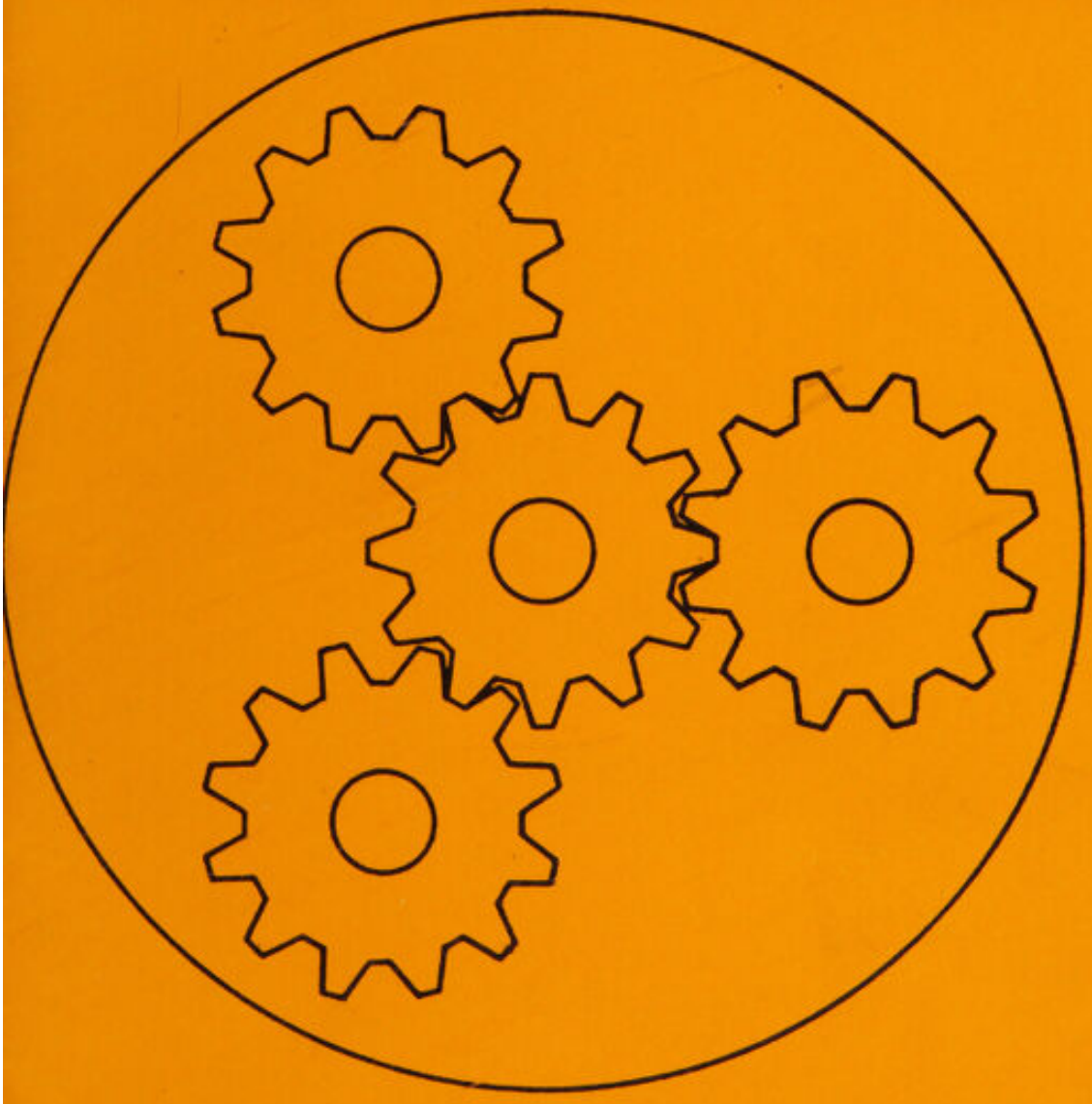
First report of the Joint Working Party on the Organisation of Medical Work in Hospitals.

First Report of the Joint Working Party on the **Organisation of Medical Work in Hospitals**



MINISTRY OF HEALTH

Published for the Ministry of Health on behalf of the Joint Working Party

First Report of the Joint Working Party on the

Organisation of Medical Work in Hospitals

LONDON

HER MAJESTY'S STATIONERY OFFICE

1967

MEMBERSHIP OF THE JOINT WORKING PARTY

Sir George Godber KCB, DM, FRCP, DPH (Chairman)

Dr J.O.F. Davies CBE, MