supportively, because this gave specialty requests more weight than if they came from the specialty alone.

The next question asked specifically about inter-specialty knowledge: Do the other consultants know enough about your specialty to come to the right conclusions about problems that you raise? The response was:

Yes	4
No	22
Maybe	1

The comments of those who answered that consultants in other specialties did not know enough were all very similar, for example:

'Oh no ... my specialty now is too specialised ... I mean I know nothing about the problems of the Orthopaedic Department.'

'No, any more than I can start telling them what to do in medicine or anaesthetics.'

'They haven't a clue what we're up against.'

There was another question which was covered in the last chapter but it is also of some interest here. It was: What about occasions when other consultants make suggestions or proposals, do you find it easy to comment and decide what should be done? Among the 27 consultants, 18 found it difficult to comment and most of these said that it was due to lack of inter-specialty knowledge.

The responses to these three questions indicated that consultants had doubts about the extent to which useful comments could be made about requests or proposals from other specialties or their own specialties. In view of this, how did the Medical Staff Association and higher levels of the structure deal with the types of requests and proposals which the Committee of Divisional Chairmen dealt with at Overton? Some of these issues were partially covered within the last chapter in relation to individual consultant autonomy but the main aspects of this and some additional material will be reported below. The matters dealt with are requests for additional junior and consultant staff, medical moveable equipment and the control of professional practice.

Specialty Requests for Additional Junior Staff

This was discussed in the last chapter. The Medical Staff Association showed no interest in dealing with specialty or individual requests for additional junior staff. The District Medical Committee was equally ambivalent about discussing such requests as the following discussion in November 1974 indicated:

Dr. Tilt: There is a letter from the Scottish Home and Health Department on junior staff increases and we will be allowed a 3% increase although that is across the board for Scotland.

Dr. Quarry (District Medical Officer): To put that in perspective that amounts to two or three posts.

Dr. Cally: What will happen to the unit requests will they just go to the area and not to the district?

Dr. Quarry: They will go to the District Executive Group first.

Dr. Lyon: Who will decide the priority?

Dr. Tilt: The Chief Area Medical Officer with medical advice, that is his job to take these decisions. The only objection we can have is if we are not consulted, if they do consult us then they either do take or don't take our advice.

Dr. Cally mentioned unit requests in this context and these were requests from individual specialties which had been sent direct to

the administration by the specialties concerned. In this discussion the District Medical Committee showed no desire to be involved in the screening process in a central way. As a result all the medical committees were overtaken by events as the Executive of the Medical Staff Association learnt when it met on the 6th January 1975:

Dr. Aldis: On junior staff requirements the administration seem to have jumped the gun and advertised the posts already.

Mr. Earn: Really, I don't believe it.

Dr. Aldis: Dr. Mathew, the Chief Area Medical Officer, wrote to the two Community Medicine Specialists for Acute Services, Dr. Maldern and Dr. Fern, asking them for their views and they came up with a registrar in general surgery at Kenmore, a registrar in accident and emergency here, a registrar in paediatrics for the area and a registrar in ophthalmology for the area. They passed their views on to Dr. Mathew and they have been advertised. There is a question of whether we should accept this, I would have thought that it should have come to us and then to the Area Medical Committee.

Dr. Carrock: Maybe they were short of time.

Mr. Earn: I wonder how they arrived at this list.

Dr. Aldis: Priorities are very hard to arrive at.

Mr. Earn: Oh yes.

Dr. Aldis: It is easier to do it by dictate than agreement.

Mr. Earn: But it would have appeared that they have not consulted the medical staff. The alternative to that in arriving at priorities is to look at the workload and if they haven't done that then how did they arrive at the priorities? I suggest that we ask Dr. Maldern how they arrived at the decision.

This was done at the meeting of the whole Medical Staff Association, immediately following that of the Executive:

Dr. Aldis: How did you decide, did you look at the workloads?

Dr. Maldern: Oh yes we looked at the workloads, we looked at

everything, how long the requests had been in, everything.

Dr. Lyon: I thought the Area Medical Committee would have been involved in this.

Dr. Maldern: The chairman was involved.

Dr. Lyon: With respect, he is a general practitioner and he doesn't know anything about the hospital.

Dr. Cally: It is up to us to decide if the advisory committee should come in or if it should be left to the area executive and the department concerned.

Dr. Lyon: But the decision was taken without any discussion at all.

Dr. Cally: I think Dr. Maldern has got the idea and the representatives on the Area Medical Committee can take this view forward and request Dr. Mathew to offer such decisions to the Area Medical Committee for comment.

Dr. Aldis: Shouldn't it be the other way round, the priorities of the Area Medical Committee should be put to the Chief Area Medical Officer?

Dr. Cally: Well I know a bit about this and the Area Medical Committee is very rambling and it's impossible to decide priorities. I think it's a matter for the community physicians to discuss it with the departments concerned and make recommendations to the Area Medical Committee. I think Dr. Lyon was expressing a general view when he said that there should be discussions.

The community physicians were then asked to explain themselves at the next meeting of the Area Medical Committee in January 1975. They stated that the Chief Area Medical Officer had asked them to do this and the point was made that it was his job to refer it to the Area Medical Committee as well. The consultants on the committee finished off the discussion with an interchange about their main concerns:

Mr. Struan: Many of my colleagues are unhappy with the way this was done.

Dr. Tidy: All you want to say is that we should have been consulted.

Dr. Lyon: I feel we should be.

Dr. Tilt: I think the moral of it is that if you have an Area Medical Committee then it is entitled to be asked.

Dr. Cally: It seems to me quite a good idea that the officers take their information from the divisions and then ask for our views rather than have a free-for-all on this committee.

Mr. Struan: Under the circumstances I think the medical officers have done a good job but justice not only has to be done it has to be seen to be done.

Throughout this discussion members of the committees seemed to be rather ambivalent about their precise role in deciding the priority between requests for junior staff, or indeed how they should be dealt with at any level. The individual specialties had continued the practice of sending their requests to the administration and so requests had not come direct from the medical staff to the Staff Association, the District Medical Committee or the Area Medical Committee. In the initial discussion by the District Medical Committee they knew that requests were being considered and thought that they would probably be consulted but they made no move to express any opinion as to how they would like this to be done. Two months later the Staff Association heard that the decision had already been taken. There were two views as to how the consultation should have taken place. The secretary of the Staff Association, Dr. Aldis, seemed to think that the priorities of the Area Medical Committee should be put to the Chief Area Medical Officer and Dr. Cally, chairman and member of the Area Medical Committee, said that it should be the reverse. Dr. Cally also thought that the Area Medical Committee would be unable to do this and it would be better if the community physicians discussed each specialty's request with the members of that specialty alone and then made a recommendation

to the Area Medical Committee. He expressed this view again at the meeting of the Area Medical Committee:

> 'It seems to me quite a good idea that the officers take their information from the divisions and then ask for our views rather than have a free-for-all on this committee.'

Nobody disagreed with this, the main concern of the other members was that some consultation should have taken place. What Dr. Cally wanted to avoid was a discussion in which the competitors would be arguing about the priorities of their own requests. He wanted the initial decision to be made outside the Medical Advisory Structure through consultation between community medicine and individual specialties with requests. The main concern here was to avoid the role conflict involved in this decision by placing the decision outside the structure in the first instance with specialties acting through an intermediary. Another interesting point is that it was Dr. Cally who requested the post of registrar in paediatrics for the area and even he, as chairman of the Medical Staff Association, chose to send it direct to the administration.

Specialty Requests for Additional Consultant Staff

This subject was also covered in some detail in the last chapter because the matter only arose once but it did indicate the way in which they saw this decision in relation to specialisation. As with the requests for additional junior staffing, specialties wrote off direct to the administration rather than using the Medical Staff Association as a first stage. All discussions took place at the Area Medical Committee. The Area Community Medicine Specialist on Manpower Planning told the Area Medical Committee that the Chief Area Medical Officer had plans for twelve additional consultants in the next year. The consultants' concern to be involved was expressed in the following exchange:

Dr. Lyon: Dr. Baird says they are looking at additional consultant appointments, is it conceivable that the Hospital Sub-Committee (comprising the hospital members of the Area Medical Committee) could look at the list?

Dr. Tilt: I think the Chief Area Medical Officer has the final word on this.

Mr. Struan: It is the existing consultants who would put forward the cases and it would be coming to them for a decision, perhaps it would be best if it went through an intermediate step, through community medicine for an unbiased viewpoint.

This expressed a very similar attitude to that which came out in relation to junior staffing priorities. That is, the members of the committee would be in competition and therefore it would be better if someone who was unbiased looked at the priorities. This was a relatively straightforward way of avoiding the role conflict. However, by the next meeting there seemed to be a change in how members of the Area Medical Committee wanted this to be done:

Dr. Baird: ... We have five consultants up for consideration already but we would like your priorities for the next twelve.

Mr. Braden: You say all staffing is bad but thoracic surgery isn't even mentioned on your list and that is even worse.

Mr. Struan: I would like the Hospital Sub-Committee to discuss this, I think the thing is that these posts have to be competed for and each specialty should gather information to put forward.

Dr. Tilt: I think you will have to co-opt people so that all the specialties are represented.

This time the view of a competitive situation was expressed again, however, the solution was rather different. The Hospital Sub-Committee was not selected on a specialty basis. The members were the hospital members of the Area Medical Committee and they had been elected by the Medical Staff Associations in the area. They were not on the committee for their specialty affiliations but for their hospital affiliations, and as such they had no specific mandate to represent the interests of their own or any other specialty. In the previous discussion the committee had recognised that the

members might be hard pressed not to represent the interests of their own specialties and that community medicine was one way out of this dilemma. However, on the second occasion it was suggested that all specialties with a request should have a member on the committee. While this may have overcome the bias of those already on the committee it did so by giving everyone a legitimate bias and turned the decision into an openly competitive one. As soon as a priority decision came up which required some mediation between specialties the nature of the Hospital Sub-Committee was changed. While this solved the role conflict for the members it changed the basis of the decision into one of open competition.

Request for Medical Moveable Equipment

Prior to reorganisation this had been handled by the Medical Superintendent and the Pharmacist had played some part in collating the requests. The Medical Staff Association had to deal with it for the first time in 1974-5 when the District Finance Officer gave the full list of requests to the Medical Staff Association Executive. The decision had to be made quickly and the Executive met with the Prescribing Committee to determine the priorities. However, the Executive had to ask the whole Staff Association if this was a good way to do it and the Executive discussed this on the 3rd February 1975:

Dr. Aldis: Previously this was left to the Medical Superintendent, it is now suggested that this should be a joint affair decided by the Medical Staff Association. When it cropped up in September, Dr. Cally suggested that this should be a matter for the Executive and the Prescribing Committee because these together represented all the specialties. They met with Mr. Meacher (the Finance Officer) and decided the priorities. It is a question of whether the Staff Association wants this to happen in the future. I would have thought the Executive was alright with representatives from interested parties ... Although Dr. Cally still thinks the Prescribing Committee should be involved.

Mr. Fillan: We don't want any more committees.

Mr. Earn: It appeared to work though.

Dr. Aldis: The combination of the Prescribing Committee and the Executive was a bit large.

Mr. Earn: It is important to have all the specialties represented though. I wouldn't for instance know the priority of a respirator but we had a good cross-section of the amalgam of the specialties. Although I could speak for the surgical staff.

Dr. Cally: I think the Prescribing Committee is a sub-committee of the Executive and the combined committee wasn't huge.

Dr. Aldis: It is not what it was set up for though, it has a different function.

Dr. Cally: My feeling was that when we broadened it to the Prescribing Committee we had representation from most of the specialties and if you then include the people who have an interest, well if someone puts in a request then they don't want it turned down by an anaesthetists or a pathologist whereas if they are involved then they can argue for it ... If you are competing for equipment then it should be handled at the hospital level.

Dr. Carrock: District level.

Dr. Cally: Well a certain amount of finance is handed to the hospital. I think the issue is that someone comes up with a list of priorities and this is at hospital level. Do you want Mr. Meacher or Mr. Dangerfield (the pharmacist) to approach the Staff Association or do you want the Prescribing Committee to go over it first?

Dr. Aldis: It is not a remit of the Prescribing Committee, it should come straight to the Staff Association.

Mr. Earn: I agree, provided the interested parties are invited along. Previously the Medical Superintendent did this, don't you think the Executive takes over this function? We could ask Mr. Meacher to give us a list in say December and June so that we are ready with the priorities when the allocation is made.

Dr. Cally: Why I am speaking on this is because I am on both committees and it doesn't matter to me. I think the problem with the big items is that some people will say it's the same people making the decisions all the time.

Mr. Earn: But the Executive is the Executive and the Prescribing Committee is the Prescribing Committee. I can see them as different.

Dr. Cally: Well committees deal with things that are sent to them and Mr. Dangerfield sent the list to the Prescribing Committee and they looked at it. Next time should we ask him to send the list to the Executive?

The meeting ended there and Dr. Cally reported to the Staff Association immediately afterwards:

Dr. Cally: We used to write to the Medical Superintendent with our requests for Medical Moveable Equipment but now he is gone a lot of the requests find their way to Mr. Meacher and he requires an idea of the priorities. He passed them to Mr. Dangerfield, who, as a member of the Prescribing Committee, raised them there and they looked at the priorities with the Executive. That was this year and it had to be done in a hurry. This was discussed at the Executive and it was felt that the priorities should not go to the Prescribing Committee but to the Executive of the Staff Association and they would co-opt anyone with a request. The Prescribing Committee was brought in to caste the net wide over all the specialties but the Executive gets close to that, provided the people with requests can attend it should be reasonably fair.

There were good reasons why the Executive Committee and the Prescribing Committee had both been involved in this decision, Mr. Dangerfield, the pharmacist, was involved because of his role in co-ordinating requests and the Executive felt it should be involved because of its position in the hospital. However, many members of the Executive thought it was a strange combination because of their distinct functions. The chairman, Dr. Cally, thought that it had

the positive virtue of representing all the specialties, indeed the secretary, Dr. Aldis, suggested that this was why the two committees had been combined:

'... Dr. Cally suggested that this should be a matter for the Executive and the Prescribing Committee because these together represented all the specialties.'

And even those who were against the combination on functional grounds thought that this had positive virtues because of the problems of inter-specialty knowledge, as Mr. Earn said:

'It is important to have all the specialties represented though. I wouldn't for instance know the priority of a respirator but we had a good cross-section of the amalgam of the specialties.'

and Dr. Cally also saw this in terms of specialty autonomy:

'... well if someone puts in a request then they don't want it turned down by an anaesthetist or a pathologist whereas if they are involved then they can argue for it.'

The compromise solution was to use the Executive Committee and co-opt members of the Staff Association with requests to take part in the decisions. Therefore on the one occasion when the Executive of the Staff Association had to adjudicate between specialties in an impartial fashion it found it impossible to act in this way, both because of lack of inter-specialty knowledge and a fear of specialties denying one another's requests. The reaction to this was to make the committee more partial by co-opting all of those with requests. While this solved the Executive's dilemma it moved further away from the Brotherston ideal.

Patient Care Evaluation and the Control of Clinical Practice

There was no discussion of this by the Medical Staff Association or its Executive apart from that which was covered in the last chapter. The two issues dealt with there concerned responsibility for patients in the Intensive Therapy Unit and the responsibility of anaesthetists for cardiac arrests. No firm proposals were forthcoming in either

discussion apart from the 'immediate' notification of consultants as soon as a patient of theirs was admitted to the unit.

Conclusion: Allan Hospital

This section has been concerned with the way in which the structure at Allan Hospital dealt with specialty issues. Responses of consultants to questions about the Medical Staff Association have been presented and the way in which the structure dealt with requests for junior and senior staff and medical equipment and matters relating to specialty medical practice have been described and analysed.

The theoretical arguments presented in Chapter 3 about the role conflict inherent in the position of chairmen of divisions are less applicable in this case because Allan did not have a Committee of Chairmen. Each member of the Staff Association may experience role conflict with respect to specialty requests in the sense of having to make broad judgements and look to his own interests as well. However, the position of members of the Executive Committee is rather different. Members of the Executive were elected and they happened to belong to particular specialties, but unlike the chairmen of divisions they had no mandate to represent the interests of their own specialties, although they might of course attempt to do this.

However, the Medical Staff Association and its Executive are the hospital level of the Medical Advisory Structure and it would therefore be anticipated that they would take on the function of deciding whether specialty requests should become hospital requests and examining problems and proposals which specialties might raise. At the same time the characteristics of specialisation, lack of inter-specialty knowledge, specialty autonomy, and differential specialty status, may still influence the way in which decisions are handled.

The interview data suggested that this was the case. Of the 27 consultants interviewed, 20 did not think the Medical Staff Associa-

tion could play a useful part in solving problems in their specialty. This was echoed in the fact that the specialties did not use the Staff Association to vet or gain support for their requests for either junior or senior medical staff. Instead they wrote direct to the administration. The interview data suggested that this was because of a lack of inter-specialty knowledge, 22 of the consultants did not think consultants in other specialties knew enough about their specialty to comment upon problems they might raise. In addition, 18 of the consultants said they found it difficult to comment on matters raised by other consultants and most of them said that this was also due to lack of inter-specialty knowledge. Even when these issues came up at the Area Medical Committee consultants were rather ambivalent about how the requests should be dealt with. Partly in terms of whether they advised the Chief Area Medical Officer as to the priority order, or the Chief Area Medical Officer got them to ratify his decision, and also how the consultants should make the decision. The chairman of the Allan Staff Association was in favour of the community physicians discussing requests with the specialty concerned and thereby arriving at a list of priorities, rather than have the Area Medical Committee or its Hospital Sub-Committee make the decision. This was in relation to junior staff and the committee seemed happy to accept this way of doing it, as long as they were consulted. However, this took the decision outside the structure with the specialties competing with one another through the intermediary of community medicine.

A similar attitude was expressed with regard to additional consultant staff, they seemed happy for the Chief Area Medical Officer to make the decision and it was only when they were asked to discuss priorities that they began to consider how this might be done within the structure. The obvious forum was the Hospital Sub-Committee and the members were not on the committee because of the specialties they belonged to, they derived from the Medical Staff Associations of the hospitals in the area and happened to be members of particular specialties. This was the first time the impartiality of the structure would have been put to the test and yet they decided they would have to '... co-opt people so that all the specialties are represented',

thereby insuring that people would be on the committee because they belonged to particular specialties.

A similar process occurred with the requests for medical moveable equipment. The Staff Association had not made it mandatory for requests to be submitted to it once the Medical Superintendent post had come to an end. Instead the Pharmaceutical Committee and the Executive Committee became involved with the perceived virtue of covering most of the specialties. This had been a rush job and the Executive had to decide how it would be done in future years. One of their concerns was lack of inter-specialty knowledge and the other was specialty autonomy. They felt that members of a specialty might object to having a request denied if the denial came from a member of another specialty.

Again the impartial nature of the committee was found wanting the first time it was tested. The consultants had decided against divisions and rejected a structure based upon specialty and yet they modified the Executive along specialty lines for the purpose of decisions about medical moveable equipment where choices had to be made between specialties. In this case they decided to invite along those consultants who had requests to take part in the decision. Like the Hospital Sub-Committee at the area level they removed the vestigies of impartiality. Again this paved the way for open competition between those with interests in the decision.

Finally, the Staff Association and its Executive showed no inclination to evaluate specialty practice. The issues which might have required some attempt to shape specialty clinical responsibility concerned cardiac arrests and the Intensive Therapy Unit but the Association did not wish to make a general ruling on these which told specialties what they should do.

Specialties did not use the Staff Association for their requests for additional staff. They by-passed it and sent them direct to the administration. The main reason for this appeared to be the opinion among consultants that other specialties did not know enough about

their specialty to be in a position to comment. At the same time, even if this was the case, specialties were not even prepared to give other specialties the opportunity to comment. At the higher level of the Area Medical Committee at which the making of priority decisions was discussed the approach of the consultants became clearer. They were chary of discussing priorities between different specialty requests because of a role conflict between the presentation of these requests and making the broader decision for the area as a whole. They feared that because each hospital member of the Area Medical Committee happened to belong to a specialty then the first element of the role conflict would take precedence. They put forward two solutions. One was to let each specialty discuss its own requests with community medicine specialists and let them arrive at a conclusion on the basis of a series of separate discussions. The other was to involve all the specialties and thereby make the representation of specialty interests legitimate and turn the decision into a competition between the interests. Both of these alternatives indicate that the characteristics of professional specialisation made it difficult if not impossible for them to take on the broad unbiased advisory and decision-making role which the Joint Working Party proposals had planned for them. Medical moveable equipment produced a similar response. They changed the basis of their structure from one in which specialty was not a criterion of committee membership to one in which a specialty stake in the decision was a criterion of participation and thereby the decision became legitimately competitive.

MEDICAL ADVISORY STRUCTURES, MATTERS INTERNAL TO THE PROFESSION AND SPECIALISATION: THE EXPERIENCE AT OVERTON AND ALLAN

In this chapter the way in which the Medical Advisory Structures in the two hospitals dealt with matters internal to the profession at the specialty level has been analysed. The general aim has been to assess the extent to which decision-making is affected by the characteristics of specialisation.

The level at which specialty issues are discussed in a broader context is the Committee of Divisional Chairmen at the hospital level,

according to the first Joint Working Party report. The members of the committee are the chairmen of the individual specialty divisions. The purpose of the committee is to deal with matters of medical policy which have implications for more than one specialty and deploy resources in an effective manner.

It was argued in Chapter 3 that these functions and the role of the chairman of a division result in a role conflict between (a) representing the interests of the specialty and (b) making decisions in the light of the service as a whole at the hospital level. At this level the structure is concerned with specialties and it was argued that certain features of specialisation in medicine might affect the way in which this role conflict was solved. The first of these was lack of inter-specialty knowledge. It was argued that chairmen would not know enough about other specialties to comment upon their proposals and that therefore they would tend to agree with what other chairmen said in the context of their own specialties. In this way the expectation of representing specialty interests would be the solution to the role conflict. The second feature was specialty autonomy. It was suggested that specialties have developed as autonomous units and that a member of any specialty is unwilling to comment upon features of practice in other specialties. If chairmen were unwilling to comment critically upon proposals from other divisions then this would also favour the first expectation. The third feature was differential specialty status. It was argued that the committee would not always be able to grant every single specialty request and that choices would, on occasion, have to be made between specialties. In view of the influence of the other two characteristics it was suggested that such decisions would tend to be based more upon specialty status differences than the relative validity of the requests.

It should be remembered that Allan was not the same as Overton, the hospital level of the Medical Advisory Structure in Allan was the Medical Staff Association and its Executive, rather than the Committee of Divisional Chairmen. It was clear in Chapter 6, which described the development of the structure in Allan, that the Medical

Staff Association wanted to avoid giving members of the Executive a mandate to represent their own specialties, because of the number of interests which wanted to be represented, and therefore the members were selected for their personal characteristics. In this sense the role conflict inherent in the position of chairmen was not inherent in the role of a member of the Executive (although in personal terms they might have to weigh up the interests of their specialty with those of the hospital, but they were not members because of their specialty affiliation).

However, members of the Medical Staff Association were there in an individual and specialty capacity and the role conflict in specialty terms was inherent in their position. They could legitimately press for their own interests but at the same time they had to arrive at decisions in the light of broader criteria if the structure was to fulfil the functions outlined by the Joint Working Party proposals.

This level of the structure is particularly important because it is intended that narrower specialty interests and perspectives are mediated by broader consideration of the service provided by the hospital as a whole. If the structures operated as proposed it would therefore be expected that specialty requests for additional staff and equipment would be considered in a broader light both as individual requests and relative to requests from other specialties, particularly when choices will be made between the items at a higher level.

The issues discussed in this chapter have been described as 'matters internal to the profession' and stem from, or directly relate to, specialty practice. The decisions which have been analysed have been requests for junior and senior medical staff, equipment and patient care evaluation and the practice of medicine.

On the surface the way in which the hospital level of the structure dealt with these issues varied considerably in Overton and Allan. In Overton specialties went to the Committee of Chairmen to get support for their requests for junior staff before they were passed

up to a higher level. In Allan, the specialties by-passed the Medical Staff Association and its Executive and sent their requests direct to the administration. Consultants did not seem to want the Association to take on a dominant role in considering these requests. The Medical Advisory Structure was involved to a greater extent at the area level but the point is that in Allan requests for junior staff were not screened by the hospital level of the structure. In Overton the Committee of Divisional Chairmen considered the requests but it imposed no standards upon the method of presentation and all the requests were agreed to and sent up to the area level. While the process was different in the two hospitals and in Overton the structure was used as proposed in formal terms, this made no effective difference to whether or not the requests reached the area level.

The same was true of requests for consultants in the two hospitals. Overton used the structure, Allan did not, but all the requests in both hospitals reached the area level.

In terms of outcome alone and the role conflict between specialty interests and broader considerations, the former was fulfilled on every occasion. It may be that all the requests were fully justified in their broader service implications, but the process at Overton did not enable them to find out if this was the case. Why did the doctors in the two hospitals take these courses of action rather than put every request through a birth of fire?

The interview data in both hospitals indicated that consultants and chairmen felt that members of other specialties did not know much about their specialty and vice versa. This was one reason for chairmen at Overton being unable to comment upon requests for additional staff, and specialties at Allan feeling that the Staff Association was not an appropriate forum for discussing such immediate specialty concerns. In Overton, specialty autonomy also played a part when the Committee of Divisional Chairmen had to give a reason for going along with a specialty in the face of all the evidence. The reason was:

'... it would create a precedent if we go against the Psychiatric Division, it could happen to any of us, if we bring something up then others could reject it.'

The value of specialty autonomy was a relevant consideration here and presumably to have gone against any specialty in any of the contexts involving requests for additional staff would also have created this precendent. This was also evident in the case of the replacement for the chest physician which had been delegated to the Medical Division. It was obvious that their decision had severe implications for other sections of the service but the committee was unwilling to tell the Medical Division that its decision was unacceptable.

In Allan there was more emphasis upon the lack of inter-specialty knowledge and at the area level the desire seemed to be to remove all possibility of other specialties commenting upon requests, or, as a last resort, letting all the specialties argue it out by co-opting additional members. However, at the hospital level in both Allan and Overton there was no deep consideration of the individual or relative merit of requests for additional staff. Overton went through the motions, Allan ignored them, and lack of inter-specialty knowledge and a concern for specialty autonomy played a large part in these outcomes.

However, the structures could not avoid the question of priority in relation to equipment. How did they make these decisions? In Overton relative specialty status did appear to have an impact upon priority decision-making. For medical moveable equipment, a sub-committee made the decisions and the physicians and to a lesser extent the surgeons had advantages in membership of the committee. For Higher Medicine medicine and surgery did best in terms of getting what they wanted, medicine by becoming top priority and surgery by being funded from other sources. In both cases the physicians seemed to expect to have advantages and other specialties seemed to think that they should have advantages. These two forces combined to give them advantages.

In Allan, on the other hand, where they had been careful to avoid specialty representation because of the mandate it gave the representatives, the structure was unable to make the decision. On the first occasion, admittedly under duress, they used the Executive of the Medical Staff Association and the Prescribing Committee to make sure the whole range of specialties was represented because they felt the lack of inter-specialty knowledge and a concern with specialty autonomy made the decision impossible. To overcome these problems they decided that in future the Executive would be augmented by members of specialties with requests. This changed the basis of membership and made specialty representation the major legitimate stance of those involved. In this case the decisions were not observed and it was impossible to tell whether they were influenced by the relative status of specialties rather than the merits of individual cases.

In relation to patient care evaluation and the nature of specialty practice there was limited discussion and in that which took place there was no willingness to tell specialties what to do.

In terms of the theory chairmen at Overton seemed to experience the role conflict inherent in the structure or seemed to see specialty representation as the dominant expectation. The structure reflected this by agreeing to all requests for staff with limited discussion. This was partly due to lack of inter-specialty knowledge and thereby, as they said in the interviews, reliance upon guidance from the chairman concerned, but in these cases they did not even ask for guidance and this was the influence of a mutual concern with specialty autonomy.

In Allan the structure at the hospital level was not used for this purpose and the overt reason for this was the lack of inter-specialty knowledge and hence the role conflict was avoided for the members of the Medical Staff Association.

When priority decisions could not be avoided and choices had to be made between specialties, specialty status had an influence in

Overton, but in Allan this did not appear to be the case. In both hospitals priority decisions tested the structures and in both of them the structure was in some way adapted. In Overton sub-committees were used, in Allan additional members were co-opted to the Executive.

These findings are not very encouraging for the aims of the hospital level of the structure. The influence of professional values appears to be strong and decisions are largely shaped by a concern to respect them in the first instance. The structure tended to be used supportively rather than critically or, when choices had to be made, the more prestigious specialties in Overton had more influence and potential for influence. If this continues and it has probably had a similar effect through other mechanisms in the past, then biases in services will continue to be towards the more prestigious areas.

While the Medical Advisory Structures provided some answers for administrative action and action by the Area Medical Committee, it was unwilling to impose a structure upon the profession such that reasonably objective and critical forms of decision-making could take place.

The decisions which have been examined in this and the previous chapter have been matters directly affecting specialty practice and have sprung primarily from within the specialties in terms of perceived needs. These are issues in which the influence of professional characteristics would hypothetically be strongest. The structures also had to deal with more wide-ranging issues and these will be examined in the next chapter. In addition, this and the last chapter have tended to focus upon specific levels of the Medical Advisory Structure in isolation. The next chapter will provide a better idea of the way in which decisions travelled back and forth between committees.

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Chapter 9. Medical Advisory Structures and the Management of the Hospital

Introduction

The last two chapters have focused upon issues related to medical practice at the individual consultant level and at the specialty level. In most cases the issues were initiated by the medical staff. However, the Medical Advisory Structures in Overton and Allan dealt with other issues which were less centrally involved with medical practice and were initiated by the administration or other groups of staff. This chapter is concerned with the way in which these issues were dealt with.

The aim of the chapter is two-fold. First of all, the issues covered in the previous chapters have been rather narrow in their conception and, as was argued at the time, if the various characteristics of the profession were going to have an impact upon the way in which the structure operated, then this would be strongest in those issues closest to professional concerns. While these professional characteristics appeared to have an influence upon decision-making about professional matters, the interest here is to see if these characteristics featured in decisions of a broader nature with more ramifications for the hospital. Secondly, the last two chapters concentrated upon two levels, those of the individual consultant and the specialty, and this resulted, in Overton at least, in a focus upon particular parts of the structure. This chapter, which will follow issues through from start to finish, will furnish a better picture of the way in which the structure functions on a more continuous basis.

Three broad groups of decisions will be described and analysed. The first is the use of hospital beds and the way in which the consultants dealt with a shortage of beds in both hospitals. Secondly, there are requests for additional supportive staff, technicians and ward clerkesses in Overton and blood takers in Allan. Thirdly, the implementation of two policies will be examined, in Overton it is a decision to introduce open visiting and in Allan it is the reaction to a circular on parenteral infusions and their safe administration.

THE USE OF BEDS IN THE HOSPITAL

Wards and hospital beds are key resources in hospitals. The way in which hospital beds are used is now something with which Medical Advisory Structures are supposed to be concerned. Issues involving the management of beds arose in both hospitals and initial decisions about them were left to the divisional system in Overton and the Medical Staff Association in Allan.

Although clinicians tend to speak of beds as being their own rather than resources belonging to the hospital as a whole these issues serve to illustrate the approach of clinicians to questions with broad implications for the hospital.

The decision in Overton involved the linkage of wards in the hospital and the way in which a shortage of beds was dealt with. In Allan there were two decisions about the use of beds. One concerned a nurse staffing shortage and the consequent necessity of reducing the number of staffed beds in the hospital. The other involved a proposed exchange of facilities between paediatrics and E.N.T. surgery.

Overton Hospital: The Linkage Scheme and the Allocation of Beds

This issue was discussed on and off over at least three years and there were many developments which are of interest. However, space does not permit a full coverage and certain parts of the story will have to be omitted.

Overton Hospital was seventy years old and most of the wards ran off long corridors in single storey pairs. In general each pair of wards, a ground floor and a first floor ward, belonged to a single specialty with one ward being male and one female. The pairs of wards were spaced at intervals along the corridors and as a way of saving space the Regional Hospital Boards suggested in the early 1970's that pairs of wards should be linked to form two horse-shoe shaped wards out of what had been four wards.

The Regional Board proposed six linkages of this type and it was suggested that each horse-shoe ward would be suitable for some form of progressive patient care with one end having intensive nursing facilities and the other being based largely on self care.

The first linkage on the list involved a pair of surgical wards (Wards 6A and 6B) and a pair of medical wards (Wards 5A and 5B). The plan was that the two horse-shoe shaped wards so formed would become surgical wards. The Regional Board planners came to discuss the scheme with the Committee of Divisional Chairmen in March 1973. The chairman of the committee, Dr. Gregor, reported that the medical staff, apart from the surgeons, were unanimously opposed to the scheme because the hospital was too old and money would be better spent on a new hospital rather than revamping the old one. The planners from the Regional Board explained why a new hospital was out of the question at that time and it was agreed that the first pair of wards should be linked and then the Committee of Divisional Chairmen would review the position.

One of the concerns of the Chairmen was the number of wards which would be out of action at any one time. They were assured by the Medical Superintendent that only two of the four wards to be linked would be out of action at any one time and that there were two empty wards in the hospital (Wards 7A and 12A) although these were in need of repair. However, they all seemed to think this might be a problem in the future, as the Medical Superintendent explained in an interview:

> 'We had a meeting between the gynaecologists, the surgeons and the physicians and it looked as though it might decide that gynaecology should move to another hospital if medicine or surgery could not find alternative beds in Overton. The gynaecologist present said that if they wanted him to move then they would have to get a letter from the Regional Board because his contract stated that he worked at Overton, unless he had that he would refuse to go. Hopefully only one of the 5's or the 6's will be out of action at any one time. We

have 12A and 7A but the latter cannot be used so we would require thirty beds to house the second half of the surgical unit (each ward consisted of thirty beds). There is also a problem in that money is likely to be available for upgrading 12A and 7A and if that were so we would have to look for sixty beds when the 6's are decanted. In that case we would probably have to move beds to one of the other hospitals. Geriatrics would be the ideal one to move out to Wallace but that is the professorial unit and Professor Wall is likely to retire soon and his position is divided between here and Lambourne Hospital. If his unit is moved out to Wallace it might be that his successor would be wholely based at Lambourne. Also in medicine one of the old wards in the hospital is being converted into a laboratory for Professor Alexander's department. This would be ideal for housing beds but if we tried to touch that all hell would break loose.'

These comments at this stage set the scene for the long-term progress of the issue because it was mainly a three-cornered battle between medicine, surgery and obstetrics and gynaecology. Even at this stage things seemed to be going against gynaecology and in favour of medicine and surgery and had geriatrics not been a university department that would probably have been sacrificed and moved to the less central Wallace Hospital.

The surgeons were going to have to move out of Wards 6A and 6B first and they raised the matter at the Committee of Chairmen on several occasions but the Medical Superintendent placated them. At this time the Wallace Division of Obstetrics and Gynaecology was still meeting and in June 1973 the Medical Superintendent asking them for their views on possible bed usage. They discussed the matter fairly openly but were not prepared to make any firm proposals:

Dr. Leven: His letter is concerned with the vacation of the 5's and the 6's for the linkage scheme ... There are really a lot of vested interests involved in this. The surgeons want

their ward linkage to go through so that they can have their new wards with progressive patient care, whereas the physicians wanted to plea for a new hospital and felt that such a plea would suffer if the linkage went ahead. As it is the surgeons will be the ones to gain and yet they do not want to give anything up while their wards are being improved. The proposals seem to be that gynaecology should lose a ward so that all the gynaecological work would be concentrated upon the 42's and that other work might be transferred here to our wards. Also the abortion beds in Overton, thirty in all, may have to be reduced. Abortions are a problem, they cannot be done here as the theatre is fully used and there wouldn't be enough nursing staff. The only way to do it would be to use the main theatre here and I'm sure the present user, Dr. Sutton, wouldn't like that. You see I don't think there's been much discussion by Dr. Falk with other people here at all. I told him about the problems involved here and it was like water off a duck's back. We may be able to spread the load here but he cannot transfer thirty beds here unless they move into wards close to the main theatre and use that and I'm sure the people at Overton wouldn't like that. Dr. Falk goes on to say that he would like a firm proposition.

Dr. French: Could he move medical beds out of Overton?

Dr. Leven: Yes, Dr. Hudson worked in Reeve for a long time. Surgery could also move but nobody wants the inconvenience. I can see the gynaecologists at Overton getting very irritated by this.

Dr. Dyne: The other thing is that Overton do not really have to have thirty beds standing by for abortions, these could easily be cut down to twenty. What do we reply to Dr. Falk, do we say that we think the number of abortion beds can be cut down?

Dr. Leven: Oh no, that's not our business, we just say we couldn't cope with the move with our present number of staff.

This was admittedly a rather unusual situation because there were still two Divisions of Obstetrics and Gynaecology. Also Dr. Dyne had been a Senior Registrar in the obstetrics and gynaecology unit in Overton and he knew very well how many abortion beds they needed. However, the obstetricians and gynaecologists at Wallace were not going to make any comments about the bed usage of members of their own specialty in Overton. They in no way wanted to impinge upon their colleagues, and yet this issue required the structure to make a broad management decision and they had to be prepared to comment upon the work of other specialties if a solution was going to be found.

Throughout the autumn of 1973 the surgeons continually raised the matter at the Committee of Divisional Chairmen and a lot of pressure was put upon the obstetricians and gynaecologists. Eventually they agreed to give up 12B to the surgeons on the understanding that ten beds would be available to them elsewhere in the hospital if they were required, this meant that their gynaecology beds were reduced and the surgeons moved into the already vacant 12A, and 12B.

Although it was planned that only one pair of the 5's and the 6's would be out of action at any one time the general physicians and patients in the 5's found the noise from the work in the 6's increasingly distracting. The physicians started to look for other wards in Overton. At the same time the birth rate in Lennox had been following the national trend and the obstetrics beds in Overton were rarely at full stretch. By now the two Divisions of Obstetrics and Gynaecology had amalgamated and the fact that the physicians were interested in obstetrics beds was reported at the meeting of the Division of Obstetrics and Gynaecology on the 25th March 1974:

Dr. Leven: I have had letters from you about the physicians wanting to take over ward 25B and I believe they and the Medical Superintendent came and looked at the ward without asking permission.

Dr. Large: Yes, we would have moved in more patients if we had known they were coming.

Dr. Leven: We must really stamp on this though.

Dr. Large: Yes, it happened with the Regional Board as well, they just came along and looked in without asking first.

Dr. Leven: You will say 'no' of course.

Miss Torrance: The nursing staff came and looked at it as well.

Dr. Leven: This is bad. I have a letter spelling out the dates and the intolerable working conditions on the 5's as the linkage proceeds. My heart doesn't bleed too much for them. They could use Reeve and Wallace although Dr. Collis does have a problem as he has the Coronary Care Unit so it would be hard for him to move, but they could fiddle about within the Medical Division.

Dr. Large: It's not just the beds, we have offices on the wards too and a nurses' seminar room.

Dr. Leach: We cannot do any more early discharge than we do already.

Dr. Leven: I think that we have to write and complain and tell them that the ward is not for sale.

Dr. Pollen: Tell them to look at Wallace.

The gynaecologists in Overton had already given up beds and despite the fall in the birth rate they were obviously loathe to give up obstetrics beds as well. At this stage therefore resources were still being seen in narrow specialty terms, with the physicians examining wards to see if they were suitable for their purposes. However, at the next meeting of the Committee of Divisional Chairmen in April 1974 a new factor in the linkage was made known by Dr. Hill, the District Medical Officer:

Dr. Hill: The District Executive Group was called to the Area Board yesterday and it was revealed that in the work on the linkage it has been found that the supporting beams in the sanitary annexes on the wards have rotted away. This means that it is highly dangerous and the wards will have to be buttressed and this will require outside access. They don't

know the extent of it, whether it goes into the main structure of the wards or whether it only affects the block in which the 5's and 6's are, but it seems that instead of having to find just two extra wards we now have to find four wards and this is why the situation has changed and we have organised a meeting for Friday to discuss this.

Dr. Leven: I think this is very bad and I think that Professor Alexander will agree that this backs up what we said when the linkage was first proposed.

Professor Alexander: Most definitely ... I think this is now a hospital problem it is not a specialty problem any more, and we will have to work together on this, we will have to co-operate.

Dr. Leven: I'm not sure what the problem is, in Wallace we had to move out of some wards a long time ago and we just rotated them round and cut our beds down and we did not have beds in other hospitals to move to like you do with Wallace and Reeve.

Dr. Henley: But this is a problem for the whole hospital, it will affect four wards and they will have to be emptied.

Mr. Alwin: I am not sure about that, the Area Board did not say that.

Dr. Hill: They did say that they would need inside access to the towers and as they are the only sanitary facilities in the wards they have to move out.

The position had now changed radically. The general physicians now required beds urgently and one might have thought that the fact that the hospital was suffering structural damage would have resulted in the chairmen taking a broader perspective. However, the obstetricians were still loathe to give up beds and the reason became clear in an item later on in the meeting when Dr. Leven elaborated upon a report on obstetric services for the District:

Dr. Leven: The aim is to create one obstetrics unit from the two presently in Overton and Wallace. You must be aware that with

the falling birth rate there is a problem in obstetrics and it is costing a lot of money to staff beds that are under-used. Our feeling is that this is the only sector of Lennox without good obstetrics beds and this is the reason for the difficulties of nursing recruitment and not attracting patients when there are palaces in other parts of the city. The best site is the 29's where some of the obstetrics beds are at present and this is one of the reasons why you cannot muck about with obstetrics beds while this is hanging in the air, as the plan would involve vacating the 29's while they were altered.

The obstetricians were admitting that they had too many beds, but they did not want to give them up to the general physicians because of their own long-term goals. A meeting was held to discuss solutions to the problems of movement, but no answers were found and Professor Alexander reported on the position to the Medical Division on 16th April 1974:

Professor Alexander: There are two main problems. One is the immediate matter of what happens to the 5's and the other is what happens about the linkage and the soundness of the wards ...

Dr. Frome: This is really a triumph for us as it shows that we, what we have felt all along that the structure cannot be converted for a large modern hospital.

Professor Alexander: It will be a tremendous problem if all the wards are found to be unfit, we can only hope that it is a localised problem ... I think the surgeons might give us a ward and with the Intensive Therapy Unit I think we can possibly manage ... I think the only solution is for the Medical and Surgical Divisions to get together and solve the problems and for us to get together and help with the receiving and every-thing else. If we can get one medical ward to replace the two and open up a ward in Wallace plus the Intensive Therapy Unit, I think we can manage.

Dr. Hudson: I support the view that the division should support Dr. Collis in every way possible. But what about the obstetrics and psychiatric beds which are empty?

Professor Alexander: They are not available.

Dr. Hudson: You mean they are full.

Dr. Gregor: They are not available.

Dr. Hudson: Well I hate to say this but it seems to me that the divisional system and in particular the Committee of Divisional Chairmen has failed.

Professor Alexander: Well they have discussed it.

Dr. Hudson: It is a failure.

Dr. Ashton: Yes, it is a complete failure. There is an obstetrics bed occupancy of 64% here and 33% at Wallace. There are two geriatric wards which we cannot touch and the psychiatrists won't let us use their beds. It is a complete failure.

Dr. Hudson: The system is supposed to be based upon co-operation but when it comes to it the Committee of Chairmen is a failure.

Dr. Collis: I agree and if this latest move doesn't work I thought of putting it in the hands of independent people who can make the right priority decision, the Chairmen can't act independently.

Professor Alexander: Yes we will have to rely on informal compromise and an administrative arbiter.

Dr. Frome: There is also some moral pressure here. The need for acute medical beds in a central hospital is greater than the need for obstetrics beds in our view, but they do not see it like that.

Dr. Hudson: Well I think Dr. Collis accepts the present proposal but if that doesn't work we will go to an external arbiter and the division will support Dr. Collis.

This discussion highlighted a number of the theoretical difficulties associated with the Committee of Divisional Chairmen. The physicians

thought the committee was a failure because it would not give them what they wanted, i.e. beds in Overton Hospital, and they blamed this on the fact that the chairmen could not act impartially. Whether or not the physicians' case was justified is another matter but the Committee of Divisional Chairmen was, at this stage, incapable of arbitrating between the various specialty interests, presumably because it did not want to impinge upon the autonomy of the specialties and the chairmen were bent upon protecting their own interests. This was a prime example of the role conflict. The physicians wanted beds in Overton and did not want to move to Wallace, and the obstetricians wanted to keep their beds empty so that they had room to manoeuvre when their new unit was built. The failure of the Committee of Divisional Chairmen to arbitrate was a result of the role conflict and its solution by permitting the retention of the status quo. Also it was clear that some of the physicians thought that general medicine was more important than obstetrics, although one of them commented afterwards on the more pragmatic reasons for medicine remaining in Overton:

> 'I don't think that one can claim that General Medicine is more important than other specialties but if other people have beds which are under-occupied consistently then I don't see how they can defend not letting them be used for a short-term purpose.'

As a result the physicians and the surgeons came to an agreement outside the structure and the latter gave the Medical Division one of their wards. The physicians from the 5's also obtained a ward in Wallace and were able to use beds in the Intensive Therapy Unit if they had problems. This was put into operation but the three physicians concerned were unhappy with the solution and made this clear at the May meeting of the Medical Division, and again in June when the following discussion took place:

Dr. Stott: The situation has become intolerable, on the past few receiving days we have been unable to find beds for new patients and Dr. Hill has said we cannot turn them away and we have had to use the Intensive Therapy Unit. We have received consider-

able help from the other two units but the situation cannot continue. Dr. Collis's suggestion is that Unit C should stop receiving one time in two and that this should be covered by the other two units.

Dr. Gregor: I think we would be prepared to do anything but that. With Dr. Mells concentrating on the renal side there are effectively only two consultants in our unit. The load would be too heavy.

Dr. Gilbert: I think we have to look at the figures. In the 5's we had fifty-six beds, now we have twenty-one in Overton, plus the four in the Intensive Therapy Unit and those in Wallace which cannot be used for acute admissions, only for convalescence. I have heard that next week there will be no nursing staff for the Intensive Therapy Unit. If you look at the occupancy figures in the last few weeks you find:

13B	Medicine	91%
Wallace -	Medicine	87%
25AB	Obstetrics	56%
29AB	Obstetrics	63%

Those beds in obstetrics are standing empty.

Professor Alexander: Shall we go to the District Medical Officer?

Dr. Gilbert: I think we should go to the Chief Administrative Medical Officer. This thing has to be settled.

Dr. Frome: I think we have to show the turnover as well. I disagree with going to the Chief Administrative Medical Officer though. I think we have a structure and we should use it. We have divisions, a Committee of Divisional Chairmen and also an Area Medical Committee and we should try that out, we cannot dismiss the system without seeing if it works.

Dr. Gilbert: We need an independent body though.

Dr. Hudson: I agree with Dr. Frome we have to try the system.

Dr. Ashton: The obstetricians will only stall, I think you have to call an extraordinary meeting.

Dr. Frome: Yes, and we have to present a case which cannot be broken.

This discussion brought up the same claims that the chairmen could not act independently. However, they decided to try the structure once more and an extraordinary meeting of the Committee of Divisional Chairmen was called with co-opted members of the Medical, Surgical and Obstetrics and Gynaecology Divisions. The meeting produced three offers which were volunteered without pressure, from infectious diseases, which would try to keep four beds free most of the time, from geriatrics in Overton, which would take patients over the age of seventy-five, and from surgery which would take cases of haematemesis. However, obstetrics was not mentioned at all, the figures which had been discussed by the Medical Division were not presented in the broader forum. The reason for this became clearer at the next meeting of the Division of Obstetrics and Gynaecology:

Dr. Leven: There was a special meeting of the Committee of Chairmen and the physicians approached us beforehand about 25A and we said 'no'. Eventually they got help from infectious diseases, geriatrics and surgery. I'm sure these were available before the meeting. I'm not sure that surgery, getting four new wards, shouldn't be a little out of joint.

Dr. Leven elaborated on this after the meeting:

'The physicians wanted to get beds from obstetrics but I had already persuaded them to give up one gynaecology ward and I wasn't and indeed couldn't persuade them to give up any more. They could use Wallace if they were prepared to move staff there, after all we have to cope with emergencies which are more acute than the ones they have to deal with. They make out that their cases can go nowhere apart from Overton but this applies to very few of them. The reasons why they don't want to move to Wallace are partly because of the status attached to working in Overton. Dr. Hudson operated with beds in Reeve. The same goes for the surgeons, if they

wanted to they could hold theatre sessions in the two smaller hospitals. The other thing is that they don't want to travel around because of the inconvenience but there is nothing in the cases themselves to stop them from doing that.'

So the physicians had found out prior to the meeting that the obstetricians would not play ball and had chosen not to raise the matter in front of the Committee of Chairmen, and the Committee of Chairmen was unwilling to dictate to any specialty that it should give up beds to another. The only solutions were those which specialties chose to offer.

These arrangements worked reasonably well throughout the summer and in the autumn a report was sent to the District Executive Group which outlined the results of a survey of the buildings which had been conducted by a civil engineering firm, this stated that testing of the buildings would continue. At the same time it was suggested that the existing buildings would not be used indefinitely and it was reported that the Area Health Board would visit the hospital and discuss the future of the hospital with senior doctors. The Committee of Chairmen discussed their approach to this meeting in October:

Mr. Alwin: The programme is broadly that we will show them various parts of the hospital and in the afternoon they will have a discussion with senior consultants to find out what they think should happen about the future of Overton ...

Professor Alexander: In medicine we have problems because of the position of Unit C and also with the unprecedented number of students because of the curriculum change.

Dr. Henley: Mr. Sander, do you have the same problem with students?

Mr. Sander: No, we have a reduction this year with the curriculum change.

Dr. Henley: What about gynaecology?

Dr. Leven: No, it's about the same as usual.

Professor Alexander: They say in the circular that it has to be decided what will be built first so there has to be a consideration of priorities. We are going to speak with a number of voices if previous discussions are anything to go by and they will say 'They don't know what they want and we will have to decide for them'.

Dr. Henley: Yes.

Professor Alexander: We haven't really done our homework.

Dr. Leven: If the ward blocks are falling down then they have to be rebuilt.

Mr. Sander: But the Outpatient Department is at the end of its tether.

Professor Alexander: But people have to live in the wards. With outpatients people can at least get there, they are not as ill as the ones who are on the wards. They will ask us questions and they will want a simple answer, if they don't get it they will ignore us, if we want a voice then we have to be united.

Mr. Sander: I think it takes more thought we are bringing in more consultants and we need more outpatient space, ultimately they are all of the same priority.

Professor Alexander: Yes, but we have to look at the short-term priorities and you have your surgical palace with your new wards and your new theatres. You have excellent facilities and my heart warms for you but what about Jock MacTavish with a coronary sitting in his bed shivering, our main concern should be with patient care and we should hammer that home to them. We have to decide on the wards or the Outpatient Clinics.

Dr. Leven: Presumably in the end we want to rebuild the whole hospital.

Dr. Hill: Yes, but everything has to be keyed in, you cannot just start with the bit you want, there may not be much flexibility at all.

Professor Alexander: Those on the wards are sicker ...

Dr. Henley: ... Well, am I right in saying that we push down the priority of the Outpatient Department and push up the wards ...

Professor Alexander: But Mr. Sander, how do you feel about the general priority of the wards?

Mr. Sander: I have to think about it. Previously the Outpatient Department has been the priority, the showpiece of the hospital. I agree with you but we need some Outpatient Clinic outlet, orthopaedics badly needs a clinic.

Professor Alexander: Yes, young Deness being here is a great asset to the hospital but that really is a side issue.

Mr. Sander: Well don't worry I won't say this at the meeting tomorrow.

Dr. Hill: I think we must emphasise the short-term problems or we will cut the ground from under our feet ... If we make the present too acute that will put them off any developments.

Dr. Henley: We'll emphasise the ward blocks then and particularly the medical.

This is largely what happened. The members of the Committee of Divisional Chairmen kept by their decision to hide their differences for the purposes of the meeting, as Mr. Sander reported to the Surgical Division:

> 'The members of the Board were highly delighted with the meeting and their greatest fear was that they would go back with six different views. But they went away with the view that what we want is more patient and nursing care areas but this has to be linked with the kitchens and boilers plus some patchwork. I said that I would mention orthopaedics and Dr. Ivar (the Chief Administrative Medical Officer) said that if all this meant that the Orthopaedic Clinic would not be first priority then this made the need for the Orthopaedic Clinic all the more clamant.'

After this the various technical officers of the Area Board and the Common Services Agency started to plan developments along these lines, as Mr. Alwin reported to the Committee of Chairmen on the 6th November 1974:

'I had a meeting with some of the officers at the Area yesterday and the up-to-date thinking on this is that we need a development and the first priority in this is ward blocks. Wards 1-9 will be upgraded but the wards in the other corridor will be knocked down. They plan initially on two five-storey blocks of three hundred beds each. The only projects which will go ahead are the Department of Medicine and the Orthopaedic Department, internal maintenance will be up to us. The officers reckon it will be five years before the first ward block is completed and it will have to go up to the Scottish Home and Health Department.'

This was a very complex issue and it featured in the meetings of the divisional system for a long period of time. The way in which vacated wards were accommodated was left to the divisional system. Admittedly a number of contingencies arose which made this more difficult but in general terms the system did not appear to be capable of dealing with this kind of issue. The major reason for this was the reluctance of the Committee of Divisional Chairmen to tell individual specialties to either move to Wallace Hospital or give up beds. The major solutions came through informal agreements, between medicine and surgery, or help voluntarily given, as in the offers of assistance from infectious diseases, geriatrics and surgery. This appeared to be largely because of the respect for specialty autonomy. It was obvious that specialties considered the beds they used to be their own rather than resources belonging to the hospital or the district. The three main specialties involved, general medicine, general surgery and obstetrics and gynaecology, did not want to lose any of their beds or move to Wallace for three separate reasons:

(1) Medicine wanted to stay in Overton and take over beds there. The consultants did not want to move to Wallace because they

said it would be inconvenient to be stretched between two hospitals (which were three miles apart). In addition some of them claimed that '... the need for acute medical beds in a central hospital is greater than the need for obstetrics beds in a central hospital.'

(2) Surgery wanted to stay in Overton and their argument was that they had new operating theatres and facilities in the hospital and it would be a waste if these were not used. In addition they said that the theatres in Wallace were inferior.

(3) Gynaecology initially did not want to give up beds apparently just because they were theirs. Their bed occupancy figures were low and they subsequently gave a ward to surgery. The obstetricians wanted to hold onto their beds in Overton in order that a new obstetrics unit for the district could be built there. They had spare capacity and were prepared to move to Wallace in the future but only for the purpose of upgrading their existing facilities, not for the benefit of medicine or surgery.

Geriatrics was marginally implicated. The specialty was practised in Wallace already and there were no medical reasons for rejecting a move. However, the fact that it involved a professorial unit meant that such a move was politically unacceptable from the viewpoint of the continued location of the chair in the district.

The chairmen of the three divisions involved were committed to representing their specialty interests and it was the job of the whole Committee of Divisional Chairmen to arbitrate between them if the structure was to act as proposed. It failed to do this and the attitude to telling other specialties what to do or telling others what should be done was made clear in the Wallace branch of the Division of Obstetrics and Gynaecology:

Dr. Dyne: The other thing is that Overton do not really have to have thirty beds standing by for abortions, these could easily be cut down to twenty. What do we reply to Dr. Falk,

do we say that the number of abortion beds can be cut down?

Dr. Leven: Oh no, that's not our business we just say that we couldn't cope with the move with our present numbers of staff.

Decisions evolved from arguments between the interests of the parties concerned rather than as a result of broader objective consideration. The gynaecologists gave up a ward for the surgeons, but that was their decision, not that of the Committee of Divisional Chairmen. Chairmen could not take on the broader expectation involved in the role conflict and the representation of specialty interests dominated the way in which solutions were found.

This changed a little when it was learned that the hospital was falling down. However, it took something as dramatic as that and the fact that they had to meet the Area Board to discuss the future, for specialty interests to be dropped in favour of a common view and an assessment of which interests were most important overall.

One of the most interesting developments was the charge by the Medical Division that the structure was a failure because '... the Chairmen can't act independently.' Their reason for saying this was that the committee would not give the physicians what they wanted. While this is not necessarily the criterion of whether the committee was a failure or a success, their analysis was correct. The committee would not make specialties do things which they did not want to do.

It seemed therefore, that the hypothesised role conflict was being solved by not impinging upon specialty autonomy and allowing specialty interests free play.

According to the theory of the structure the decision should have been made by the committee choosing between the arguments of the specialties involved. In the last chapter in the analysis of the choices made between specialty requests for equipment, medicine appeared to have certain advantages. Were these at play in this issue?

Certainly the physicians thought they were right and some of them argued that they were more important than other specialties, specifically obstetrics. However, they were not successful in their aim of keeping all their beds in Overton. The reason was that obstetrics and the other specialties did not acquiesce to their demands. This went as far as the physicians marching into the obstetrics wards, to see if they would suit their purposes, without permission. In the case of higher medicine, discussed in the last chapter, the physicians expected to get more, everyone else expected them to get more, and, not surprisingly, they did get more. In this issue the physicians expectations were the same but the obstetricians were determined not to give in and the Committee of Chairmen did not force them to. Therefore, the concern for specialty autonomy was stronger than the pressure by, and status of, medicine.

On the other hand, medicine and surgery did reasonably well out of the whole episode (in so far as anyone did well). Surgery benefited by the linkage of the 5's and the 6's and in the plans for the new building medicine was specifically mentioned as being in line for beds ahead of other specialties. In addition the only planned projects which were to continue in the light of the crisis were in the Department of Medicine and in the Orthopaedic Department.

Allan Hospital: A Nurse Staffing Shortage and Ward Closure

An issue with some of the characteristics of the one above was also discussed by the Allan Medical Advisory Structure. Allan Hospital had an acute shortage of nursing staff and wards had already been closed in surgery to cope with this. In Spring 1974 the shortage worsened and the Medical and Nursing Liaison Committee discussed possible solutions to this. They decided that two of the eight medical wards should be closed. The District Executive Group wrote to the Staff Association asking for their opinion and the Executive of the Staff Association discussed it on the 6th May 1974:

Dr. Cally: Well, what about this letter from the District Executive about the medical ward closure?

Dr. Glen: I think it's a bit heavy to read out, particularly the sentence which says '... unfortunately there was no physician present and the meeting decided to close two medical wards.'

Mr. Earn: Well, I was there and I didn't think that was the decision. We just discussed that as the main possible solution. Perhaps we should give the background to this.

Dr. Glen: This was a meeting of the Medical and Nursing Liaison Committee and for this meeting we tried to get other people along particularly physicians. I wrote to Dr. Birnam asking if he could come along but he couldn't because he had a clinic so I arranged for another physician to come but he forgot about the meeting ...

Mr. Earn: Yes, I was the only clinician there and they suggested that I might be the chairman which put me in a rather invidious position. I tried to get hold of some physicians but they were all at clinics except the one who was supposed to come and I saw him drive past the window and made several efforts to telephone him. When we discussed the matter of closure it was clear that geriatrics could not really be cut down because those patients would be a heavy call on beds elsewhere in the hospital. We were told that orthopaedics was stretched to the limit already and in general surgery we have already cut down our beds by one-third. (At this point Dr. Gow, the physician, arrived). I don't think there is much harm in reading out the letter. Although I didn't think that it was decided definitely that the two medical wards would be closed. I thought it was a discussion and a recommendation to the Medical Staff Association.

Dr. Cally: What do you think Dr. Gow?

Dr. Gow: Well, I think this should be a matter for the Medical Division and the District Executive Group alone, they cannot make this kind of decision about ward closure.

Dr. Cally: Well, they think they can.

Dr. Gow: But they can't.

Dr. Cally: There is another point, the letter says that you want the Medical Division to meet the District Executive Group but matters like this go further than that. It has to be considered what happens to the patients who are not treated in the closed beds, when this kind of thing happens other people are affected. We should be widening the discussion not narrowing it.

Basically there was a shortage of nursing staff and they had to cut down on their commitments. The medical staff were involved in the management or priority decision of how nurse workload should be reduced.

Central to this issue was whether the structure could or would make a decision about a specialty and its use of resources without that specialty's consent. In the discussion above there were obviously disagreements as to whether the Medical and Nursing Liaison Committee could make this decision - the physician thought they could not - and whether or not anyone other than the physicians should be involved - and the physicians thought they should not (apart from the District Executive Group). It was also clear that the Medical and Nursing Liaison Committee had found it very difficult to make a decision because the physician on the committee did not turn up, which also raises questions about the independence of the structure to act. It implied that none of the possible alternatives would be subscribed to unless the physicians agreed.

After the Medical Staff Association Executive had discussed it, the matter was raised at the meeting of the whole Staff Association. Little attention was paid to the recommendation of the Medical and Nursing Liaison Committee, rather the discussion focused initially on alternative ways of making the decision:

Dr. Cally: Would the Medical Division like to propose that they have a meeting with the Medical and Nursing Liaison Committee?

Dr. Gow: I think Dr. Barr would like to say something.

Dr. Barr: Well, I can only reiterate what my colleagues have said although I would stress that the patients we have to pass on to others will tend to be the long-term chronic cases. In more general terms the whole situation is deplorable. Even at present we are having to discharge patients who in normal circumstances would have to stay in another few days. While there is no danger in these, some of the early discharges are bad ...

Dr. Cally: Well, can I propose a joint meeting of the Medical Division and the Medical and Nursing Liaison Committee ...

Dr. Gow: The Medical and Nursing Liaison Committee has failed to find a solution to this problem, I propose a meeting between the District Executive and the Medical Division.

Dr. Barr: May I suggest as a gesture that the Sick Bay be closed and that the nurses from there be transferred to the wards.

Mr. Earn: Well, we have been using it for overflow with our critical bed situation. I think that we have to accept that when the District Nursing Officer says that he is worried about the situation then we have to take note. In surgery we have had to reduce our beds by a third and in geriatrics and orthopaedics a loss of beds would create other problems. Medicine was the only specialty that could be looked at.

Dr. Birnam: Yes, but what a lot of people don't realise is that general medicine is the end of the road for many cases. If they cannot be fitted in elsewhere then it is assumed that it is a general medical problem and we get landed with them.

This again brought out the question of who should be involved in the decision, with the physicians arguing that it should be limited to them, on the medical side. Various possibilities were discussed, such as agency nurses and the transfer of more skilled nurses from the theatres to the wards but then the discussion returned to the question of who should make the decision:

Dr. Cally: Are we agreed then that we have a member of each specialty, the Medical Division and the District Executive Group?

Dr. Barr: Agreed.

Dr. Cally: What about nursing staff apart from the District Nursing Officer?

Dr. Gow: No.

Mr. Grange: I think the nursing staff could be of great help in the discussions.

Dr. Gow: This is just introducing additional talkers though.

Dr. Barr: Agreed, I think we should keep it to the District Nursing Officer and the Salmon Number 8 in medicine.

Mr. Earn: Well, I also think we should have the surgical Number 8, as there will have to be some interlinking between them.

Dr. Barr: But then there are so many other people as well.

Dr. Gow: Yes, I think we should return to the simple form of the District Nursing Officer and nobody else on the nursing side.

Dr. Cally: What about the nurses on the Medical and Nursing Liaison Committee?

Mr. Earn: There are three, they should go on.

Dr. Barr: I agree.

Dr. Gow: I think it would be better to leave it to the Medical Division right from the start.

Dr. Aldis: Can I propose that there is a meeting between the Medical Division, the Medical and Nursing Liaison Committee and the other divisions who want to come.

Dr. Cally: And the District Executive Group?

Dr. Aldis: Yes.

Dr. Cally: Can we vote on that, that's For - 9 votes, Against - 2 votes. Any counter proposals?

Dr. Gow: It's too big.

Dr. Cally: Well the Medical Division could meet with the District Executive Group.

Dr. Barr: But this is a plethora of meetings, we have had the Medical Division and now this one, the joint meeting and now another.

Dr. Cally: It's only two more.

Dr. Gow: I think we should have the Medical Division and the two officers.

Dr. Glen: But Dr. Quarry has stressed the amount of time involved and the need for haste, they should meet this week.

Dr. Cally: Is anyone against the Medical Division meeting the District Executive Group? Nobody, well Dr. Aldis's proposal has to stand as it was voted for. Can I ask Mr. Earn to convene the wider meeting?

Mr. Earn: I would suggest the first meeting be held this week.

Dr. Cally: Would you like the wider meeting to be withdrawn?

Dr. Gow: Would Dr. Aldis agree to have the words 'if necessary' inserted in his proposal?

Dr. Aldis: I'll leave it to the discretion of Dr. Cally, if the first meeting reports to him he can decide if the second meeting is needed.

Dr. Cally: We'll leave it in the hands of the Staff Association Executive as to whether the larger meeting is needed.

In this way the more protective physicians managed to limit discussions to themselves and the District Executive Group, taking it away from the Medical Advisory Structure and the potential influence of other specialties. The final decision went against that of the Medical and Nursing Liaison Committee which had recommended the closure of two wards. Instead the physicians said they would keep eight beds empty on each ward except in an emergency. This resulted in the same number of beds being closed and it had two advantages to the physicians

as a solution to the problem. Firstly, it meant that emergencies could be handled, whereas if wards were closed it would be harder to open up a ward if extra beds were needed. Secondly, each physician had a pair of wards and he used the beds at his own discretion. To close two wards would mean that they would have to double up on the wards and share the beds and they seemed remarkably reluctant to do this, they wanted to keep their own units intact. However, the decision did not go such a long way towards easing the strain for the nursing staff who had wanted the closure of two wards. It takes more staff to keep all the wards open with beds closed than to close two wards. In this way therefore the decision appeared to have been shaped largely by the desire of the physicians to keep their own units intact.

There was further discussion about the way in which the decision had been reached at a meeting of the District Medical Committee in November 1974:

Dr. Tilt: There is a letter from Dr. Quarry to the Chief Area Medical Officer mentioning the difficulty of the ward closure.

Mr. Penny: I wonder how Dr. Quarry would react to the suggestion that this sort of thing should come to the hospital members of this committee rather than picking people from the hospital.

Dr. Quarry: In this specific case only the medical and surgical wards were involved.

Mr. Penny: We do have the power of co-option though.

Dr. Cally: Yes, it was not really an isolated decision, it did have implications for surgery and geriatrics, indeed all the adult wards.

Mr. Turret: Well the District Executive Group is meeting with the surgeons on the reorganisation of A Block. Would the District Medical Committee want to be involved?

Dr. Cally: No that's just an internal matter.

Dr. Quarry: But it could affect other specialties in the same way as the medical bed closure.

Dr. Lyon: I think the Hospital Sub-Committee should meet to decide if anyone should go.

This came back to the broader issue of how such decisions should be made and what part the Medical Advisory Structure should play in them. Decisions about issues like the closure of beds have ramifications over and above the specialty concerned and certainly the hospital level of the structure should be involved. Although there were some members of the Staff Association who thought the decision should involve nursing staff on the ground (rather than just at the senior level), and other medical staff, the Association agreed to the physicians' suggestion that it be restricted to themselves and the District Executive Group.

This ensured that other specialty viewpoints did not enter into the decision, thereby making it more likely that the physicians would achieve what they wanted and reject the recommendation of the Medical and Nursing Liaison Committee. At the meeting of the District Medical Committee one or two of the members were arguing for a continuous management role for the structure, such that the decision-making body on broad issues would not change dramatically from issue to issue (although they were less enthusiastic about the concrete example of the reorganisation of the surgical block).

Overall the Medical Staff Association played little part in this decision. It showed no inclination to discuss the issue in a constructive way and left the decision up to the specialty concerned. This was largely because the physicians did not want others to be involved and the members of the Association did not want to force the involvement of others upon them. In this way the professional respect for and concern with specialty autonomy took the decision out of the Medical Advisory Structure, and limited it to the specialty concerned. There was one other decision in Allan which involved the use of beds and the specialties involved were paediatrics and Ear, Nose and Throat surgery.

Allan Hospital: The E.N.T. Unit and Paediatrics

Paediatrics was not a particularly well-served specialty in Allan Hospital. There were two consultants for the Aldershire area and in Allan they had one ward and that was in the Surgical Block. Consultants were generally agreed that their facilities were inadequate but nothing had been done to improve them. In the past there had been a proposal for a new chest medicine department and the Medical Staff Association had considered the relative priority of chest medicine and paediatrics. The vote had gone in favour of chest medicine but a majority of the consultants who were interviewed commented, unprompted, that this had been the wrong decision and that they had been '... fooled by the better presentation of the chest medicine case'.

The E.N.T. Department had a separate block, including a theatre, and money had been given in the recent past to improve these facilities. At the same time it was planned to make certain changes to ward 5 in the Surgical Block, where paediatrics had its beds. At this point there was a move by the administration, supported by the paediatricians, for the latter to take over the E.N.T. Block and for E.N.T. to move into ward 5 in the Surgical Block.

This was discussed by the Staff Association Executive in the latter part of 1973:

Dr. Carty: After the chest medicine decision I think we decided that paediatrics should be top priority and this cannot be rescinded. However, there has to be a compromise as we cannot really disposess E.N.T. of their accommodation as the ward and theatre have had a good deal of Regional Board money spent on them and it might be difficult to use them for another purpose.

Mr. Fillan: I thought the matter had been decided a long time ago because the general surgeons and the E.N.T. surgeons met and decided that they could not have both specialties using the main theatre block at the same time.

Dr. Gow: What do the anaesthetists think?

Dr. Currie: We would naturally prefer to have all out theatre commitments in one block as we could use more junior staff through supervision and hence staff more theatres at the same time. But what we think is irrelevant as the two main specialties do not agree and it would be unworkable.

Dr. Gow: I thought your opposition was stronger than that, I thought you said the E.N.T. theatre in the E.N.T. Block was not suitable for surgery.

Dr. Currie: Dr. Lyon said that at the time in order to bargain for one theatre to be used by the two specialties.

Mr. Fillan: We cannot comment on that though as the users have said they are prepared to use it and we cannot really attack that judgement.

At this stage, apart from any other considerations, the E.N.T. and general surgeons were against the move because they did not want to work together and the anaesthetists were for it because it would make the deployment of their staff more effective.

The Staff Association discussed the matter immediately after the Executive:

Dr. Carty: There is a letter from Mr. Turret the Hospital Secretary.

Dr. Glen: He says ... 'As you are probably aware ward 5 is now ready for use and so is the theatre. I doubt if ward 5 can be used for paediatrics again and recommend that ward 5 be used for E.N.T. as it could be improved and extended to meet the E.N.T. requirements and I doubt if it could be extended to meet the requirements of paediatrics. The import of this is for paediatrics to take over the present accommodation of E.N.T. and for E.N.T. to take ward 5.'

Dr. Carty: We also have a letter from Mr. Struan of E.N.T..

Dr. Glen: He says ... 'Thank you for your letter, I am most upset to hear of Mr. Turret's suggestion that paediatrics should move into the present E.N.T. Block when the surgical specialties are

all against this. We cannot do our work in A Block. Apart from this, the Regional Board gave money to improve the E.N.T. facilities and to rehouse paediatrics there would be a misuse of Regional Hospital Board money. If attempts are made to bludgeon this through we will take it up with our M.P. or the Secretary of State.'

Dr. Cally: I have never wished to spoil anyone else's unit but I am frightened that in two or three years' time we will still be without a paediatric unit and the only way to overcome this is that suggested by Mr. Turret. It is unfortunate that this is the only way that he can see that this can be done but if there are no other alternatives then I have to support him because I represent the sick children of Aldershire and I must look after their interests.

Mr. Verity: I also speak for my E.N.T. patients you know, we need our operating theatre. Our waiting list is still going up and the question of beds is really secondary. At the moment it is a matter of putting patients on an endless waiting list unless they are real emergencies. This building was extended on our direct appeal to the Regional Board with the removal of our theatre at Comyns Hospital. Our patients are in a more desperate situation than paediatrics. We are being deprived of something we shouldn't even have to fight for ...

Dr. Carrock: Surely this is a Regional Board matter, the E.N.T. people have made a case and got what they want. The Regional Board also approved the posts of paediatricians here, surely it is their responsibility to provide adequate facilities.

Dr. Carty: Dr. Cally has made this plea and yet although this Staff Association gave paediatrics first priority the Regional Board approved money for E.N.T. after that.

Mr. Verity: Isn't there a difference between a priority and evicting a sitting tenant?

Dr. Carrock: I feel for the problems of paediatrics but they cannot raid another department ...

Dr. Gow: Haven't the anaesthetists said that the E.N.T. theatre is unsuitable for operating?

Dr. Currie: Well we would prefer to operate from one base.

Dr. Lyon: That theatre is not suitable and it would take £30,000 to make it suitable and they have not had that amount of money.

Dr. Barr: They have spent more money than was originally planned.

Dr. Lyon: It still won't be enough. This stuff about Comyns is not true, they only had twenty cases a week there.

Mr. Verity: Yes and you take twenty cases a week and look at how many that is a year in relation to our waiting lists. We just want as many sessions as possible, to cope, we will take all we can have.

Dr. Currie: That's not true, we have offered you Mondays but you won't take them.

Mr. Verity: We have other commitments on Mondays which cannot be changed.

Dr. Currie: But this will not change if you get your theatre. We can still only offer you those times and you still won't be able to take them. This is why we would prefer to have all operating in the same block so that we could have junior staff under supervision and then we could service more theatres at the same time.

At this point here was a movement to come to a decision. Mr. Fillan put a motion that E.N.T. should stay where it was and Dr. Cally put a counter motion that E.N.T. should be moved out. The former motion was carried by a large majority.

Possibly the most compelling reason for rejecting the suggestion of the administration that E.N.T. and paediatrics should swop their accommodation was that E.N.T. had been specifically allocated money by the Regional Board. However, this was not the major focus of the discussion. One of the key factors in the decision was the prior

agreement between the general surgeons and the E.N.T. surgeons that they did not want to operate together in A Block. This was made clear by Mr. Fillan, the general surgeon:

> 'I thought the matter had been decided a long time ago because the general surgeons and the E.N.T. surgeons met and decided that they could not have both specialties using the main theatre block at the same time.'

and by Mr. Struan in his letter to the Staff Association:

> '... I am most upset to hear of Mr. Turret's suggestion ... when the surgical specialties are all against this.'

From the viewpoint of the administration such a move was desirable because it rationalised the use of theatre resources. One of the anaesthetists went so far as to say that the theatre in the E.N.T. Block was not fit to operate in (although another anaesthetists said that this argument had only been used to '... bargain for one theatre to be used by the two specialties'). Also, Mr. Fillan thought that whether or not this was the case it was not open for comment because '... the users have said they are prepared to use it and we cannot really attack that judgement.'

It was therefore apparent that the Staff Association was not going to challenge a decision reached by the general surgeons and the E.N.T. surgeons, and thereby tell them where they should practice. Whatever the rights or wrongs of the matter the opposition of the group involved was the main reason for the rejection of the proposal. Also it was clear in the discussion that the use of beds was seen as the possession of beds, as when Mr. Verity said 'Isn't there a difference between a priority and evicting an existing tenant?' and the reaction 'I feel for the problems of paediatrics but they cannot raid another department.'

These were the background assumptions within which the issue was discussed. Beds were seen as specialty resources rather than resources belonging to the hospital as a whole and if a specialty did not want to change its beds, the Staff Association was not going to consider going against that view.

REQUESTS FOR SUPPORTIVE STAFF

In the last two chapters there were accounts of the way in which requests for additional medical staff were dealt with by the structures. There were also several requests for non-medical supportive staff.

The medical staff can exercise a strong influence over para-medical staffing levels and in Overton the demands were for technicians and ward clerkesses and in Allan they involved a request for blood takers by the pathology department.

Overton Hospital: Request for Senior Technicians in Bacteriology

The laboratory specialties rely upon technicians to a considerable extent and this issue involved a request for two additional senior technicians from Dr. Pepper, the bacteriologist. He wrote direct to the Medical Superintendent in March 1974, outlining two reasons for the request:

'1. There are at present only two technicians available for the P.K.U. screening programme, i.e. Mr. Hope, Chief Technician in charge, and one lady technician who is married and whose tenure is a little uncertain. I consider that a Senior Technician should be appointed in order to cover for Mr. Hope during holidays and also to look after the work problems which arise in the routine work section of the laboratory. Apart from the P.K.U. work, I can assure you that the hospital section is a very real problem as it includes the media-making section which does not have a Senior Technician in charge. This media-making section has always been difficult simply because we have never had a senior in charge.

2. We require an additional Senior Technician as deputy for Mr. Cain in the Salmonella Reference Laboratory during holidays and illness. This section can become very much of a problem, as was the instance last week, with the sudden

discovery of two cases of typhoid in our paediatric medical block. The work involved in the screening of contacts was massive and one senior man can hardly be expected to cope with it. A Senior Technician is urgently required to cover this department.'

The Medical Superintendent sent the letter to the Committee of Divisional Chairmen and it was discussed there in April 1974:

Dr. Leven: Has this request gone through your division?

Dr. Henley: No, he mentioned other aspects of his shortage, particularly on the clerical side and I said write. I have not discussed this with Dr. Pepper but it seems to me, knowing his department, that the P.K.U. request is particularly valid as it is an all-Scotland commitment. In this he is dependent upon one man, and if he is sick or on holiday there is no replacement. Money for this should be provided from the Scottish Home and Health Department, he probably has a technician he can promote for this.

Dr. Leven: Would you put it to the area first?

Dr. Henley: I recommend that we make an application for a Senior Technician.

Dr. Leven: If Dr. Henley is convinced I am sure everyone else will agree.

Dr. Henley: The second request concerns Salmonella which he also regards as an all-Scotland commitment, again he has a case for exactly the same reasons. Against this, Mr. Stock, the Chief Technician takes an interest in that as he does with everything else. It is a good case but it is not really an all-Scotland, although he will accept them from all over Scotland.

Dr. Murdoch: It might be more important with the second one to produce figures to support it.

Dr. Hill: You could put them in priority, one and two.

Dr. Henley: I think the P.K.U. is the most important although I think it would be a shame not to get the second one. Widening

out the problem this will also have implications for his need for secretarial staff.

Mr. Alwin: Are you suggesting we try the P.K.U. on the area?

Dr. Henley: Yes, as a whole Scotland commitment.

These requests were therefore forwarded to the Area Board with the support of the Committee of Divisional Chairmen. In terms of the overall operation of the structure these requests had not been screened by the Laboratory Division before their consideration by the Committee of Chairmen. Although the committee found this out it did not send the request back to the division. As with the requests for medical staff, screening by the division was not seen as a prerequisite for consideration by the Committee of Chairmen. A second point is the basis on which the requests were agreed to. Although the consultant's letter referred in some detail to why the technicians were wanted, there were no figures on changes in workload which might have supported the requests.

There was no real attempt to test out the request, support was based upon the statement 'If Dr. Henley is convinced I'm sure everyone else will agree.' The reaction to the second request is of interest as well. There seemed to be more doubt about it on Dr. Henley's part and this provoked the comment that 'It might be more important in the second one to produce figures to support it.' While they recognised supportive figures as a justification for requests, they did not want to know about them in making their decision on whether the hospital should support the requests. The committee therefore seemed unwilling to challenge the requests and acted supportively. They were not so concerned with the validity of the requests at that level but with making suggestions about how success might be achieved at higher levels. Chairmen relied mostly upon the chairman of the Laboratory Division to provide them with information and opinion, they obviously knew little of the position themselves and once more they seemed to respect the autonomy of another specialty more than the requirements of decision-making for the hospital.

Overton Hospital: The Introduction of Ward Clerkesses

The proposal for the employment of ward clerkesses in Overton was partly provoked by the shortage of nursing staff and the feeling that some form of secretarial-cum-administrative assistance would allow senior nursing staff on the wards more time to use their nursing skills. The Medical Division proposed this early in 1973 and the Board of Management agreed to finance a pilot study of two ward clerkesses to see if the idea was worth pursuing. The matter was referred to the Committee of Chairmen to allocate the two ward clerkesses in the pilot study, and at this time Dr. Gregor, Chairman of the Medical Division, was still chairman of the committee:

Dr. Gregor: Well we have to allocate these two ward clerkess posts and I would suggest that the surgeons with their two units and large theatre commitments should have one of them.

Mr. Scott: Yes we would like one of them very much.

Dr. Henley: What about obstetrics and gynaecology, they have quite a large turnover of patients?

(At this time there were still two Divisions of Obstetrics and Gynaecology, and both of the chairmen opened their mouths to say they were agreeable at the same time, Dr. Leven got the words out first.)

Dr. Leven: Yes, we would like to have one, we could use one.

Dr. MacAulay: What about medicine, they have a large number of wards, their claim must be as good as anyone else's?

Dr. Gregor: Well we would be happy to have one. I suggest that we now have a pilot study of three ward clerkesses instead of two.

This came back to the Board of Management and Dr. Gregor, Mr. Scott and Dr. Leven were all on the Board and the following exchange took place:

Dr. Gregor: We looked at this and decided that they should be allocated to medicine and surgery.

Dr. Leven: Oh no, we said three and the other one was to go to obstetrics and gynaecology.

Mr. Alwin: Well if you spend the money on this it won't be available for anything else.

The Board therefore ratified the decision that the pilot study would involve three ward clerkesses.

The Committee of Chairmen had had to allocate two ward clerkesses. After two proposals had been made, surgery and obstetrics and gynaecology, either the discussion should have stopped, if they were going to allocate them on a 'first suggested, first served' basis, or, if more were proposed, they should have attempted to decide which of the three suggestions were most deserving or would best illustrate the utility or otherwise of clerkesses. However, the chairman was a physician, his division had suggested that they be introduced, and he wanted one and it was fairly obvious that he was not going to stop the discussion until medicine was suggested. Once this had happened they were not prepared to say which of the three should be dropped. Dr. Gregor realised this because he tried unsuccessfully to change the decision when he reported it back to the Board of Management. The only comment from the administrator, Mr. Alwin, was that if money was spent on an additional clerkess then it would not be available for anything else.

As was the case with the Higher Medicine allocation, discussed in the last chapter, the chairmen would rather change the parameters of the decision and find money from elsewhere, than consider the relative priorities between certain specialties. This in turn stemmed from their preference for agreeing with specialties and what they wanted rather than mediating between them, although in this case the fact that the chairman of the committee was a physician made a crucial difference. If medicine had been put forward as the second specialty then the chairman would doubtless have stopped the discussion there.

A further allocation of clerkesses was made in November 1973, although this time the nursing staff decided where they were needed (which was logical as it was nursing work which they were undertaking). The practice with the three appointed for the pilot study was for them to

work on a single ward and the one which had gone to the Medical Division worked in Dr. Gregor's unit. In this second allocation it was suggested that one of the twelve being proposed should be shared by the other two medical units, wards 5A and 5B and wards 2A and 2B, but Dr. Gregor suggested that this be changed when they were discussed by the Committee of Chairmen:

Dr. Gregor: There is one to be split between the 2's and the 5's, this looks to be a rather heavy load. When we got the original allocation Professor Alexander said they wouldn't take one on the 2's because they had more secretarial staff then they knew what to do with and Dr. Collis on the 5's said they didn't have anywhere to put her, so I had her. I think the 5's need one more than Professor Alexander.

This was agreed and this was the only change in the list made by the nursing staff. The issue came up again in March 1974 when the position was reassessed:

Dr. Henley: A list has been supplied of the clerkesses in post.

Mr. Alwin: ... should we enlarge this or keep it as it is?

Dr. Murdoch: Was this not a trial?

Dr. Henley: The initial three were a trial. In the general wards the clerkesses are proving a success but there are gaps. Professor Alexander did not get one and his nurses are angry about this. In due course I feel that each unit should get one and preferably each ward. What has been everyone's experience of this?

Dr. Leven: Most of them have been successful ...

Professor Alexander: I think they must be very useful. The case sheets in the 2's are in a terrible mess and the nurses are being diverted. I haven't pushed this and I wondered whether by doing nothing justice would be done. I think it is an injustice that the 2's have not got one.

Dr. Leven: Is it not possible that another one could be authorised?

Dr. Henley: Are they really needed in all the places they are in at Overton at the moment?

Professor Alexander: The last thing I want is to remove one from another ward.

Dr. Falk (Medical Superintendent): On the background to the allocation, twelve was just a figure that came up and it was mainly the nurses who decided on the allocation. I think the 5's were eventually given priority over the 2's but initially it was the other way round.

Professor Alexander: I think that was alright.

Dr. Falk: It's the old story, if you agree to the 2's then you also raise arguments for the 7's, 13's and 3's, it is a developing situation which should get better as we get more funds.

Professor Alexander: When, when we get North Sea oil?

Dr. Falk: When we get the new allocation, although I'm not confident that the new allocation will be large, it may only be 1% up on last year.

Professor Alexander: We may have to wait five or six years, we can't recruit enough nursing staff. Looking at it at the naive level we employ nurses to care for the sick. We have insufficient nurses to care for the sick, surely the employment of ward clerkesses would be in the spirit of the use of the money. I'm not only speaking for the 2's, it has been a successful experiment, why can't we have as many as are needed?

Mr. Laver (Chief Nursing Officer): Don't think I am against you, I am glad the ward clerkesses are giving the Sisters more freedom, but I think there are many ways in which we can relieve the nurses. We are going to try out housekeeping teams and we are willing to pass money on for the comprehensive relief of nursing work, but I don't think we should spend the money all in one area.

Professor Alexander: I think we have found an area and these other alternatives won't mature for a while and I'm sure that

vacancies will appear in the clerkesses and then you can put in the alternatives.

Dr. Leven: I would like to say something in Mr. Laver's support. I want ward clerkesses and I was convinced by Mr. Laver that they could lead the housekeeping teams, however, in the meantime I think we should continue with ward clerkesses.

Dr. Henley: Should we resolve to pass it on that we need at least one clerkess and possibly three or four and that would be a start?

Mr. Alwin: We will get a development allocation and the fact that the 2's were on the list last time suggests that they should be first. We could advertise now although we won't get the money until April. If we get six then the 2's could be first.

Dr. Henley: If we get six that would be lovely.

Professor Alexander: I don't want you to be moved by my pleas, sometimes I start believing myself, what about somebody else as well, how about psychiatry?

Dr. Galbraith: Yes, we'd like to have one.

Dr. Henley: So if we get six we can couple the first two and say they are for psychiatry and the 2's and not just the 2's.

Mr. Laver: I would like to say that we should consider the problem in other hospitals. We want them to support the nursing staff and not all the problems are in Overton.

Professor Alexander: Yes, but in Overton there is the problem of turnover.

As a result of this the 2's obtained a ward clerkess. Professor Alexander made two interesting statements in pressing his case. First of all he said:

'I haven't pushed this and I wondered whether by doing nothing justice would be done, I think it is an injustice that the 2's have not got one.'

This raises a number of questions, the first being whether the Committee of Chairmen can 'do justice' without being told what justice is. The implication here was that the chairmen did not know enough about the 2's to suggest that they should receive a ward clerkess and that they had to be told by the chairman concerned what was needed in his specialty. A second question is whether 'justice' is what any chairman wants, by definition. In the initial allocation the chairmen had been reluctant to decide between specialties and in this case they were also reluctant to turn down medicine's request. Again this suggested that the Committee of Chairmen was generally prepared to agree with what specialties asked for. Also Professor Alexander was undoubtedly using 'justice' as an added argument, making it appear that his need was in some way absolute and above discussion rather than being relative to other specialties. The second statement he made was:

> 'I don't want you to be moved by my pleas, sometimes I start believing myself, what about somebody else as well, how about psychiatry?'

Why should Professor Alexander ask for another ward clerkess for a specialty, in addition to his own? The choice of psychiatry seems to have been fortuitous, for the psychiatrist at least, who happened to be sitting next to Professor Alexander, and who also looked most surprised when his specialty was brought into the discussion. In the light of his previous statement about 'justice' there was no indication at all that psychiatry required a clerkess. More likely he wanted to implicate someone else as well, having been so obviously successful in achieving his own ends. In role conflict terms he was blatantly chasing what he wanted and he was trying to appear more even-handed. The choice of psychiatry was more to accommodate that than because psychiatry needed a clerkess.

The last exchange between Professor Alexander and Mr. Laver was also of some interest. Mr. Laver said he thought other hospitals in the district should also be considered, and Professor Alexander replied 'yes, but in Overton there is the problem of turnover'. It was hard to square this with his championing of psychiatry because

they had one of the lowest turnovers in Overton. Also it was obvious that Mr. Laver saw the ward clerkesses as being of assistance with all extra-nursing work, rather than just those concerned with large numbers of admissions. They might be asked to undertake different tasks on a geriatric ward, than say a surgical ward but they could be just as helpful in a nursing shortage. However, it was clear that the acute specialties' view of them tended to predominate in their allocation and medicine had again been successful in attaining its ends.

There was only one request for additional non-medical staffing in Allan and that came from the pathologists and was for blood takers.

Allan Hospital: The Employment of Blood-Takers

This request was made by the pathology department and arose from their difficulty in obtaining all blood samples for auto-analysis at the time when they needed them. One of the pathologists wrote to the Staff Association and the Executive discussed it in January 1975:

Dr. Aldis: The next item is the employment of blood-takers, particularly for orthopaedics. Dr. Lyon (an anaesthetist) has spoken to me about this and said that it is just papering over staffing shortages and also that if they mess up veins then it can affect him, but then he can bring anaesthetics into anything ...

Mr. Earn: How do the laboratories feel about this?

Dr. Carrock: Well we want them so that we can get all the bloods in for our two analysis times of eleven o'clock and three o'clock, at present with the junior staff doing it they come in dribs and drabs and you can't get full loads on the auto-analysers.

Dr. Cally: How many do you want?

Dr. Carrock: Four part-timers.

Dr. Cally: Well I think if the laboratories want them and the

orthopods are in favour then we should let them try it.

Mr. Earn: I don't know, I think it comes back to the residents, whenever there is a problem we always think in terms of more money or more staff but this is a matter of management and when you tell the residents to take off bloods.

Dr. Gow: I don't think we should have them either.

This was raised at the meeting of the whole Staff Association immediately after that of the Executive:

Dr. Cally: The feeling of the Executive was against taking on more people or spending more money when a problem arises.

Dr. Carrock: The problem is that the samples trickle in at odd times.

Mr. Earn: But it is a matter of telling the residents when to do it, it is a matter of education.

Dr. Maldern: So you don't want any blood-takers, but to try and improve the pick-up and have better education on the procedures for new residents.

The request for blood-takers from the pathologists was therefore rejected. This was the only request for additional staffing which was turned down at the hospital level in both Allan and Overton, although it was a close call because the chairman, Dr. Cally, used the normal reasoning in his initial comment when he said:

'If the laboratories want them and the orthopods are in favour then I think we should let them try it.'

Again the premium placed upon specialty autonomy seemed to be leading them towards automatic agreement with the request. However, it was immediately pointed out that the residents should be doing this and that the fault lay in the instructions, or lack of them, given to the junior staff. For this reason, the request was rejected.

There are a number of reasons why the pattern may have been different here compared with other requests for additional staff. First of

all, it involved the creation of new posts to take over a job which belonged to the residents. It was not more junior staff. Secondly, it was clear that those on the wards were in a position to do something about it and therefore other consultants in the clinical specialties may have felt happier about commenting adversely because they knew what the problem was. Thirdly, on a broader plain this measure would have involved removing from doctors what is traditionally a medical task. In view of these background explanations it is perhaps disturbing that Dr. Cally was willing to accept the request solely because two specialties wanted it. While this indicated that at least some members of the Executive of the Staff Association were prepared to consider some requests in a critical light, the request for blood-takers was rather different from a request for, say, an additional house officer or a laboratory technician. A final section in this chapter is concerned with the implementation of policies, in Overton the decision related to open visiting and in Allan it was a system for checking parenteral infusions.

THE IMPLEMENTATION OF POLICIES

Overton Hospital: Open Visiting

This issue started with a memorandum from the Scottish Home and Health Department on Visiting of Patients By Children (No. 57/1973) which suggested that children should be allowed as much access as possible to visit most types of patient. The Medical Superintendent passed it on to the Chief Nursing Officer and suggested that they might introduce open visiting in concert with this. Mr. Laver replied that children had reasonable access already and open visiting might be possible after two or three o'clock in the afternoon, with the exception of the maternity wards where a certain amount of rest was desirable. The Committee of Chairmen discussed it in January 1974 and the only obstacle raised was by the chairman of the Radiology Division who said:

> '... during visiting times the wards are reluctant to let patients come to X-ray and this does cause problems. If visiting times were extended this might lead to even greater problems for us.'

It was referred to the divisions and the Surgical Division discussed it at their February meeting:

Mr. Scott: This involves changes that are set out by the Scottish Home and Health Department. There are three problems involved. First of all, the X-ray Department is unhappy about this ...

Miss Raven: The complaint must be within X-ray because we have heard nothing of this in the wards.

Mr. Scott: The second point concerns the visiting and when they are allowed. At present we have every day at three o'clock, the request is that this be modified and visiting be allowed at all times of the day. The third point concerns children visiting and infection. Although in the surgical wards I don't think we turn the children away, that does not really pertain to us, so should we allow visiting every afternoon for an hour?

Miss Raven: No, we would rather have it from ten thirty to seven as we would not be so affected, as it is we have a large number at one time.

Mr. Wren: Would eleven o'clock be better after the ward rounds?

Mr. Scott: It is awkward if you are on the ward when a relative comes, unless they are very ill in which case they are allowed at any time. I think it would interfere with treatment.

Mrs. Waiters (Matron): I think if we have it, it should be at the discretion of the ward sister so that we could ask relatives to leave. If patients are being visited all the time then there are only a few at a time and it need not interfere with ward rounds ...

Mr. Scott: Well we have a Scottish Home and Health Department request here and we have to give some reason as to why we won't comply. We have the suggestion of half-day visiting.

Eventually they agreed that open visiting would be best between two o'clock and seven o'clock. It was interesting that Mr. Scott was under the impression that it was a recommendation from the Scottish

Home and Health Department whereas in fact it was an idea of the Medical Superintendent. The Division of Obstetrics and Gynaecology discussed it and decided that it would be unwise on the obstetrics side. The chairman of the Medical Division did not report on the matter and so the physicians did not discuss it. The Committee of Chairmen returned to the question in March 1974:

Mr. Alwin: This was referred to the divisions but I have had no reports on this. Has anyone replied?

Dr. Murdoch: The Division of Infectious Diseases has not met for one reason or another since then but I think we are against open visiting of children without the sister's permission.

Dr. Henley: I assumed that the I.D. Unit would have to keep children out.

Dr. Falk: We have always said that visiting should be conditional upon medical and nursing staff agreement. It has been applied successfully in some hospitals but not in others. I think it is more socially acceptable than one great rush at a single time.

Dr. Leven: On the whole my division feels that it would be bad from the point of view of post-natal rest and that after that feeding takes place.

Mr. Scott: The Surgical Division feels that there should be open visiting apart from post-operative cases.

Dr. Henley: Well if the general wards are willing to try it then O.K.. Do you agree that a general or limited trial should go on?

It was agreed to have a trial of three months starting on the 1st April, with limits in obstetrics. The Medical Division discussed the issue for the first time on the 26th March:

Professor Alexander: ... What is the general feeling on this? Would it be an imposition Matron?

Mrs. Waiters: I understand that we do not have a choice, it is starting on April 1st from three until eight o'clock.

Dr. Gregor: Where did that come from?

Mrs. Waiters: The Medical Superintendent.

Dr. Gregor: It has not been through the Board of Management. However, I do feel we have always allowed some lee-way on this.

Dr. Marsden: Yes, I feel it is ridiculous to cram all the visiting into one hour.

The Medical Division therefore agreed although they had little option because the matter had been decided already, the chairman had failed to report on it. The first reaction to the trial came at the Surgical Division meeting on the 26th April:

'So far there appear to be no adverse comments from patients or visitors. But most of the medical and nursing staff have not liked the change. Many of the patients are distinctly over-tired as they have too many visitors and the latter smoke very freely on the wards, and expect tea along with the patients, and on one occasion appear to have monopolised the television room. It is suggested that the complaints should be channeled back to the Department of Health.'

On the 23rd May Mrs. Waiters wrote to the District Nursing Officer, Mr. Laver, outlining the problems raised by the trial and asking that visiting be restricted to between two thirty and three thirty in the afternoon and seven o'clock to eight o'clock in the evening. The Committee of Chairmen went over these points at the June meeting:

Dr. Henley: ... However, I get the idea that it would be premature to change as we did say we would have a three month pilot. I think we should have a rapid survey of the patients themselves and see how they feel about it. Maybe one of Mr. Laver's staff could do this? What about the divisions, how do they feel about it?

Mr. Cole: Mr. Sander asked me to make four points. One, it is destructive of ward routine. Second, it is exhausting for ill patients. Thirdly, it is difficult for surgeons to visit

their ill patients. Fourthly, there are security problems with people running around the corridors. For myself, we have had open visiting in the surgical paediatric ward and things have settled down after a while. If it does remain I think the sisters must be allowed to make the rules.

Dr. Langton: We have had no difficulty although we are a medical specialty.

Dr. Gregor: We haven't had too many problems ...

Dr. Malcolm: We have had no problems.

Dr. Henley: I think the problem is most acute in the most acute wards so it may boil down to a specialty or unit problem.

Dr. Leven: In gynaecology they are not happy with the situation, it is a battle with security with children being found in cupboards.

Dr. Little: In psychiatry we are relatively isolated, we have liberal visiting hours but we have no difficulties.

Dr. Henley: I think we will have to continue with it and if the surgeons feel strongly about it then we must make specialty rules although I know Dr. Gregor is against this ...

Mr. Alwin: The three month period is up in June and if you follow the normal routine of this committee then it does not meet in July and August.

Dr. Leven: Could we leave it to Dr. Henley, Dr. Hill and the surgeons to review the situation at the end of the first week in July?

This reconsideration took place and was reported at the Committee of Divisional Chairmen in September:

Dr. Henley: You remember that we had letters on this from Mr. Scott and Mrs. Waiters, well I made enquiries and Dr. Gregor took me to see one of his wards. On that occasion he was not sure that there was much disruption but after a couple of months he has changed his mind ... A student teacher attached to Mr. Laver interviewed sixty patients, the number

being small because they were the only ones who could really engage in conversation, and half of them said that open visiting was too wide open. Dr. Hill and myself took up the suggestion, made by Mrs. Waiters and others, of one hour in the afternoon and one hour in the evening daily. This has been in operation for one month and there have been no grumbles ...

Dr. Little: Regrettably there has been some disagreement from the psychiatrists here, they think it should be more liberal.

Dr. Henley: Yes it has mainly been a problem in surgery and latterly medicine but the psychiatrists can change back if they want to.

Dr. Hill: Geriatrics and paediatrics have been left alone, psychiatry could be changed back if it wanted to.

Dr. Henley: You can consider what is best and inform Dr. Hill of any change.

Dr. Elton: What is the evening hour?

Mrs. Waiters: Two thirty to three thirty in the afternoon and seven o'clock to eight o'clock in the evenings.

This was reported back to the Division of Obstetrics and Gynaecology although it had been changed slightly in the passing on and a certain licence on the part of consultants had been introduced:

'It was reported that this experiment had not been a success and had been altered to Wednesday, Saturday and Sunday afternoons and every evening from seven to eight p.m.. However, it was felt that each consultant could choose the afternoon most suitable to his ward.'

And this is what happened in obstetrics and gynaecology, each consultant chose his own visiting afternoons. In surgery as well they had not quite finished tinkering around with the arrangements as the minutes of their 8th November meeting indicated:

'Mr. Scott suggested that visiting might be delayed to 3.00 p.m. instead of 2.30 p.m. at present, which would allow the clinicians one hour in the afternoon in which to see patients.'

However, Dr. Hill argued that they should leave it for another few months before they considered making any more changes. There was also some pressure on the gynaecologists to fit in with everyone else. From a nursing viewpoint surgery and gynaecology were in the same division and it was confusing for them to have different visiting hours, they would prefer every afternoon rather than three afternoons a week on days which suited the individual consultants. This was reported at the November meeting of the Division of Obstetrics and Gynaecology:

> 'Dr. Pollen read a letter from Mrs. Waiters stating that she had consulted the sisters on the gynaecological wards, who did not seem to think that afternoon visiting every day would be an imposition and that she felt that we should conform to the Surgical Division. It was agreed that the four consultants in the Overton Unit should meet and discuss this further.'

The decision about visiting hours therefore ended with a number of different arrangements throughout the hospital. From geriatrics which had open visiting, to gynaecology with three afternoons a week according to consultant preference and every evening for an hour, and the surgeons were obviously keen to change their afternoon hour to give them more time to see patients.

This decision involved the Committee of Divisional Chairmen and the clinical divisions in reshaping the visiting policy of the hospital. A number of general points need to be made which in some ways echo the general pattern of previous decisions.

First of all, the issue did not receive uniform treatment by the clinical specialties. For example, while surgery and obstetrics and gynaecology discussed the matter, the members of the Medical Division knew nothing about it until the decision had been taken by the Committee of Chairmen, their chairman forgot or omitted to tell them.

Secondly, in the initial period it was the surgeons who were complaining most about the change and it was agreed that they, the

District Medical Officer and the chairman of the Committee of Chairmen would review the position in the summer because there would be no meeting of the chairmen. When this was done the Medical Division was also less happy with the position, although this was during the school holidays and problems might have been anticipated at that time. The decision to shorten the visiting hours was therefore taken by the acute specialties, although paediatrics and geriatrics were left as they were. The division which suffered from this was psychiatry and the chairman was quite apologetic about his division's disagreement with the change:

'Regrettably there has been some disagreement from the psychiatrists here, they think it should be more liberal.'

Although they were allowed to change back to the longer hours this again indicated a stronger role for the acute specialties in hospital policy and a certain deference on the part of the more chronic specialties. The visiting hours in psychiatry had been changed by the acute specialties.

Thirdly, the initial discussions concentrated upon the likely effects of such a change and the impact upon patients and the routine of the wards was monitored by medical and nursing staff. There was even a survey of patients to see what they thought. However, in the aftermath of returning to set visiting times other factors were introduced. In obstetrics and gynaecology it was stated that visiting would be allowed on three afternoons per week and:

'... it was felt that each consultant could choose the afternoon most suitable to his ward.'

In surgery:

'Mr. Scott suggested that visiting might be delayed to 3.00 p.m. instead of 2.30 p.m. at present which would allow the clinicans one hour in the afternoon in which to see patients.'

The former suggestion happened and the latter was forestalled by the District Medical Officer who suggested that they waited a while before

making any more changes. Here it was evident that visiting times were being changed in line with individual consultant preferences, that the divisional system alone was going to do nothing to curb that tendency and in the case of obstetrics and gynaecology it tacitly supported it. This was the cause of some strain among the nursing staff. There were therefore two levels of discretion in visiting times. Firstly the specialty level and it was evident that specialties were different relative to this issue. In infectious diseases children would probably be in some personal danger, in obstetrics post-natal cases probably required more rest than some other patients, in geriatrics visitors were welcome at any time and anything which deterred visitors was probably a bad thing.

Secondly, there was the consultant level and it seemed less defensible to allow individual consultants to decide their visiting times, but this occurred in gynaecology. There were a series of different regulations shaped by specialty differences and consultant preferences. Only Dr. Gregor thought this was a bad thing because of the confusion it would create among staff, patients and visitors alike. However, the Committee of Chairmen was unwilling to impose a more general solution which would have limited the confusion, it showed no tendency to challenge specialty or individual consultant autonomy in this respect, and while the former was probably beneficial in this case, the latter was probably less defensible.

Allan Hospital: The Administration of Parenteral Infusions

This was raised by Dr. Maldern, the community medicine specialist in Allan Hospital, at the meeting of the Staff Association in June 1974:

Dr. Maldern: There is a memorandum from the Scottish Home and Health Department which recommends the setting up of a committee to look at the administration of bottle fluids to make sure there are no flaws in them.

Dr. Cally: I think that this stems from a number of incidents that have occurred in the use of bottle fluids in the south of England.

Mr. Grange: Not another committee though.

Dr. Cally: I wonder if we could safely ignore this one.

Dr. Gow: It could go to the Prescribing Committee, that meets with the pharmacist.

Mr. Earn: I would support that.

Dr. Maldern: When did the committee last meet?

Dr. Cally: A long time ago, however, we have a proposal that this is referred to the Prescribing Committee, is that agreed? Right.

It was discussed again later in the month at the meeting of the Allan District Medical Committee:

Dr. Tilt: This is a circular in the administration of parenteral infusion fluids. They want nominations for a physician, a surgeon and a microbiologist for the District.

Dr. Cally: We felt that we could carry on as we do now. We don't want to rely on the pharmacist if we have to set up a drip in the middle of the night, we would have to wait until morning when he came in.

Dr. Tilt: Should the Area Medical Committee not lay down rules for the Area?

Dr. Quarry: I would have thought each hospital should lay down its own regulations.

Dr. Cally: I would have thought the hospital members of this committee could see to this.

Mr. Earn: I think it is an area matter.

Dr. Quarry: The Chief Area Medical Officer passed it on to us.

Dr. Tilt: Where did it come from originally?

Dr. Quarry: The Scottish Home and Health Department.

Dr. Cally: Do you want to hand it back to each hospital, it says in the light of local circumstances?

Dr. Lyon: With the area ordering of such fluids, shouldn't it be an area matter?

Dr. Tilt: I think they are saying here are some general criteria and it is up to the hospital people to decide how to use them. I suggest the hospital people talk to Dr. Maldern.

Dr. Lyon: I think it all stems from the disaster in Southampton last year ...

Dr. Quarry: If the hospital people are satisfied that the points in the circular are covered by present practice, could we just carry on as we have been?

Dr. Tilt: I think it is a medico-legal problem, if something goes wrong then the area should be able to say we took all the necessary precautions ... I suggest you write to Dr. Maldern, Dr. Lyon, have a chat with him and see what the problem is.

Dr. Lyon spoke to Dr. Maldern about this and reported back to the District Medical Committee in August:

Dr. Lyon: I saw Dr. Maldern and I don't think he has any more idea of what to do than we do. He thinks that we should maybe just continue with the Prescribing Committee and he thought it should probably meet infrequently, he wasn't sure if it should be at hospital, district or area level.

Mr. Earn: I don't think there is a solution in having a committee, we need continuing education.

Dr. Lyon: Dr. Maldern seemed to think there were two parts to the job, part of it being to look at parenteral infusions and also to look at the standardisation of equipment. What do we say then? Shall we say it is important at the ward level?

Dr. Ossian: Say it is a job for the pharmacist and the clinical tutors.

Mr. Earn: Say it appears to involve two things, one, faulty techniques, which can be dealt with by education, and secondly, the standardisation of equipment, for which there could be a committee at area level.

The solution to the problem of faulty parenteral fluids was to rely upon education. Although initially the main reaction of all those involved was to avoid doing anything:

'I wonder if we could safely ignore this one?'

'We felt that we could carry on as we do now.'

'If the hospital people are satisfied that the points on the circular are covered by present practice, could we just carry on as we have been?'

There was very little discussion about the aim of the circular: to make sure that faulty fluids were not administered to patients. Furthermore, they were not encouraged in this by Dr. Maldern, the community medicine specialist, whose main contribution was to reiterate the recommendation of the circular. The problem appeared to be an organisational or bureaucratic one in which a system was desired where by there would be a minimal chance of a faulty bottle fluid being dripped into a patient.

However, the solution chosen was education which, while not a monopoly of professionals, is a characteristic professional solution. Contingencies are prepared for by letting the individuals know what they are and having done that letting them avoid the contingencies in the way they want to. The problem here was that the committee did not define what the education should be or who should be responsible for it. Dr. Ossian mentioned the clinical tutors, but Mr. Earn, a clinical tutor himself, just referred to 'education' in framing the decision. In this way the problem was turned over to individual initiative. It was up to consultants to tell their juniors what the problem was and it was also up to the junior staff how and whether they checked the fluids. The structure was therefore unwilling to devise a system which had to be followed, instead a professional solution of leaving the matter to individual conscience and initiative was employed. This is not to imply that this solution would not, if put into operation throughout the hospital, have the desired outcome, but in this case it seemed to be more of an excuse for doing nothing concrete because no clear instruction was given to the clincial tutors or the units in the hospital.

CONCLUSION: DOCTORS AND THE MANAGEMENT OF THE HOSPITAL

In this chapter a number of decisions have been described and analysed. The main aim has been to determine how Medical Advisory Structures tackle broad management decisions, rather than the narrower professional concerns dealt with in the last two chapters. Three broad categories of decision have been examined, the use of beds, the employment of supporting staff and the implementation of policies. Parallel issues have been covered in Overton and Allan. The primary interest has been in the factors which influenced the way in which these decisions were handled.

One of the major reasons for the introduction of Medical Advisory Structures was to provide better specialty co-ordination and some form of mediation between specialties and the work of hospitals in a general sense. The issues involving bed usage were ideal tests for the aims of the structures. In Overton it was the linkage scheme and the way in which the beds in the hospital were used to accommodate the various specialties. In Allan it was the necessity of closing beds because of the nursing shortage, and the proposal that E.N.T. and paediatrics swop their accommodation. Although the structures in the two hospitals were different there were similarities in their handling of these issues.

In both the linkage and the ward closure there was a marked reluctance on the part of the Committee of Divisional Chairmen and the Medical Staff Association to tell specialties what to do, in either giving up beds or moving them elsewhere. The structures provided no solutions and arrangements were made outside them. In Overton there were informal agreements between the physicians and the surgeons and various voluntary offers from other specialties, but the Committee of Divisional Chairmen did not redeploy the hospital's resources when some specialties unavoidably lost beds. In Allan the Medical Staff Association would not make a ruling on ward closure and played no part in the decision to close eight beds in each of the medical wards. It was left to the District Executive Group and the specialty concerned to find a solution which suited the latter - with no attempt

to see how any of the possible solutions might affect other specialties.

The Staff Association was equally reticent on the proposed exchange of resources between E.N.T. and paediatrics. The E.N.T. surgeons and the general surgeons had decided previously that they did not want to work in the same block and this was the main reason for the Association's rejection of a changeover.

The structures did not want to take a broader role primarily because of the value placed, by all participants, upon the autonomy of specialties to decide their own future. This was evident in the attitude to beds in both hospitals. They were not seen as resources for the hospital to use as it saw fit in the light of changing circumstances. They were seen as specialty resources which were in their gift, not in the gift of the hospital level of the Medical Advisory Structure. There was also a certain pressure towards the status quo. It could be argued that the autonomy of paediatrics was being questioned by the lack of agreement to the displacement of E.N.T., but this was also threatening the independence of E.N.T. and any change which had this result was seen as a bad thing.

In Overton there were three interests involved, those of medicine, surgery and obstetrics and gynaecology and the Committee of Divisional Chairmen did not mediate between these interests. The chairmen stood back and let the three specialties argue it out among themselves, occasionally chipping in with an offer of assistance.

In the issues dealing with requests for additional supportive staff, technicians and ward clerkesses in Overton and block-takers in Allan, the hospital level of the structure had to make decisions. In Overton the requests were agreed to, in Allan the one request was rejected. The requests for senior technicians again illustrated the approach of the committee and its willingness to agree with what specialties wanted. They knew that the request had not been discussed by the Laboaratory Division but this did not stop them from considering it. Also they seemed more concerned about making a good

case for higher levels than whether the request was justified at the hospital level. They just took the word of the chairman of the Laboratory Division and it was clear that they knew little or nothing of the day-to-day running and requirements of the bacteriology department. This was apparent in their reaction to the second request which the chairman of the Laboratory Division said was less strong. However, this did not lead them to consider whether it was justified but rather that '... it might be more important in the second one to produce figures to support it.'

The introduction of ward clerkesses was rather different. There was to be a pilot study of two and the committee had to decide which specialties should be piloted. Three specialties were proposed and so the pilot study was changed to three ward clerkesses. This was partly because the chairman was a physician and the third specialty suggested was medicine. It also indicated that the chairmen were unwilling to mediate between specialties and would rather change the parameters of the decision to suit the number of proposals. In the second part the chairman of the Medical Division asked for another ward clerkess and this was agreed to more or less automatically by the committee.

The blood-takers in Allan represented quite a change, because the Staff Association rejected the request. However, this was not before the chairman had expressed his agreement, purely because the laboratories and the orthopaedic surgeons were in favour of it. The other clinicians pointed out that they were needed not because there was nobody to collect the blood, but because those who were supposed to do it were not doing it at the right time, and therefore it could be rectified by the consultants in their instructions to their juniors. In view of this the attitude of the chairman was more alarming.

The section on the implementation of policy involved two contrasting issues, open visiting in Overton and parenteral infusions in Allan. In looking at open visiting the structure did not operate uniformly in Overton. It was referred to the individual divisions but the

chairman of the Medical Division failed to report on it and the ruling came as something of a surprise to the physicians. More generally the change in the visiting hours and the subsequent retrenchment from open visiting resulted in a series of different visiting hours throughout the hospital and the structure had little control over this movement. This may have been beneficial on a specialty basis, where many specialties would have suffered if visiting had been shortened to the lowest common denominator. However, the decision in gynaecology to allow the consultants to say which afternoons suited them best was taking consultant autonomy to extremes, and yet the division concerned condoned this and the Committee of Divisional Chairmen showed no inclination to change it.

For parenteral infusions, the Scottish Home and Health Department was asking that a co-ordinating committee be set up to devise a system whereby faulty fluids would not be dripped into patients. The Medical Staff Association and the District Medical Committee were reluctant to form the recommended committee or devise a system for the hospital and they seemed to think it best to carry on as always. However, their eventual solution was to leave it to education which avoided a general ruling and allowed the consultants the autonomy to do it or not do it, and if the former, to do it how they wanted to.

Most of these decisions have involved the hospital level of the structure and the Committee of Divisional Chairmen in Overton and the Medical Staff Association in Allan were both reluctant to make decisions which went against the requests or wishes of individual specialties or told them what to do.

It was argued in the theoretical chapters that at the hospital level chairmen of divisions faced a role conflict between representing divisional interests and taking the broader decision-making role for the whole hospital and the service provided. It was argued that three professional characteristics, specialty autonomy, lack of inter-specialty knowledge and differences in specialty status might influence the solution of this role conflict.

The cases indicate a strong concern with specialty autonomy as a professional value which the structure will not challenge. The role conflict was solved largely by avoiding the hospital decision-making role and agreeing to individual specialty requests. If there was more than one specialty request then either the status quo was retained, as in Allan, or the interests were allowed to fight it out in whatever way they chose, there was no attempt to mediate.

It was this factor rather than a lack of inter-specialty knowledge which influenced the solution of the role conflict and the approach to management decisions. Only in the request for senior technicians in bacteriology was there an indication that the other chairmen had to be told of the detailed position in that specialty. The other issues were more general and involved sharing or redistributing existing resources which were not specialty specific in terms of the knowledge required to make the decision.

The last hypothesised influence was specialty status differences. If this had an impact then it would be anticipated that individual requests from higher status specialties would more likely be agreed to than requests from other specialties and that if choices had to be made between specialties then the specialties with more status would do better. In the last chapter choices could not be avoided in the Higher Medicine Allocation and medicine and to a lesser extent surgery, benefited from this. In this chapter the only issues which demanded choices were in Overton, in the linkage and the initial decision about clerkesses. The Committee of Divisional Chairmen avoided the decision in both cases, presumably because the desire not to interfere with specialties was stronger than the influence of the specialties with higher status. However, it was also clear that medicine considered itself to be rather special and deserving of special treatment. In the linkage they inspected the obstetrics wards, although the obstetricians resisted their advances, and in the ward clerkess issue they managed to get more than the other specialties. The acute specialties also saw the ward clerkesses as being best suited to the acute wards and this view influenced their allocation. In addition, the open visiting issue was salient to all

specialties, and yet the retrenchment was the result of the influence of the acute specialties and psychiatry had its visiting hours changed, against its will in the first instance.

In the light of these conclusions about the failure of the structures to act as they were intended and the influence of professional values upon the way they operated, the comment of the Medical Division upon the structure was particularly interesting. This arose when the physicians were unable to secure beds for one of their units in Overton and they stated that the Committee of Divisional Chairmen was a failure because it was incapable of acting independently and taking on a hospital decision-making role. Their reasons for saying this may, or may not, have been valid as they wanted the chairmen to act in their interests, but certainly the committee was unwilling to tell any specialty to give up beds or move to other beds. Obstetrics, surgery and medicine all had different interests but the committee would not decide between them in terms of the continuing service provided for patients. It was therefore apparent that in both hospitals the Medical Advisory Structure would not take on the broader management approach required in mediating between specialties. Instead professional values tended to shape what were perceived as acceptable decisions or solutions to problems.

PART 4. CONCLUSION: DOCTORS AND THE MANAGEMENT OF THE HOSPITAL

Chapter 10. The Medical Profession and Medical Advisory Structures in the National Health Service.

Chapter 10. The Medical Profession and Medical Advisory Structures in the National Health Service

Introduction

The main purpose of this final chapter is to sum up the research findings described and analysed in previous chapters and to examine these in a broader context. Apart from their relevance for the hospitals studied the implications of the findings for Medical Advisory Structures in the National Health Service as a whole will be discussed. In addition, and from a sociological point of view, the results will be looked at in relation to theories of professionalism and the position of professionals in large complex organisations.

The Research Background

Medical Advisory Structures are one of a number of significant changes which took place within the reorganisation of the National Health Service in 1974 (1). The foundations for this aspect of the reorganisation were laid in 1967 with the publication of the First Joint Working Party report recommending the introduction of divisional systems in hospitals (2). This was before definite plans had been formulated for the reorganisation of the administrative structure and the report indicated a broad concern with the resources which doctors use and are responsible for on an individual basis. The unit or firm system of clinical organisation (3) was seen as being out of date and too diffuse as a basis for the rational use of resources. The divisional system, based upon specialty committees of consultants, was put forward as a structure which could overcome these problems and, in addition, channel the considered advice of the medical profession, within hospitals, to the Boards of Management. Subsequently when the design of the reorganised structure was formalised the theory behind the divisional system was extended in two reports to provide a Medical Advisory Structure up to District, Area and national levels in Scotland (4,5). Apart from managing itself more effectively, the profession was also

expected to contribute to planning and policy at all levels through the Medical Advisory Structure. A series of three reports in England and Wales recommended a similar structure for the rest of the National Health Service (6,7,8).

This study has attempted to examine and analyse the way in which doctors adopted and used Medical Advisory Structures in the period immediately before and immediately after reorganisation. Implicit in this has been some assessment of the extent to which the divisional system has fulfilled the expectations placed upon it by the Joint Working Party recommendations (2,4,5).

As a basis for this research and its associated purpose two theoretical and more abstract aspects of the structure and what is expected of it were examined in Chapters 2 and 3. The aim was to define specifically what the profession is being asked to do and what might stand between the profession and the achievement of the goal of better advice to management. Chapter 2 examined the specialty division and Chapter 3 looked at the Committee of Divisional Chairmen. In both chapters two separate strands were teased out:

a. the influence of the formal structure and its proposed function. It was argued that at both levels there was a role conflict between the expectation of representing self interest or group interest and at the same time being expected to arrive at broader specialty or hospital answers to problems; and

b. the influence of the nature and characteristics of the medical profession. At the divisional level this was identified as individual autonomy and at the specialty level three characteristics of specialisation were described - a lack of inter-specialty knowledge, a concern with specialty autonomy and differential specialty status.

In both chapters the intent was to analyse the influence of these two structural inputs upon the way in which decisions are made.

The Specialty Division

At this level it was argued that the structure expects doctors occupying the role of member of a division to fulfil two expectations. First of all, to put forward their own ideas and proposals relative to their own practice and experience. Secondly, to assess their own ideas and proposals in relation to ideas and proposals from other consultants and the position of the specialty generally, in order to decide what is the right course for the specialty as a whole.

It was further argued that within a specialty and between consultants the major professional value is individual autonomy and an attempt was made to assess the impact of this upon the role conflict and its solution. It was suggested that this professional value would make the representation of individual interests and their support by a division preferable to a rigorous consideration and possible rejection of proposals from consultants which derived from their own perception of their own clinical practice.

The Committee of Divisional Chairmen

At this level it was suggested that a similar role conflict was entailed in the role of chairman of a division on the Committee of Divisional Chairmen. Firstly, they are expected to represent the interests and perspectives of their own specialty, both by the structure and those they represent. Secondly, they are supposed to act as a medical decision-making body for the whole hospital, mediating between specialties and assessing the relative merits of different specialty proposals and requests, including their own.

The potential influence of these characteristics of specialisation within medicine upon the solution to this role conflict was analysed. It was argued that specialty autonomy would tend to make chairmen reluctant to disagree with proposals from other specialties because this would impinge upon a mutual concern with specialty autonomy. Therefore the committee would tend to ratify specialty requests and thereby serve that expectation. Lack of inter-specialty knowledge

might be expected to have a similar impact. Chairmen would not know enough about the business and claims of other specialties and would be unable to comment critically, the tendency would be to agree with what other specialties said they wanted. However, this assumes an absence of conflict between specialties either in perspective or competition for resources. Undoubtedly there are occasions when all specialty wishes cannot be granted and choices have to be made between specialties. In such cases it was argued that the third characteristic, differential specialty status, might have an impact, with the higher status specialties of general medicine and general surgery being more likely to get what they want than the lower status specialties. If these influences operate in the way suggested then the structure will not achieve the intended results as proposed in the Joint Working Party reports with either a lack of criticism or status competition determining the way in which decisions are made.

The main purpose of the theoretical chapters was therefore to provide a perspective on the divisional system which would assist analysis and also to assess the ways in which the professional values of doctors might influence or interact with the more managerial aims of Medical Advisory Structures.

The Fieldwork and Research Methods

The fieldwork was carried out in two separate Area Health Boards and the research focussed upon a single hospital within the two Boards. The structure was examined within the hospitals, at the District level in the districts in which the hospitals were located and at the area level. In Overton Hospital the divisional system had been adopted in its recommended form, while in Allan Hospital it had been rejected and the Medical Staff Association and its Executive Committee were used as the hospital basis of the Medical Advisory Structure.

Two main methods of data collection were used. The first was the observation of meetings within the Medical Advisory Structure - divisions and the Committee of Divisional Chairmen in Overton and the Medical Staff Association and its Executive in Allan and the District

and Area Medical Committees associated with both hospitals. This was supplemented by access to minutes and correspondence from the past and present. Case study material was assembled on the discussions surrounding the formation of the structures and the process of decision-making. The process of the committees was observed for two years - the year before and the year after reorganisation. Secondly, semi-structured interviews were conducted, towards the end of this period of observation, with consultants in both hospitals. In Overton half the consultants and all of those who had been chairmen were interviewed - 42 interviews in all. In Allan all the consultants were approached and 27 out of the 29 consultants agreed to be interviewed. The interviews focussed upon their general attitudes towards the structure and its aims and within this some of the material gathered in observation was discussed. In the fieldwork chapters these two sets of data were integrated so that the decisions and their analysis were set against the backcloth of consultant opinions about general principles.

The development of the structure in the two hospitals was described and analysed in Chapters 5 and 6 and then in Chapters 7, 8 and 9 the way in which decisions were made was analysed. Any study which is concerned with decision-making faces problems, and potential criticism, in the way in which issues are selected for analysis. This has been particularly true of studies of decision-making in local or national politics. This study was no exception although the task of selection was made a little easier by the fact that the divisional system was introduced to undertake specific functions, for example, the evaluation of patient care. The decisions analysed were therefore in areas in which Medical Advisory Structures were expected to be making decisions. There was an element of selection in that categories of decision were chosen which would test the structure. It might have been possible to look at the divisional system as a means of disseminating information but it was decided to concentrate mainly upon decisions in which consultants had to act or react rather than to receive. The three fieldwork chapters dealt with levels and types of decision. Chapter 7 examined specialty decision-making and the

way in which divisions or their equivalent handled matters relating to medical practice - such as patient care evaluation, requests for additional staff and requests for equipment. This was the bottom of the Medical Advisory Structure and in Chapter 8 the same decisions were analysed at the hospital level, through the Committee of Divisional Chairmen in Overton and the Medical Staff Association in Allan. As a balance against selectivity all decisions which fell within these broad headings in the period of fieldwork were covered in the two chapters. The decisions analysed are important for a number of reasons.

First of all, they are central to the aims of the divisional system in getting the profession to manage itself in a more formal and overt fashion. Secondly, they were issues closely related to professional practice. It might therefore be anticipated that the professional values and characteristics which have been seen as potential barriers to the operation of the structure would be at their strongest and therefore such decisions would be a good test of the structure.

In Chapter 9 a number of broader management decisions were described and analysed. These decisions were selected primarily because they involved the divisional system in making decisions which have clear implications for the hospital, other groups of staff and patients. The successful negotiation of these decisions requires doctors to step outside their own perspectives and concerns because of the immediate and obvious implications of what they decide to do in such cases.

The next two sections of this chapter will examine the conclusions drawn about the Medical Advisory Structure and its operation at the specialty level and at the hospital level.

The Operation of the Medical Advisory Structure at the Specialty Level

Divisions are intended to be committees within which the policies and priorities of individual specialties or groups of specialties are

decided. In this process individual preferences and perspectives are supposed to be mediated by their consideration in the light of the specialty as a whole. To what extent was the theory correct in its argument that the role conflict entailed in this would be solved in favour of decisions which did not go against the professional value of individual autonomy? Before looking at the way in which decisions were made the development of the Medical Advisory Structure at the specialty level in both hospitals will be briefly discussed.

The major contrast between the two hospitals was that specialty divisions were formed in Overton whereas in Allan the only specialty to do so on a hospital basis was general medicine. In Overton consultants decided to form divisions after detailed discussion at a weekend conference. One of their major worries appeared to be the potential infringement of their clinical autonomy and in dealing with this the Medical Superintendent sent out a memorandum to all consultants stating that divisions were not intended to interfere with consultant autonomy. There was also some discussion about which specialties might amalgamate to form single divisions. The general physicians were the first to organise and the other specialties followed suit several years later.

In Allan concern about clinical autonomy appeared to be stronger than in Overton. In the discussions which the physicians and surgeons had, there were worries about the possibility that the chairman might act unilaterally and that the power of divisions might extend to clinical matters. The major manifestation of this concern came in general medicine when the physicians only formed a division on the understanding that each of the five members had the right of veto. Nothing could be imposed upon a consultant unless he agreed with it. The other difficulty in forming divisions was the number of small, independent specialties. This will be discussed in more detail in next section. In both hospitals clinical autonomy was raised in relation to the formation of divisions suggesting that this value would also affect the way they made decisions in whatever structure they adopted.

The way in which the Medical Advisory Structure dealt with specialty matters was described and analysed for both hospitals in Chapter 7. The decisions discussed were requests for junior and senior staff, requests for equipment and the nature of medical practice and its evaluation and control. Overall, in terms of the way in which individual consultants used the structure and the way in which divisions, in Overton, and the Medical Staff Association, in Allan, reacted to individual requests, the role conflict was solved in ways which go against the expectations of the Joint Working Party reports (2,4,5). The Joint Working Party ideal is the presentation of individual requests and perspectives as a matter of routine in specialty divisions. These requests and views should be critically scrutinised in terms of the broader specialty context with which the division is concerned.

In Overton, in most of the divisions, individual requests were agreed to automatically. No standards were set down stating that specific information was required in support of such requests. Some consultants presented detailed supportive data. Some consultants in some specialties by-passed their divisions altogether and wrote directly to the Committee of Divisional Chairmen. But such differences did not affect the normal outcome which was that individual consultant requests were agreed to irrespective of mode or route of presentation. The role conflict was therefore solved by adopting the expectation that consultant views would be put forward and rejecting the expectation that these views or requests would be considered in their broader specialty context. The expectation that consultants would review and critically discuss proposals and requests was not fulfilled.

In Allan there were no divisions and in theory consultant requests should have been considered by the Medical Staff Association and its Executive. In this case consultants solved or rather avoided the role conflict by by-passing the structure. Individual consultants tended to write direct to the administration or the District Medical Officer rather than put their requests before the Medical Staff Association. Consultants in Allan had been reluctant to form divisions because of the potential threat to their autonomy and this

concern was carried over in the way they avoided using the Medical Staff Association for their own requests and matters of clinical concern.

For those requests which were submitted to the divisions in Overton the judgement of individual consultants was rarely questioned. Their approach was more in terms of securing agreement higher up the structure than deciding whether or not the request was valid at the specialty level. All this suggested that consultants did not want to go against one another and intrude upon individual professional autonomy. It was clear in the interviews that consultants did not want to impinge upon one another's autonomy and saw the division as an almost totally supportive device rather than a constructively critical one.

Another aspect of this was that divisions tended to look at requests on a piecemeal basis without considering the longer term needs of the specialty and fitting issues into that context. The one exception to this was the Medical Division in Overton Hospital. This division realised that with their consultant requests relative priority was being decided by other people higher up the administration or Medical Advisory Structure. They decided that this was bad and that they should be concerned with local priorities. This was a considerable advance, although to be fair a number of the other divisions did not generate enough staffing requests for priority in the short or medium term to have any real meaning. The Medical Division took the same attitude to their Higher Medicine requests. It appeared, initially at least, that they were prepared to look at a series of different consultant proposals in the light of broader considerations and criteria in order to decide upon their relative priority for the specialty as a whole. However, they did not make the decisions in this way and the methods they chose again highlighted the theoretical difficulties outlined in Chapter 2. In both cases, consultant priorities and the priorities for the Higher Medicine allocation, the members of the division obviously found it hard to arbitrate between competing requests. As a result any suggestion of open decision-making was rejected. In one of the decisions it

was proposed that the chairman and the secretary and possibly other members of the division without requests should make the decision. This was unacceptable to those involved because of the role conflict, i.e one of them said that they would be the judges and the judged and that this would be intolerable. They were also reluctant to compare the requests other than in broad personal judgements, the bases of which were never made apparent. As a result of these difficulties they chose the ballot as a means of handling priority decisions. Indeed on subsequent occasions the ballot was swung into operation with even less discussion of general issues and relative value than on the first occasion they decided to make a priority decision.

While the ballot differentiated between consultant requests it did so in such a way that allegiances, reasons for support and criticisms were not brought out into the open and discussed in broader frameworks. People voted in line with their own clinical interests and individual views rather than after a discussion of differential patient requirement in the specialties proposed. The Medical Division in its decision to make priority decisions had come considerably closer to the Joint Working Party proposals for self management and appraisal on the part of the profession. However, the priority decisions were not then made in this spirit. The reason again lies in the way the role conflict was solved. The decision required detailed comparison between competing consultant claims and the standard against which these claims were measured should have been patient need and workload in the case of consultant staffing and contribution to medical science in the case of Higher Medicine. While the competing claims were ranked in a priority order this ordering did not stem from the application of broader criteria. The choice of the ballot avoided the open fulfilment of the broader role expectation and the decision depended as much upon the voting system employed as any other variable. Various voting systems were used and the rank order of priority changed on consecutive votes. It seemed that consultants were not prepared to openly criticise one another's requests and as a consequence individual autonomy was largely safeguarded.

Divisions and the Medical Staff Association did not therefore act as systematic screeners of individual consultant requests and proposals in the way they handled matters springing from professional practice. The doctors did not subordinate professional values and relationships to the organisational purposes of the Medical Advisory Structure, divisions tended to be used as legitimating devices for what individual consultants wanted. This was particularly evident in the interviews when consultants were asked about the way in which they made priority decisions. This produced a number of different answers none of which indicated a careful assessment of the implications of any course of action in the light of existing circumstances. Some consultants said that they tried to vote in such a way that, over time, everyone got an equal share of available resources. Others said that people tended to vote for colleagues with whom they were friendly rather than for colleagues who had the best proposals. Neither of these reasons suggested an effective screening and both of them indicated a predominant concern with ongoing professional relationships. Other consultants said that these approaches were used in the Medical Division and said that they were inappropriate. They argued that merit and need are not evenly distributed among consultants and that receiving first priority in one year may provide the foundation for first priority the next year, if any advance is to be maintained. Whereas the equal sharing of resources may go against the development of merit.

Lastly there were issues involving the evaluation of patient care and the control and management of practice within specialties. In both hospitals few decisions dealt with these issues. The Surgical Division came closest to a comparison of their clinical practice with one another. They discussed the possibility of a reduced length of stay for hernia operations but they decided against it because they did not like the idea of a set length of stay which might limit their discretion and autonomy. Freidson has argued that observation and knowledge of clinical practice among colleagues must exist as a prerequisite for control of standards (9). However, other discussions indicated that consultants knew very little about the details of one another's practice and may not have had an adequate foundation from

which to move to joint action. Another discussion on kidney donors indicated that consultants were reluctant to set rules which would impel them to react to contingencies in a set way. Some would have been agreeable but the division reacted to those who were most concerned that autonomy should not be restricted. It seemed that consultants in both hospitals lacked the knowledge or, if they had the knowledge, the willingness to control, monitor, or shape one another's work.

In relation to the evaluation of patient care it therefore appeared that the Joint Working Party proposals had expected too much of consultants. It seemed that divisions did not have the capacity to evaluate patient care and the management of practice. Professional values were a stronger influence upon behaviour than the expectations placed upon divisions and their members.

Medical Advisory Structures at the Hospital Level

In this section the conclusions which have been drawn about the hospital level of the Medical Advisory Structure in Overton and Allan will be examined. At the hospital level specialty or divisional perspectives and requests have to be assessed from the viewpoint of the service provided by the hospital as a whole. It was argued in Chapter 3 that the role of member of the Committee of Divisional Chairmen entails two potentially conflicting expectations. First, representing specialty interests and secondly, making decisions on the basis of broader considerations in terms of what is best for the service provided by the whole hospital. It was argued that there were three potential influences from within the profession which might affect the way in which this role conflict was solved and the way in which the Committee of Divisional Chairmen or its equivalent made decisions. These professional characteristics were lack of inter-specialty knowledge, a concern with specialty autonomy and differences in specialty status and prestige. Before looking at the process of the system attention will be focussed upon the formation of the hospital level of the structure in the two hospitals. It was argued that if some groups, in any system based upon competing

groups, have more status and/or political resources than other groups then the system will tend to be biased in favour of those groups. In examining the hospital level of the structure the intention was to identify any mobilisation of bias which might indicate benefits or privileges accruing to higher status specialties (10). In structural terms it might be anticipated that bias would be manifest in, for example, some specialties providing more office holders or being nominated to represent other specialties. What were the main threads of the development of the hospital level of the structure in Overton?

In Chapter 3 it was clear that in terms of the status indicators employed, general medicine, general surgery and their related specialties have more status and prestige within the profession than other specialties. This appeared to have some impact upon the design and formation of the Medical Advisory Structure. The general physicians were the first specialists to form a division and general surgery was the second specialty. A general physician was elected by the other chairmen as the first Chairman of the Committee of Divisional Chairmen (and this was also true of three of the other four districts in Lennox). When the districts and the profession had to form the Interim Area Medical Committee, seven of the twelve hospital members were consultants in general medicine and its related specialties. When the definitive Area Medical Committee was constituted five of the twelve hospital members came from general medicine and its related specialties.

The physicians, through their own initiative, were the first to organise. In addition, and as a result of their status within the profession, physicians were nominated as chairmen of Committees of Divisional Chairmen and as representatives - in larger numbers than any other specialty - on the interim and definitive Area Medical Committees. The physicians therefore enjoyed structural advantages which other specialties lacked. The mode of organisation favoured them and in this way status within the profession was mobilised as bias in the Medical Advisory Structure.

There were also less obvious indicators of the specialty hierarchy. For example, when the District Medical Committee was formed there was agreement that it need not be a large committee and that the hospital membership should be limited to seven. There was therefore some temporary amalgamation of specialties in Overton for district purposes. Infectious Diseases was put in with general medicine, anaesthetics with general surgery and radiology with laboratory medicine - but there was never any doubt which specialties would represent these joint divisions, general medicine, general surgery and laboratory medicine. It therefore appeared, in setting up the structure, that the specialties with higher status within the profession enjoyed structural advantages both through their own initiative and through the respect of other specialties.

Concern with specialty autonomy and a lack of inter-specialty knowledge were less in evidence in the formation of the structure although there were indications of their importance in the way consultants argued about certain constitutional details. In discussing the constitution of the District Medical Committee the general practitioners were against deputies and the hospital members were for them because the general practitioners were homogeneous whereas nobody could or would represent the views of another specialty if he was there to represent his own specialty. This suggested both a concern with autonomous representation and a lack of inter-specialty knowledge.

The need to form district and area committees gave a number of insights into the way in which the profession perceived the structure which were less apparent at the hospital level. In the hospital it was possible for specialties to argue that they needed specialty representation and they were allowed to have it. There were as many divisions as specialties which wanted them to start with, even including two each in chest medicine and obstetrics and gynaecology. This freedom was not possible higher up the structure. Choices had to be made and the way in which these choices were made and perceived indicated underlaying values and concerns. The Area Medical Committee employed a seemingly unbiased method of selection and yet members

complained about the specialty mix which this produced - too many physicians and no psychiatrists. The psychiatrists protested and one of their number was co-opted. This, in a sense gave the lie to the method of selection. The Area Medical Committee was not supposed to be a forum for the representation of specialties, it was to represent the whole profession. It was apparent that the members did not think that it would be able to do this unless certain specialties were represented. At the same time this implied that the absence or presence of specialties on the committee would have an impact upon the way in which decisions were made. This suggested that in the early stages doctors had little faith in their ability and willingness to represent and talk about interests other than their own.

There were similar problems with the specialty sub-committees at the area level. For this purpose the orthopaedic and accident surgeons had been included in a sub-committee for all surgeons. They argued that they should have a separate committee. This was rejected but there were still complaints from them and other surgical sub-specialties. The urologists complained the most and they were co-opted onto the committee. Again this implied that the consultants thought that the specialty composition of committees would have an impact upon the decisions which were made, and that this would not be in favour of specialties who were not represented. This indicated a concern with a specialty identity and autonomy and a strong feeling that specialties could not or would not represent interests other than their own. Events like these suggested that the theoretical doubts about the mediating potential of the Medical Advisory Structure were justified even in the way that consultants thought the structure would operate. Consultants seemed to think that members of committees would solve conflicts in their role by pursuing their own interests first.

The development of the structure at the hospital, district and area levels in Allan and Aldershire was rather different. It was not apparent that any specialty enjoyed structural advantages in Allan and Aldershire. Consultants did not form a divisional system in

Allan. They used the Medical Staff Association as the basis of the Medical Advisory Structure. One of the main reasons for this was the concern among all specialties, however small, that they should represent their own interests, rather than giving others a mandate to do so.

Specialties did not want to amalgamate because they valued their autonomy and did not think members of other specialties could represent their interests. On two separate occasions they identified fifteen and twenty-three specialty divisions which would want to be represented. These were ridiculous numbers in view of the fact that there were in the region of thirty consultants. In the Medical Staff Association, by contrast, everyone was represented. The divisional system could only reduce the extent to which they could all influence their own future. Because of this membership of the district and area committees did not spring from a specialty-based organisation. In the divisional system specialties were structurally <u>for</u> themselves, in the Medical Staff Association specialties were only <u>of</u> themselves. In Overton and Lennox members came from specialties and were nominated and chosen by representatives of all specialties. In Allan and Aldershire members of the Staff Associations in all the hospitals were put forward as individuals not as representatives of specialty blocks. In contrast with Lennox the membership of the Aldershire interim and definitive Area Medical Committees did not show any bias in favour of some specialties rather than others. Organisation on a specialty basis almost inevitably led to advantages for the more prestigious specialties.

Despite the fact that divisions were not formed in Allan there was still some concern about specialty autonomy and autonomous representation at the higher levels of the structure. For example, the District Medical Committee was going to involve representation from two specialty hospitals and consultants in Allan saw this as giving the representatives of these hospitals a definite specialty mandate which representatives of the Staff Association would not have. This led to the assertion that '... if we are to compete with them on an equal basis we really need to have specialties as well'. Similarly,

and as in Lennox, specialties which did not happen to gain representation on the Area Medical Committee asked for representation. In Lennox some of these requests had been acceded to, in Aldershire they were rejected because '... this committee derived from hospitals/ groups and not from specialties'. They felt that to co-opt would imply that those already on the committee could not act in an unbiased fashion.

Similar attitudes were expressed when specialty sub-committees to the Area Medical Committee were discussed. It was decided that, rather than having standing specialty sub-committees, members of a specialty would be co-opted to the Hospital Sub-Committee when necessary. In Allan consultants wanted all members of a specialty to be co-opted on such occasions - so that there was no chance of them being outnumbered by the standing members of the Hospital Sub-Committee. This indicated that they did not want specialties to be unable to get what they wanted - a prime concern with autonomy. It also suggested that consultants saw decisions being taken on the basis of numerical strength rather than reasoned argument.

There were therefore strong structural contrasts in the Medical Advisory Structures developed by the two hospitals. However, in both hospitals there was a concern with specialty autonomy which shaped the reaction to local circumstances. In Overton this resulted in a multiplicity of divisions with some duplication. In Allan, this concern with autonomous representation would have meant a large number of divisions with few consultants in each. They would not amalgamate and so the Staff Association was retained. A concern with specialty autonomy therefore influenced the structure in its formation in both hospitals. On the other hand, bias in terms of advantages accruing to the more prestigious specialties was only apparent in Overton. Specialty is the unit of organisation in the divisional system and because people were representing specialties and were selected and nominated by representatives of other specialties prestige and status differences seemed much more likely to be expressed than in an organisation, the Medical Staff Association, which had no specialty basis.

The influence of the professional value of specialty autonomy was therefore apparent in both hospitals and their related structures and in Overton there were certain structural advantages accuring to the general physicians. Did these influences upon the formation of Medical Advisory Structures also have an impact upon the way in which consultants approached decisions and solved the role conflict at the hospital level? This will be considered in two parts, the first, dealt with in Chapter 8, relates to matters internal to the profession, and the second, covered in Chapter 9, concerns decisions about the management of the service in a broader context.

Decisions on Matters Internal to the Profession

On the surface there were considerable differences in the way in which the Medical Advisory Structures in the two hospitals dealt with matters internal to the profession. To take staffing requests as an example, in Overton all requests for consultant and junior staff were passed through the Committee of Divisional Chairmen. In Allan, consultants by-passed the Medical Staff Association, writing direct to the administration with such requests. Formally the Committee of Divisional Chairmen was used to screen requests and the Medical Staff Association was not. However, in examining the way in which the Committee of Divisional Chairmen in Overton dealt with such requests the contrast is less striking. All requests which were passed to the committee were agreed to more or less automatically with a minimum of discussion. Furthermore, there were no guidelines from the chairman as to how requests should be processed below that level or how they should be presented to the Committee of Divisional Chairmen.

Some requests had been discussed by the division concerned before being sent to the Committee of Divisional Chairmen - but in other cases the consultant wrote direct to the committee. Sometimes supportive data were presented, in other cases there were none. Whatever their origin, and whatever the supportive information, requests were agreed to by the committee.

It therefore appeared that in the role conflict between the representation of specialty interests and the making of decisions on the basis

of broader criteria, the former took precedence in the eyes of the members. This seemed to stem in part from a lack of inter-specialty knowledge because in the interviews a majority of the chairmen said that they knew little about what went on in other specialties. In the meetings themselves, however, they made little attempt to find this out in relation to specific requests. They were not prepared to ask for such information. They did not want to take on the authority such that they would overrule what other specialties wanted and this in turn stemmed from a mutual concern with specialty autonomy. This was especially evident in one of the few decisions in which sufficient information became known for it to be reasonably clear that the committee would have to disagree with what a specialty wanted. This involved the redesignation of a Junior Hospital Medical Officer and this should have been a matter of routine. However, the specialty concerned was against it and the Committee agreed with the specialty because it would create a precedent if they went against what a specialty wanted. Subsequently the decision was changed but only after the Scottish Home and Health Department had been brought into it and it was clear that there was no alternative. The first and predominant inclination of all members of the committee was to agree with what other chairmen wanted, provided there was no immediate conflict with what they themselves wanted.

The Committee of Chairmen did not therefore fulfil a role of judging requests on the basis of broader criteria, it merely added its weight to requests placed before it. The first chairman of the Committee of Divisional Chairmen recognised this and stated that the committee was reacting to staffing requests on a piecemeal fashion. It was agreeing to things without looking at them in relation to other requests competing for the same resources or in terms of the broader aims of the hospital as a whole. However, the committee did not change its ways after this comment.

In Allan, consultants with staffing requests avoided the Medical Staff Association altogether. This also stemmed in part from a concern with autonomy and the fact that specialties did not think the Medical Staff Association should be involved in such decisions or had

anything to contribute to such requests. The fact that Overton had a divisional system including a Committee of Divisional Chairmen therefore made little difference as all the requests in both hospitals successfully reached the area level more or less unchallenged by the structure. In Overton the role conflict was resolved by agreeing to all specialty requests and thereby fulfilling the expectation of representing specialty interests. In Allan the role conflict was resolved by avoiding it and by-passing the hospital level of the structure. In both cases the autonomy of specialties remained intact.

However, there were other decisions in which this option was not easily available such as those in which priorities between specialties could not be avoided. The major cases of these were the Higher Medicine requests in Overton and requests for medical moveable equipment in both hospitals. If differential specialty status was to have an influence upon decision-making as well as the formation of the structure then it might be anticipated that it would have an effect when valuable resources had to be allocated.

This seemed to be the case in Overton Hospital. In the Higher Medicine allocation requests for different pieces of medical equipment from various specialties were discussed by the Committee of Divisional Chairmen. The committee knew that priorities had to be assigned but they were very reluctant to do this. In both years the Medical Division had four requests, which it had itself put in order of priority, and these were ranged against requests from several other divisions.

In both years the first priority of the Medical Division became the first priority of the hospital as a whole. In the first year the discussion took place between all the chairmen. There was lengthy debate about whether they could submit the requests without ranking them and hardly any about the relative scientific merits of the submissions. Partly as a result of deference on the part of the other chairmen and partly as a result of pressure applied by the chairman of the Medical Division, the physicians got a better deal than any of the other specialties. The only pressure against this solution

seemed to reflect notions of specialty autonomy and equality. This was because a number of the chairmen were reluctant to put the second medical request above the first request of any specialty - and this was without reference to their merits. In the second year the decision was made by the chairmen of the two divisions with requests, the Medical Division and the Laboratory Division and the District Medical Officer. Again the first medical request became the first priority for the hospital. In addition, in both years the general surgeons were given money outside the allocation from the district. In the first year this was apparently because they asked for too little money and in the second year because their request was late in arriving. In Higher Medicine it appeared that the physicians and to a lesser extent the surgeons did better than the other specialties.

For medical moveable equipment the Committee of Divisional Chairmen was given the budget to allocate between the many requests. A sub-committee was appointed every year to undertake the task of deciding priority. The researcher could not attend these meetings and so the process of the sub-committee was not open to observation. It did seem, however, that there were some biases in the selection of the sub-committee. In the first couple of years the composition of the sub-committee was not based upon specialties but in subsequent years the physicians, and to a lesser extent the surgeons, had advantages in membership of the sub-committee and informal consultation which were not enjoyed by other specialties. Although it is impossible to say whether this was used to their own advantage.

In Allan, on the other hand, the Staff Association was reluctant to handle the allocation by itself and the claims of the Executive to be a representative but non-partisan body seemed to be refuted in practice. In both years the Executive was supplemented by additional consultants primarily so that all or a particular selection of specialties could be represented. The first year it was by combining with the Prescribing Committee and the second year by supplementing the Executive with those having requests for equipment. This was

partly due to a concern with specialty autonomy and the fact that specialties would not want their requests turned down by members of other specialties. As the chairman said - '... well if someone puts in a request then they don't want it turned down by an anaesthetist or a pathologist'. This resulted in a legitimated competition between specialties with bargaining between competing interests rather than the consideration of the different proposals in the light of broader hospital criteria. Such a competition may have resulted in advantages for the more powerful specialties but there was no evidence to indicate whether or not this was the case.

The other major issue discussed in Chapter 8 was the evaluation of patient care. This was supposed to be one of the key functions of Medical Advisory Structures. In Overton this came up directly in the form of a computer print-out containing a consultant activity analysis. This was circulated to consultants regularly. The Medical Records Officer, who supplied the print-out, was aware that the consultants were not using it to evaluate their care and he had asked consultants in the past to make suggestions as to how they would like the data presented such that it would be of use to them. They made no suggestions for improvement. The Medical Records Officer therefore asked that the system be discontinued, but the Committee of Divisional Chairmen did not want to do this either. The chairmen thought that it was the job of community medicine to use the data and the community medicine specialist in the district thought it should be the job of the clinicians. It was clear that consultants did not want to take any initiative upon this or direct individual divisions or consultants to do so. It seemed that the Committee of Divisional Chairmen was not a body which was capable of persuading or telling specialties to instigate some system of evaluation, and this in a situation where data were readily available and the providers of those data were willing to change the method of presentation to whatever was required. There was no discussion of patient care evaluation in Allan Hospital. The first report of the Joint Working Party stated:

> 'We consider that the development of a systematic critical evaluation of clinical work should be one of the most

important functions of a division.' ((2), para. 36)

Consultants in both Overton and Allan were unwilling to engage in such an evaluation.

In both hospitals there was some discussion of certain aspects of medical practice involving standard modes of procedure across specialties or the delineation of responsibilities for certain types of cases. However, neither the Committee of Chairmen in Overton nor the Medical Staff Association in Allan wanted to tell individual specialties what to do. They preferred to leave specialties to define their own rules. Again it appeared that specialty autonomy and its maintenance was a barrier to the aims of the structure.

In general, therefore, the concern with specialty autonomy seemed to be the key influence in the solution to the role conflict faced by members of the Committee of Divisional Chairmen. Wherever possible specialty requests and claims were granted as a matter of course. When it was impossible and priorities had to be determined between specialties, the specialties with the higher status, general medicine and to a lesser extent general surgery, seemed to have more advantages than other specialties - either in getting what they wanted or in having more opportunities for controlling the allocation process than other specialties. In Allan specialties tended to by-pass the Medical Staff Association with many of their requests. They did not think that the Association should have any jurisdiction or influence upon the acceptance of what they wanted. Again this could not be avoided in the case of medical moveable equipment requests, however, the structure proved inadequate and the Executive of the Association was supplemented to provide a spectrum of specialty representation. This in turn legitimated the competition between specialty interests rather than removing the decision from narrower concerns and perspectives.

However, these issues have been closely concerned with specialty medical practice - controlling standards and requests springing from the clinical perceptions of staffing and equipment needs. It might therefore have been anticipated that specialty autonomy would have

been at stake in these decisions. In Chapter 9 slightly broader management issues were covered dealing with hospital resources which had obvious implications for other groups. Similar issues were examined in both hospitals.

Matters Relating to the Management of the Hospital

Various types of issue were discussed and the first of these was the management and use of beds. In Overton the decision involved the ward linkage scheme, the consequent ward closure and the necessity for managing the use of beds in Overton and other hospitals in the district. The Committee of Divisional Chairmen was given responsibility for much of this - particularly in redistributing beds once it became clear that some wards would be out of operation while structural faults were rectified. However, the Medical Advisory Structure failed to find solutions and the Committee of Chairmen showed a marked reluctance to direct specialties to give up beds or move into other beds. Settlements were negotiated outside the structure by the specialties primarily involved.

The position was similar in the two issues dealt with by the Medical Staff Association in Allan Hospital. One involved a proposed exchange of resources between E.N.T. surgery and paediatrics in which the former would take the place of paediatrics in the surgical block. The main reason for the rejection of the proposal was that the E.N.T. and general surgeons did not want to share the same accommodation. The second Allan issue involved the closure of beds because of a nursing shortage. The Medical Staff Association failed to find a solution acceptable to the specialty concerned, and the physicians negotiated directly with the administration and achieved the solution which they wanted.

In both hospitals the stumbling block between the hospital level of the Medical Advisory Structure and these management decisions was the value placed upon specialty autonomy and the reluctance of the chairmen to impose decisions upon specialties - knowing full well that they would not want the structure to impose decisions upon them with which they disagreed. An extension of this was that beds were seen

as specialty resources rather than hospital resources - only available for reallocation with the consent of the specialty which happened to be using them at that time. Chairmen favoured the expectation involving the representation of their own interests and the interests of their colleagues. None of them wanted to operate the structure in such a way that decisions were imposed upon specialties against their wishes. Because the structure did not take on an arbitrating role in Overton, the allocation of beds turned into a competition between the main parties, general medicine, general surgery and obstetrics and gynaecology. Most of the arguments and negotiations between these specialties took place outside the structure. This was one case in which it was possible to see specialties operating as pressure groups attempting to maintain and further their own interests. It looked at one point as though specialty status would have an impact when it seemed that one specialty would have to move some beds to one of the smaller hospitals in the district. The physicians argued that general medicine was more important to a general hospital than obstetrics and gynaecology and they even went to the extent of inspecting wards in the latter specialty to see if they would suit their purposes. However, the obstetricians refused to give into this pressure and the Committee of Chairmen refused to back the physicians against them. In previous decisions the physicians had been more successful in acquiring resources than some other specialties but this decision indicated that they were not always able to get what they wanted. Although there is a crucial difference between this case and others involving requests for equipment. In the ward linkage scheme beds were already in the possession of the specialties involved and the physicians wanted to take some of them over, whereas in the case of requests for equipment new resources were available and being allocated. However, this does suggest that specialty autonomy was the more dominant value and also that the effect of specialty status was in some way dependent upon the acquiescence of the lower status specialties in the manner of Scott's boon deference (11). A high status specialty could apply considerable pressure but if the lower status specialty did not want to give in then the Committee of Chairmen would not tell it to do so. As a result it was the physicians who had to move to another hospital.

The decision had not been the result of a careful consideration of the various options and their effect upon the service provided to patients. Rather it had been a complex battle between competing interests in which the Committee of Chairmen had played little part other than maintaining the status quo.

The next category of management decisions involved requests for supportive staff. In Overton the requests were for laboratory technicians and ward clerkesses and in Allan there was one request for blood-takers from the pathologists. The requests for laboratory technicians were treated in much the same way as those for medical staff. The Committee of Divisional Chairmen agreed more or less automatically. The chairmen seemed to be more concerned with how the case should be presented at the area level than whether or not the case was justified at the hospital level. This again indicated that the chairmen were reluctant to deny what any specialty wanted provided it did not conflict obviously with what other specialties wanted. The requests for ward clerkesses were slightly different. The appointment of clerkesses began as a pilot study and the initial allocation again indicated the reluctance of the chairmen to arbitrate between competing specialty claims. A pilot study of two had been agreed by the administration. At the meeting to decide which specialties should get them three specialties were put forward and the pilot study was changed to one involving three clerkesses. However, the physicians had introduced the idea and played a strong part in influencing the way in which they were allocated in the pilot and in later allocations.

By contrast, the request in Allan for blood-takers was rejected by the Medical Staff Association. The pathologists wanted them because of problems with the junior medical staff collecting samples in time for auto-analysis. The chairman of the Staff Association was in favour of immediate acceptance because the pathologists and another specialty said they were necessary. Instead the clinicians realised that the solution to problems of getting samples to the laboratory in time was in their own hands. They decided that the problem could be overcome by better organisation on the wards. This decision was

an exception because the wishes of a specialty were not agreed to, although in this case the decision involved ward routine in all specialties and the decision would have affected junior staff of all consultants. For this reason they felt that the request involved them in an immediate way and were therefore less reticent about commenting adversely.

The final group of decisions involved the implementation of policy, open visiting in Overton Hospital and the administration of parenteral infusions in Allan. In the former the structure reacted quickly to the apparent success and failure of open visiting but the result was a proliferation of different visiting times for each specialty. Within gynaecology it was left to consultants to decide which afternoons best suited them for visiting. At this extreme it again appeared that the Committee of Chairmen was not prepared to make rules which would be binding upon specialties. Also in this decision the physicians and surgeons were the specialties who were consulted informally and what they wanted was applied to most of the other specialties. Indeed psychiatry found that its visiting hours had been shortened and the chairman of the Psychiatric Division had to ask for their hours to be extended again.

In Allan the decision about parenteral infusions originated with a memorandum from the Scottish Home and Health Department which asked the Medical Advisory Structure to set up committees to plan the safe administration and storage of these fluids. However, consultants were unwilling to do this and it was left to individuals and a vague commitment to education to ensure that faulty fluids were not administered. There was a reluctance again to produce a solution which might have resulted in the structure telling consultants and specialties how to organise one small aspect of their work.

The decisions discussed in this section have involved problems in the management of the hospital and the health service. In both hospitals the Medical Advisory Structure was again reluctant to look at decisions and problems from broader perspectives. As in previous

issues discussed in the last section there was a role conflict between representation of specialty interests, for example, hanging onto beds already in their possession and refusing to move to another hospital, and the broader expectation of examining problems in the light of how any decision might affect the provision of services for all patients.

It was apparent that both the Committee of Divisional Chairmen and the Medical Staff Association would not tell specialties to do things against their will. The role conflict was solved by avoiding the broader decision-making expectation. In most cases what any individual specialty wanted was agreed with as long as this did not conflict in an immediately obvious sense with what any other specialty wanted. In issues involving conflicts of interest between specialties the committees were reluctant to arbitrate or support one specialty against another. This had the effect of preserving specialty autonomy and from the interviews with chairmen it seemed that they were most reluctant to interfere with what other specialties wanted. In many cases the role conflict was solved by avoiding the broader expectation and automatically agreeing to individual specialty interests. In other instances such avoidance was more difficult because interests were involved.

In the last section it was clear that in Overton there was some specialty bias in the way that scarce resources or priorities were allocated with general medicine and general surgery doing rather better than other specialties. Was there any evidence of such bias in these more managerial decisions? In Allan specialty status differences had no obvious impact upon the way in which decisions were made but in Overton the process was more complex. The physicians seemed to take more initiative on these issues than most of the other specialties. The linkage scheme had much of its momentum because the surgeons wanted it and they were the ones who would use the first completed linked wards (and as it happened the only linked wards). The physicians also played a leading role and even spent some time contacting the architects who were involved in the project. Both specialties played a major part in the discussions about open visiting hours and their subsequent reduction. In the case of the ward

clerkesses the physicians were more prepared to push for what they wanted. In some senses these two specialties were more active than other specialties and benefits followed from this.

However, it was less evident that the physicians were able to get their way when wards were closed in Overton and beds had to be re-allocated and at least one specialty had to move to another hospital. The physicians acted as if they should receive priority. They thought that their specialty was more important to a general hospital than obstetrics and gynaecology. They even visited the wards of the latter to see if they would suit their own needs. However, the obstetricians and gynaecologists refused to give up any more beds. They had empty beds but they had plans for redevelopment themselves which would be delayed if those beds were occupied by anyone else. As a result the physicians had to move a ward to one of the smaller hospitals in the district. The Committee of Chairmen would not back the physicians against the obstetricians and gynaecologists, not because the validity of the latter's argument was analysed and thought to be better than that of the physicians, but because the obstetricians and gynaecologists did not want it to happen. In this and other issues it seemed difficult, if not impossible, for the structure to do anything without the consent of those concerned. The ability of the physicians to get what they wanted was dependent not only upon their initiative and pressure but also in large measure to the willingness of other specialties to let them have it. Specialty autonomy therefore seemed to be a stronger influence than differences in specialty status with the caveat that in this case the beds were already in the possession of the obstetricians and gynaecologists whereas in the case of Higher Medicine and medical moveable equipment the money available did not belong to any of them - it was a new resource.

To most of the chairmen the beds belonged to the obstetricians and gynaecologists. The beds were not seen as resources which could be used in the light of changing circumstances. In this case and with this perspective on hospital resources the Committee of Chairmen could do nothing but uphold the status quo. It would seem that the

same reasoning might apply to other resources which specialties are in the habit of using - such as offices, space in outpatient departments and so on. It would be very disruptive if such facilities were constantly changing hands but there are occasions when circumstances change, through rebuilding in this instance, and from the viewpoint of managing and using hospital resources to the best effect, resources have to change hands. From these issues it appears that the Committee of Divisional Chairmen would find it very difficult to take on such a managerial function, because resources are seen as belonging to specialties and all specialties want to retain their autonomy. At the same time, however, differences in specialty status appear to have an impact upon the allocation of new resources, through the active pressure of higher status specialties and the agreement or acquiescence of lower status specialties. Indeed in the later stages of the linkage issue when new ward blocks were being planned it was clear that the general physicians were going to be the first to move into them.

In relation to both existing and new resources the Committee of Chairmen appeared to lack the broad perspectives necessary in managing hospital resources. In Allan Hospital the position of the Medical Staff Association was similar although in this case its reluctance to tell specialties what to do was matched by the reluctance of specialties to use it as a body to which they would take their requests and problems.

It therefore appeared in these decisions that professional values and characteristics at the hospital level were a more potent force in shaping decisions than the managerial aims of the Medical Advisory Structure.

Why Does the Profession Use the Medical Advisory Structure?

If the structure does not produce what was anticipated by the Joint Working Party proposals, what are the advantages to the profession in using the structure? In basic terms the profession has been more or less compelled to use and accept parts of the Medical

Advisory Structure as the way in which it communicates with the administration. For example, the Area Medical Committee is the only formal means through which the whole profession can communicate with the Health Board. However, there are some more positive benefits to the profession. The structure is designed to incorporate all consultants in the decision-making process. It is possible that they feel a greater sense of involvement because of this. Whatever recommendations and decisions they make they may feel that they are being more adequately consulted with greater potential for influence than has been the case previously.

In a similar way the structure permits the solid affirmation of professional values at a non-clinical level and this may be important in view of the previous firm system of clinical organisation with the consultant in-administrative-charge or chief. During the interviews a number of consultants said that the firm system was 'great' if you had a good chief and 'lousy' if you had a bad chief. Other consultants in the firm might find themselves totally under the chief's control with much less independence and autonomy than he had. One manifestation of this was the practice in some firms of the chief's name being written on the medical record of all patients treated by the firm, rather than that of the consultant responsible for the care of the patient. In addition, consultants were often totally dependent upon the chief for whether or not their requests or ideas were passed onto the administration. The chief might stop their requests dead at the unit level. The divisional system had the potential of releasing these 'shackles' where they existed. For the first time consultants had the opportunity to present proposals openly to their colleagues - rather than to a possibly autocratic chief. This may be perceived by a majority of consultants as a positive benefit.

The divisional system and the Medical Advisory Structure is also taking on decisions which were previously made by the administration, for example, deciding the priorities for medical moveable equipment. Although they may not do this particularly well, from the standpoint of the structure's aims, this is something over which the profession now has some control. They may do it badly but at least they do it

in a way that does not violate or jeopardise professional relationships. In a sense therefore one of the benefits to the profession of running the structure is the affirmation of professional values in both clinical issues and broader matters which they were less able to influence in the past.

The Implications for Medical Involvement in the National Health Service

Medical Advisory Structures using the same principles as those employed in Scotland have been introduced throughout the National Health Service. Although this study has only focussed upon two hospitals the major influences upon the way in which the structures function are professional concerns which are relatively constant wherever the profession practices. What implications do these findings have for the more general position of medicine in the National Health Service?

It appears that the profession operates the divisional system largely in terms of the values and characteristics of the profession rather than according to the expectations placed upon the structure by those who designed it. As a result criteria of evaluation and ways of making decisions about such things as staffing increases and medical moveable equipment tend to be ones which mirror the nature of the profession. The two main ways of allocating resources appear to be, first, resources are allocated on an equal basis over time and secondly, for the higher status specialties to get more than the lower status specialties. In the former the outcome for the service is that developments tend to be spread equally between specialties over time. This tends to ignore changes in patterns of disease and also the extent to which any particular development may need even more money in the short term to make it effective, rather than piecemeal equal shares. In the case of the influence of specialty status, as in the Higher Medicine allocation and medical moveable equipment in Overton, decisions tended to favour the higher status specialties. Interestingly this was mainly the case with new developments rather than changes in existing shares of resources. In the latter there

was a reluctance on the part of the structure to take such things as beds away from specialties without their agreement. Undoubtedly in the past the more acute specialties have tended to do better, in terms of the share of resources they command, than some of the chronic specialties. In the past this distribution may have been influenced by medical members of the old hospital Boards. However, it may be that the divisional system has increased the possibilities of this happening. The Medical Advisory Structure is based upon specialty groupings making them specialties for themselves, not only, as before, specialties of themselves. Previously specialties did not meet as a formal group, if they met at all. They may have had common interests and opinions but consultants and firms worked in relative isolation from one another and even if such interests were articulated informally there was no formal mechanism through which they could be acted upon. They were fragmented and while members of particular specialties served on Boards of Management and Regional Hospital Boards they were not there to represent their own specialties, they had no mandate to do that. Specialties were divided into as many groupings as there were clinical firms and medicine and surgery, as large specialties, generally contained more firms than other specialties. The influence of these higher status specialties was therefore fragmented and they were not forced to speak with one voice. The structure has forced them to do this and they seem to have commanded the deference of other specialties in relation to the allocation of new resources. This deference may have existed in the past but it has been encouraged and legitimised by the structure.

Previously the Medical Superintendent probably bore the brunt of informal lobbying of the administration. He held the ring and any biases which were evident were those which he sanctioned or could not avoid sanctioning. It is clear from this research that the Medical Advisory Structure is just another forum in which professional relationships and characteristics are worked out. The joint impact of a concern with autonomy at all levels and differences in specialty status is to make the outcomes of such structures both less and more discriminating than is desirable. Less discriminating because the structure tends to avoid decision-making between specialties and has difficulty deciding whether individual and specialty requests are

Advisory Structure. At the hospital level the two structures studied were making some final decisions, for example, medical moveable equipment priorities. In cases like this professional influences and biases could become immediately operative. In other instances, like the Higher Medicine Allocation, the hospital structure may be asked to make a priority decision which will be compared with priority rankings from other hospitals for higher level decisions. In these cases it seems probable that each hospital or District will be granted its top priority, as a matter of course, and then some way is found of allocating the remaining funds. This has the effect of ratifying any bias which was evident further down the structure. A third type of decision involves a recommendation from the hospital level of the Medical Advisory Structure to higher levels of that structure, for example, requests for additional consultant staff. In Overton these requests were mainly treated in a piecemeal fashion, automatically receiving the support of the hospital level of the structure. They then became part of a list of staffing requirements from all the Districts in Lennox. The Area Medical Committee was then asked to advise on the priority of all requests within the Health Board. In terms of the contribution to the overall list from Overton the structure had made no difference to the number of requests which had reached that level. The result was no different to that in Allan where consultants by-passed the Medical Advisory Structure with their requests.

In such cases it was therefore left to the Area Medical Committee to make the choice and it may be that at this stage the structure would act in a rational planning manner and cut through the professional concerns. However, it was clear in Lennox that values like specialty autonomy and the impact of specialty status also affected the formation of the Area Medical Committee. I would suggest that these same professional concerns and characteristics would have their own manifestation in the way such decisions were made at the area level.

The decision of the Area Medical Committee is then passed to the Scottish Home and Health Department which says which posts it is prepared to support in principle, and ultimately, when money becomes available, in practice. It would be possible at this stage for any biases in the priority list to be identified and corrected. This did occur to a very limited extent in Lennox. A list of priorities for consultant posts was sent to the Scottish Home and Health Department. There were thirteen ranked requests and the Department agreed with the ranking apart from the relative priority of numbers eleven and twelve. It reversed the priority of these two requests. The members of the Lennox sub-committee who had made the decision were distinctly annoyed, protesting at the amount of time they had spent for their recommendation to be ignored.

Two points need to be made about this. First of all, it was obvious that even accounting for this change the Area Medical Committee was having a distinctive influence upon future staffing developments and the consequent emphases of services in the future. Secondly, if such a minute adjustment to this recommendation provoked this response it might be with some trepidation that any part of the administrative structure would reject advice coming from the Medical Advisory Structure. The attitude of consultants was that having been given the task of considering staffing priorities - albeit in an advisory capacity - they did not want or expect the administration to interfere in any way.

These three levels of decision indicate the influence of the structure

as a mobiliser of bias. At the lower levels when the structure is a final arbiter it is impossible to reverse biases if they appear. At the higher level, to do so would question the value of the structure and this may act as a primary deterrent.

There is also the issue of the general tenor of advice which will emerge from Medical Advisory Structures. The primary influences at the hospital level appear to be the concern with specialty autonomy and the influence of specialty status differences. They are, to some extent, pushing in different directions, but specialty status appears to have an impact only with the deference and acceptance of the lower status specialties. They might be pushed and bullied a little by the higher status specialties but within the Committee of Divisional Chairmen the latter were unable to seize advantages without that consent. This was clear in the episode of the linkage scheme where the physicians acted aggressively with respect to the obstetrics beds which they wanted. The obstetricians did not wish to give up beds and the other specialties, respecting their autonomy to reject the physicians' advances, refused to force them to do so. Autonomy would therefore seem to be the brake upon the influence of specialty status differences and a dominant influence upon the nature of advice and management decisions which emanate from the structure.

Medical Advisory Structure will not lightly disturb or easily modify existing professional relationships. They will not be conducive to making decisions which involve even minor changes in the nature of services and the way in which they are provided unless all parties are perfectly agreeable. If specialties can, by themselves, resist the influence of the Structure, or if the Structure is reluctant to tell specialties what they should do or reject what they want, then it will not be very good at managing or planning developments. While this may ensure the success of any change that does occur, it does not suggest that major change will arise from initiatives generated within the structure. It suggests that they will be reactive rather than active and that in their reactions they will be reluctant to transgress professional values. It is unlikely that

to fill such a role the service has lost something and the District Medical Officer seems unlikely to fill that gap. This is partly because of what District Medical Officers are supposed to do but also because of the way in which the profession is organised under the divisional system.

Previously the Medical Superintendent was able to negotiate with consultants and specialties separately. While he may not have been uniformly good at this he had the advantage of being able to negotiate with interested parties in such a way that his strategies and manoeuvres were rarely seen in their totality by all the participants. With the Medical Advisory Structure this is more difficult to achieve because the District Medical Officer may be exposed to all specialties in formal meetings. This does not rule out covert action but it reduces its effectiveness and the likelihood of it occurring. The Medical Superintendent may have looked at tower of strength but part of this stemmed from the lack of overall co-ordination among those with whom he dealt.

The experience in Overton and Allan therefore suggest that Medical Advisory Structures are not fulfilling the expectations of the Joint Working Party. Instead they are operating on the basis of profes-

sional values and characteristics which, in conjunction with the nature of the Structure, stop them from fulfilling the job for which they were designed. These two influences are relatively constant throughout the National Health Service, even allowing for local variation in their precise manifestation. It is reasonable to hypothesise that the pattern in these hospitals is fairly typical. If this is the case is there anything that can be done to move their mode of operation in the direction of the Joint Working Party recommendations?

What Can Be Done?

It could be argued that because the nature of the medical profession is relatively fixed in the short term and because there are cogent professional reasons why the structure is not being used as proposed there is little hope for any palliative action. However, there must be some criticism of the way in which these changes were made and the extent to which the profession was supported and encouraged in this period.

The notions behind the divisional system and more broadly the Medical Advisory Structure represent a considerable departure and innovation in the way in which the profession is organised and involved in the National Health Service. The changes have, as has been pointed out in Chapters 2 and 3, implications for the way in which consultants view their own work and the work of their colleagues and in general the Structure demands expertise and ways of behaving for which they have not been trained specifically. It is not easy to make priority decisions and consultants have no special training in how to do so, and the same thing applies to other functions expected of them by the Joint Working Party.

The Joint Working Party published its reports (1,4,5) and these were circulated to all consultants. Local administrative staff and Medical Superintendents suggested, with varying degrees of enthusiasm, that consultants should adopt the new methods of organisation. Some hospitals were encouraged by visits from members of the Joint Working Party but there did not appear to be a systematic attempt to prepare

consultants for the change. It is of course too late for such a strategy now but this research suggests that there are a number of areas in which some attempt could be made to improve the operation of Medical Advisory Structures. These are community medicine, the provision of more guidelines as to how rational planning decisions could or should be made, the provision of information, management training and positive coercion.

Community Medicine

Community Medicine is, among other subjects, concerned with the nature and development of resources and the adequacy of services in both quantity and quality. The Scottish Home and Health Department Reports (4,5,12) envisaged a close relationship developing between community medicine and the Medical Advisory Structure right down to specialists in community medicine attending divisional meetings. Certainly community medicine has had national problems in filling the many posts created by the reorganisation, but from the observations in this study specialists in community medicine played little part in the deliberations of the divisional system. The discussion about patient care evaluation in Overton is an example. The clinicians were reluctant to engage in this activity and thought that community medicine should be involved. The community medicine specialist thought that the clinicians should be left to decide what sort of system they wanted - he was reluctant to get involved in clinical medicine. Occasionally a community medicine specialist attended one of the specialty divisional meetings but in the main they provided information on formal channels and procedures and played little part in guiding discussions and decisions. The District Medical Officers attended the meetings of the Committee of Divisional Chairmen in Overton and the Medical Staff Association in Allan but they did not play a leading or creative role.

Community medicine may be of paramount importance as one strategy for persuading the profession to plan and evaluate services in a more objective and rational fashion. The specialty has been created out of a variety of related non-clinical specialties from epidemiologists, through public health doctors to medical administrators. The aim

has been the creation of a new and viable specialty within medicine, rather than a special group of medical bureaucrats (although this is how some clinicians may view them). As evidence of this there is the creation of the Faculty of Community Medicine within the Royal College of Physicians, the membership examinations, training grades on the model of other specialties, and the concern of the Faculty to secure consultant designations within the service, in addition to, or instead of, administrative designations. The specialty wants to be a specialty like any other. If it can achieve this - and this will be determined partly by its relationship with other specialties - then the potential for influencing the ways in which Medical Advisory Structures operate could be considerable.

Relationships between specialties and specialists involve values of autonomy but intrinsic to their nature is the notion that a specialist knows when something is beyond the bounds of his specialisation and within the bounds of another specialty. This happens regularly with general practitioner referrals to consultants and referrals between related specialties. This may involve passing the patient to the care of another specialist for a period, or seeking specific advice and help which can be accepted or rejected. The problem for community medicine is the establishment of a demarcated area of expertise recognised by clinicians as being within medicine and relevant to their problems, so that when faced with a decisions about staffing priorities they would automatically refer the problem to or consult with community medicine as a specialty with expertise and knowledge of the relative need for services within a defined population.

If community medicine can achieve specialty status in terms of the formal descriptive requirements and its relationship with other specialties as an accepted branch of medicine, rather than a medical arm of the administration, this may improve the operation of Medical Advisory Structures.

Guidelines to Decision-Making

Community medicine may therefore play the part of specialised advice

to the Medical Advisory Structure but at the same time one of the primary aims of the system was to enable and encourage clinicians to make decisions which had either not been made before, or which had been made through other mechanisms. A number of the activities required of clinicians for example, making priorities between competing requests and evaluating patient care, are totally new to them, quite apart from whether they are professionally acceptable. However, few guidelines as to how they might approach such decisions have been provided by the management structure. In the case of patient care evaluation it has been suggested that the average length of stay for any condition for Scotland should be used as one standard against which clinicians might evaluate their ways of dealing with patients. If their length of stay is significantly higher then the divisional system should look at the reasons and see if they are amenable to change. If this is feasible along with other possible strategies for evaluation then they should be made available in a clearly formulated fashion to those who are supposed to operate the system.

Again it should be said that the reluctance of clinicians to undertake such functions stems more from their professional concerns than because they do not know how to undertake them. However, a clear statement of procedures might make it more difficult for clinicians to evade them. In tandem with the method of decision-making is the question of information.

Provision of Information

Throughout this research the patchy quality of the information which the structure has been presented with in seeking to arrive at decisions has been overwhelmingly apparent. Again because of professional concerns with autonomy, divisions and the Committee of Divisional Chairmen in Overton and the Medical Staff Association in Allan did not tell consultants or specialties that supportive data of a particular type had to accompany any proposal. As a result some consultants provided information, others did not, some supportive data was good, some was bad - but it made no difference to the decisions. If

information was routinely provided for clinicians, possibly by community medicine specialists or the medical records officer it might be more difficult for clinicians to avoid making decisions and it might remove some of the more peripheral obstacles to their doing so. It might also be anticipated that the guidelines to decision-making suggested above would set out the data which it would be desirable to have accompanying a request for, say, an additional consultant.

Management Training

The last two suggestions above are concerned with the nuts and bolts of good decision-making and consultants, in such things as priority decisions and the evaluation of patient care, are being asked to take a new perspective on their work. They are being asked to step outside their own immediate clinical context and take on the broader expectations of the role conflict and look at issues from specialty or hospital perspectives. They have been asked to take on these new roles but have no necessary background to help them do so. This suggests the need for some new or additional training in management and decision-making techniques and perspectives. The notion of retraining or additional training was not alien to the period of reorganisation. Doctors in public health and administrative medicine went through training programmes to prepare them for their new specialty and their new roles within the National Health Service. It could be argued that the change required of these personnel was not that much greater than the change required of clinicians in adopting management roles in relation to their own clinical work. Various management courses were run in Scotland following on from the first report of the Joint Working Party (1). However, these were not specifically designed to retrain doctors for their roles in Medical Advisory Structures and were not systematic enough in their recruitment to ensure that structures in all parts of the country contained sufficient people with the necessary knowledge and skills to shape the way in which the profession reacted to and handled decisions. Ideally courses should have been run throughout the period of reorganisation but even now it would seem wise to make sure that clinicians have the basic skills required to fulfil the requirements of Medical Advisory Structures in their idealised form.

Positive Coercion

Rather than change doctors, or seek to do so, the rules of the game might be changed to encourage consultants to undertake particular activities which are supposed to make the best use of resources and improve services, by allowing them to reap the benefits. One example of this would be to delegate a proportion of the budget to clinicians and to state that if they could save money in some directions, for example, in pharmaceuticals, then they could use the money elsewhere in their work. In this way the benefits could be positively enjoyed by those immediately involved. One of the major problems here is deciding on reasonable budgets for particular specialties or institutions, this system would tend to promote the status quo between different units of the service even if it allowed for and encouraged change within them. In addition there is again the question of whether clincians have the expertise to handle such budgetry responsibilities.

There are negative coercive strategies which are being adopted in the United States of America but it is difficult to see how these might be applied in the British context. Throughout the United States Professional Services Review Organisations are being introduced on the 'suggestion' of the government to attempt to control the way in which medical care resources are used. Unless meaningful review organisations are introduced the government will withdraw or withhold federal funds and as this provides substantial revenue through Medicare and Medicaid for many doctors and the institutions in which they work this may be an effective strategy for improving the efficiency with which resources are used. Such a system is not readily applicable in Britain if only because reimbursement for consultants is based upon salary and not fee for service. It is impossible to imagine the Scottish Home and Health Department withdrawing funds from a hospital if it did not have an effective system of patient care evaluation.

Implications for Theories of Professional Involvement in Organisations

Lastly, this study needs to be considered briefly in a broader sociological light. It has been recognised theoretically (13,14) and in a variety of different settings (15,16,17,18) that the involvement of professions in large bureaucratic organisations is problematic. The theory is based partly upon the differences between professional and bureaucratic modes of work organisation and control over the content and nature of work. Traditionally professions are supposed to need and claim a large amount of autonomy in the way in which they go about their work. In large organisations it is suggested that there are broader organisational goals, implications and imperatives which may clash with any profession's claims to independence. At the same time there is also the problem of how far the broader organisation is responsive to the views of a profession working within it.

In the National Health Service hospital doctors constitute a large professional group which plays a key part in meeting the needs of patients and requires some input into the way in which services develop and change in the future. The profession is responsible for the way in which a considerable proportion of health service resources is used and yet the administration has had relatively little control over the quality and in some cases the quantity of care delivered.

In this context Medical Advisory Structures can be seen as an attempt to improve the relationship between the organisation, or bureaucracy, and the profession - or between professional claims and perceptions and broader organisational requirements - by allowing for the expression of co-ordinated professional advice on any matter and improve standards of practice by getting the profession to evaluate patient care in a systematic fashion.

The areas in which Medical Advisory Structures are supposed to operate illustrate some of the difficulties which the organisation has had in relating to and controlling the work of that professional group. Although, in addition, there have been changes in the size and complexity of hospital medical care which have made such difficulties more apparent.

There were, therefore, inadequacies in the old more anarchic ways of carrying on the relationship between professional and broader organisational concerns. The Medical Advisory Structure is an attempt to create a new relationship between the two and a new role for the profession within the organisation. The implications of this for consultants are found in a variety of specific roles on committees. At the local level the roles of member of a division and member of the Committee of Divisional Chairmen are the immediate manifestations of this.

Organisations have a variety of options in how they go about controlling professional work and involving professions in policy-making. In the past the National Health Service has used several methods, for example, the co-option of individuals onto committees. The formation of Medical Advisory Structures is a formal recognition that these less systematic strategies have not been successful. In some of its elements, such as the evaluation of patient care, the formal handing over of this function to the profession amounts to an admission that the administration cannot foresee any way of controlling the work of doctors.

Seen in this way the Medical Advisory Structure is a way of getting the profession to undertake:

a. activities which have not been undertaken before and which the administration is reluctant to perform for fear of interfering with the central definition of professional work, for example, the evaluation and specialty management of patient care;

b. activities which have been performed reluctantly by the administration, for example, the allocation of priority between medical requests for resources and mediation between specialties at the hospital level; and

c. the development of a more representative expression of the views of the profession in planning and policy-making, rather than a reliance upon individuals.

This study has addressed itself to the question of whether or not this strategy for involving the profession in policy-making and planning and getting the profession to control itself, in a systematic fashion, is successful.

In some ways it has been an improvement upon what existed before in that more consultants are aware of some of the organisational problems and issues which were only encountered by members of Boards and consultants in-administrative-charge before. Now they have the opportunity for involvement and if a view or statement emerges from the Medical Advisory Structure then it can be claimed that this is a view which is supported by a majority of doctors.

However, the ways in which decisions have been made and the nature of advice from the two Medical Advisory Structures studied suggest that this strategy is less successful in a number of important ways. The role conflict at each level of the structure can be seen as a switching box through which more limited professional concerns have to be translated into the broader setting in which the individuals work. In this study it appeared that in most cases this switching did not occur and the major influences which stopped this from happening were the professional values and characteristics which doctors share. These factors influenced the way in which the role conflict was solved away from the broader more managerial perspectives for which the structure was intended. The major influences were individual autonomy and a mutual concern with specialty autonomy linked with a lack of inter-specialty knowledge. According to Freidson (19) professional autonomy is the major factor which makes the presence of a profession within an organisation problematic and in this case the profession itself was equally unhappy about violating such a value within the Medical Advisory Structure. The factor which led to the need for a Medical Advisory Structure contributed to its difficulties.

In this context role conflict theory was used to portray the precise dilemmas which consultants faced at various levels of the structure. In practice only a minority of consultants seemed to perceive this dilemma. Some of them were aware of the two functions which they

were being expected to fulfil but a large number seemed to see the structure largely in terms of realising personal and group interests. A major factor in this was the fact that issues at both the specialty and hospital levels were discussed in an open professional forum and it was not acceptable for a major professional value to be violated in front of the colleague group. This was why consultants found it difficult even to contemplate turning down requests from fellow consultants or specialties. This is not to say that all professional requests would receive automatic support because on occasions choices had to be made at both the specialty and the hospital level. Even in such cases it was clear that professional relationships and characteristics played a far greater part in determining the way in which choices were made than any consideration of the broader organisational expectations which they were being asked to fulfil.

In cases where new resources were allocated it seemed very difficult for any specialty to deliberately press for more and achieve it without the willing consent of other specialties. Higher status specialties achieved more but this was dependent upon the acquiescence of the lower status specialties within the open forum of the Committee of Divisional Chairmen. In this sense the interest group activity which it was suggested might occur in Chapter 3 was not realised in overt political action. There was group activity outside the structure, a definite specialty consciousness and talk of pressure group activity within divisions. However, most of the decisions had to pass through the formal committees and whatever specialties had done unilaterally - such as the physicians surveying another specialty's wards to assess their suitability for their own purposes - once the decision had to be made in the open forum, specialties could not be bullied into something without their own agreement. Consultants and specialties would not manage one another and were as reluctant to do so as administrators were.

Despite this it was clear that specialties had become more aware of, more articulate about, and more able to mobilise their interests. Backed by a mutual concern with autonomy this often led to an impasse with specialties not being prepared to back down and acquiesce and

the structure thereby being paralysed. The foundations for interest group activity were there and this was particularly evident in the way in which specialties perceived the structure and were concerned that they should be specifically represented. In general the higher status specialties seemed to do better than the lower status ones but this was more the replication of an existing order within the profession than an interest group battle on each new issue. In this case Scott's boon deference (11) seemed to have some explanatory use.

The Joint Working Party was changing or attempting to change the organisational definition of what the profession is and what its organisational role should be. Overall this does not seem to have been successful in some important aspects. The question then arises as to what effect or unintended consequences this new way of organising the profession will have. In the creation of divisions specialisation has become institutionalised in a more concrete way then before. There is more specialty identity in what has amounted to the reinforcement of the national organisation and allegiances of the profession. It was precisely because specialty was the unit of organisation that differences in specialty status were mobilised as bias in the organisation (10), particularly in the structural advantages which physicians had. This may therefore be a considerable conservative influence tending to reinforce traditional professional patterns and relationships. In addition, while the Joint Working Party made a plea for flexibility between divisions, it may be increasingly difficult to move outside or cross divisions. Assuming it is a possibility it would be difficult for the profession to evolve in ways which would fall outside the divisional structure. The Joint Working Party was looking at the problem from a positive organisational viewpoint but there could be longer term negative effects for the profession and the organisation.

Specialty autonomy was one of the features of specialisation which was identified in Chapter 3 and this had a dominant influence upon the two structures and the way in which they worked. In his writing on the medical profession Freidson identified a legitimate autonomy

as the key feature which distinguishes professions from other occupations (19). In this he is mainly concerned with the autonomy granted to an occupation by the State to control entry, standards of training and standards of practice, and the autonomy of the individual to practise in accordance with his own judgement and expertise. Freidson pays relatively little attention to the specialty level within the profession. This is partly because of the focus of his work but in this study specialty autonomy is a distinctive feature and it is clearly separate from clinical autonomy. Clinical autonomy applies to all relationships between doctors in respect of clinical practice and may be applied to relationships between consultants in the same and different specialties. Specialty autonomy may also include this but it involves other areas which stem from and overarch clinical relationships and clinical issues. It is the claim by specialties to determine their own development and direction. This concern was stated very clearly when one of the chairmen in a meeting of the Committee of Divisional Chairmen said:

> 'I think it would create a precedent if we go against the Psychiatric Division, it could happen to any of us, if we bring something up then others could reject it.'

This was quite apart from any difficulties which a lack of inter-specialty knowledge caused in deterring chairmen from commenting upon other specialties.

To return to the general theme of this section, this particular strategy of attempting to persuade or enable a profession to play a greater part (a) in controlling itself and (b) in management and policy does not seem to have been successful. It has allowed doctors more structured influence than they have had before but the nature of that influence has been strictly determined by professional values and characteristics rather than a broader and more objective consideration of issues. The aims of the structure have not been realised. Instead a structure which was designed to get the profession to take on broader perspectives and control itself has been formed and run according to professional values and characteristics.

Implications of the Methodology Employed

In this last chapter there also needs to be some assessment of the success of the methodology. Essentially a two-pronged approach was used. First, meetings within the Medical Advisory Structure were observed and this was supplemented by a study of past minutes and the examination of files on particular issues. Secondly, informal and formal interviews were conducted with consultants in both hospitals. It was hoped that these two approaches together would provide a detailed and accurate picture of processes of decision-making. While this was reasonably successful there were some drawbacks which were partially anticipated beforehand.

First of all, there was the sheer quantity of data. The period of observation, two years, and the number of committees observed meant that a large body of data was amassed. Some of it covered decisions stretching over many months. The major problem arising from this is conveying a full and accurate account of the way in which the structure operated, when full coverage of all decisions is impossible (this was less of a problem in analysing the way in which the structures were set up - in this key decisions and solutions were readily apparent).

The second drawback is the major response to this first problem, that is, much of the material is discarded and specific decisions are selected for examination. This opens the way for the charge of bias in the selection process. Although the fact that the structure was recommended to play a particular role in some ways reduces the problems of selection. In tackling this I have been selective in the categories of issue discussed but not in the actual decisions outlined and analysed within these categories. I decided to look at the way in which the structures handled requests for staffing and equipment but within the limitations of space I dealt with all such decisions made on these topics. This still leaves the criticism that the categories themselves are biased. They were selected for specific purposes. They were decisions in which the outcome was reasonably clear and in which professional values may have been at stake. They were also decisions which tested the willingness and ability of those

involved to undertake the functions for which the structure was designed. It would have been possible to look at the structure as a device for the dissemination of information. However, this would have provided little or no idea of whether or not Medical Advisory Structures could fulfil their more complex and specific aims. Something like the evaluation of patient care was a much more important indicator of the present and future success of the structure than the dissemination of information.

Thirdly, there is the quality and depth of the data and the extent to which it represents an adequate and true picture of the process of decision-making. The researcher was, for the most part, only present during the formal decision-making process. It was not possible to observe all of the behind-the-scenes manoeuvering - although many of the results of this were apparent at the meetings themselves. Attempts were made to collect some of this background information in the formal interviews and also during the observation by talking to people before and after meetings, over lunch and so on. However, it was impossible to be aware of all of the interchanges between consultants having relevance for the decision-making process.

This may therefore be a limitation which in this research context could only be overcome by total participant observation. This leads on to the criticisms made by Bacharach and Baratz, in the political arena, that the examination of open and visible decisions may hide a more restrictive face of power (20). This criticism is more applicable in systems which do not have a definite or rigid structure through which decisions have to pass. In the Medical Advisory Structure all decisions have to pass through the structure and for many categories of decision there is no other route through which power or influence might be exerted, for example, in requests for additional staff at the local level. For this reason I would argue that the dominant forces operating outside the structure, if there are such forces, would be as apparent within the confines of the Medical Advisory Structure. In cases when scarce resources are at stake and the Medical Advisory Structure is charged with allocating priority more powerful specialties have to make their ability to get more apparent

within that open forum. This is not to say that there were not decisions made outside the structure which were unknown to the researcher, but rather that if there were such decisions then they would be likely to be more favourable to the higher status specialties - just as they were within the formal structural process.

Directions for Future Research

What are the implications of this study for further research? This investigation into Medical Advisory Structures was conducted shortly after their introduction and during the upheaval of the period before and after the reorganisation of the National Health Service. From the viewpoint of ascertaining the primary influences upon the way in which the structures were set up this was the only time to conduct such a study. However, this was a period of general upheaval and the profession may have been cautious in the way in which it approached all decisions at that time. This research may therefore have given a pessimistic view of the operation of Medical Advisory Structures and it would be desirable to look at their functioning again in a few years' time to see if they have changed and developed more along the lines of the Joint Working Party proposals.

At the same time it should be borne in mind that the influences upon the operation of the structure have tended to be professional values and characteristics which are not transitory phenomena. They are values constantly reaffirmed in the many different activities undertaken by the profession and as such, it may be predicted, they will probably have a continuing influence upon the way in which Medical Advisory Structures operate. This was evident in some of the decisions when chairmen expressed concern at the precedents which might be established if they went against the view expressed by another specialty about its own work. While this was a period of transition it was also a period in which professional values were translated into the rules of the game for handling decisions within the structure. In this sense initial reactions and ways of making decisions may become institutionalised and formalised. Nevertheless, further examination of the structures is required now that they are firmly established.

the general practitioner side of the Medical Advisory Structure - which links up with the hospital structure at the district and area levels. Their structure is less complex in some ways because of the absence of specialty identities but problems of autonomy may be greater because the general practitioners seem to have placed a greater emphasis, in such things as contractual negotiations, upon their independence than hospital doctors. In addition the bringing together of hospital and general practitioners on single advisory committees is intended to provide more balanced advice on the service from the profession as a whole rather than a series of views from different perspectives. It would be important to know how far the profession is able to go in achieving this and marrying general practitioner and hospital perspectives.

Thirdly, and following on from suggestions made earlier in this chapter, some applied research needs to be focussed upon methods of deciding priorities for service developments within geographically defined populations and also methods of evaluating patient care. Without methods and concrete examples to shape their thinking consultants are very unlikely to change their organisational role if this directly threatens their professional relationships.

Fourthly, there is a need for further study of the precise relationship between professional values and the ways in which they affect professional relationships - particularly between specialties. There is evidence in this research that specialty status does have an impact upon the allocation of development resources and that the higher status specialties, through the deference of the lower status ones, manage to get larger shares of limited resources than they would otherwise receive. There is little doubt that in the past the higher status specialties have tended to have better facilities than the lower status ones. This may in part reflect certain societal values and preferences and this may have affected the very status differences which were examined in Chapter 3. However, the profession in the manner in which it trains doctors and in various other ways does not only reflect societal values it can and does create and change them.

The resource allocation described in this study has been at the local level and the amounts of money have been relatively small but they represent expansion and development. This does affect the overall direction of services and it is probably no accident that recent government policy has stressed the need for development of some of the lower status specialties (21,22). What is of concern here is the extent to which, despite these national policies, the hierarchy within the profession will continue to influence the allocation of resources - based not upon assessment of need but upon specialty status differences. Further research is therefore needed upon the way in which decisions are made about the allocation of resources at slightly higher levels. This could be examined in terms of the relationship between values about health and relative need both in society and in the profession.

This is also of some relevance to the two national reports on the geographical allocation of resources based upon attempts to assess comparative need for health services (23,24). These reports recommend that through the manipulation of the budgetry growth rate in regions (in England) and areas (in Scotland) a more equitable distribution of resources can be achieved. This process is supposed to extend right down to the district level. Some geographical areas will effectively lose money and others will gain. The influence of specialties might be examined in this context - in particular which services lose in the areas losing money and which specialties gain in areas whose revenue allocation is increased.

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APPENDIX

Interview Schedules

Consultants in the two hospitals studied were interviewed. The Medical Advisory Structures in the two hospitals were different and slightly different interview schedules were used - although they concentrate upon the same theoretical issues.

The two schedules were employed to conduct semi-structured interviews, other questions were asked in order to pursue issues in more detail.

Interview Schedule A: Overton Hospital

Name ..... Date .....

Specialty .....

Division .....

I would like to start this interview by asking you some general questions about the divisional system and its introduction in the hospital.

Section a. Opinions About the Structure in General

1. What differences, if any, do you think the divisional system has made to the hospital?

2. Has it affected the way in which your specialty is organised?

3. What are the advantages, if any, of the divisional system?

4. What are the disadvantages, if any, of the divisional system?

5. On balance what do you think is better, the divisional or the unit system?

6. Has the divisional system had any effects upon the way in which you organise your clinical work?

Perhaps we could turn now to the work of divisions and the way in which they operate in practice.

Section b. Opinions About the Work of Divisions and the Way in which they Operate

7. Do you think it is a good idea for a consultant's colleagues to decide whether or not things which he or she wants or proposals which he or she has should be allowed to go forward to the next level?

8. How does this compare with the old system in which consultants would probably take their ideas to the Medical Superintendent?

9. Could you tell me about any ideas or proposals you have raised with your division?

10. Have you chosen not to take any ideas or proposals to your division?

11. Assuming the division did not agree with something you wanted would you try and get it in some other way?

12. What about situations where the division has to decide about things which other consultants suggest, how easy is it for you to do this?

13. Does your division discuss staffing and equipment priorities?
If 'Yes'
How easy is it to put submissions in some order of priority?

14. Do you think it would be better if someone other than the division made such priority decisions?

15. What about situations where you want something and somebody else wants something, how easy is it for you to argue your case?

16. Do you find it easier to get things discussed and talked about than you did under the unit system?

17. Within your own division, what do you think are the main features of the Chairman's job?

I would now like to ask you some questions about the work of the Committee of Divisional Chairmen.

Chairmen - For Non-Chairmen Only

18. What are the main functions of the Committee of Chairmen?

19. How strongly do you think your chairman should push your case when he brings up something your division has decided?

20. Do you think the other Chairmen know enough about your specialty to make the right decisions about problems your chairman raises?

21. Do you think the Committee of Chairmen is the right place to make decisions about priorities between divisions?

Section d. Opinions About the Work of the Committee of Divisional Chairmen - Chairmen and Ex-Chairmen Only

22. Do you think that you should lead your division towards particular policies and ways of doing things?

23. Are there any problems or issues upon which you have found it difficult to lead discussion?

24. How do you see your position on the Committee of Chairmen?

25. If you are raising a matter at the Chairmen's Committee at the request of your division, how do you think your division expects you to present that request?

26. When you have a divisional request to put to the committee what kind of approach do you take?

27. Do you think the Committee of Chairmen is able to make the right decisions about problems in your division?

28. How easy is it for you to decide and comment upon matters raised by other divisions?

29. What about situations where the Committee of Chairmen has to put requests in some order of priority, how easy is it to do this?

30. Do you think it would be better if someone other than the Committee of Chairmen made these decisions?

Section e.

31. Is there anything else which you would like to comment upon about the divisional system and Medical Advisory Structure in this hospital?

Interview Schedule B: Allan Hospital

Name ..... Date .....

Specialty .....

I would like to start this interview by asking you some general questions about the divisional system and the Medical Staff Association.

Section a. Opinions About the Divisional System and the Choice of the Medical Staff Association as the Basis of the Medical Advisory Structure

1. What are your opinions about the divisional system as it was outlined in the Brotherston reports?

2. How did your specialty colleagues feel about forming a division when the proposals were discussed?

3. Were there any advantages in forming a division?

4. Was there anything you did not like about the idea of forming a division?

5. When the divisional system was discussed by the Medical Staff Association what was the general reaction?

6. Were there any particular reasons why the Staff Association was preferred to divisions in Allan?

7. People sometimes refer to Divisions of Anaesthetics and Medicine, how do these relate to the Medical Staff Association?

Perhaps we could turn now to some more detailed questions about the way in which the Medical Staff Association works.

Section b. Opinions About the Operation of the Medical Staff Association

8. Do you think the Medical Staff Association is a good place to consider requests from individual consultants and specialties?

9. What are the advantages, if any, of taking things to the Medical Staff Association?

10. Are there any disadvantages in taking things to the Medical Staff Association?

11. Could you tell me about any ideas or proposals you have raised with the Staff Association?

12. Are there any matters you have deliberately chosen not to take to the Medical Staff Association?

13. Do you think that the Medical Staff Association plays a useful part in solving problems in your specialty?

14. Do the other consultants know enough about your specialty to come to the right conclusions about problems that you raise?

15. What about occasions when other consultants make suggestions or proposals, do you find it easy to comment and decide what should be done?

16. What are the most important functions of the Staff Association?

17. What about the Staff Association Executive, what does that do?

Section c.

18. Is there anything else you would like to comment upon about the Medical Staff Association and Medical Advisory Structure in this hospital?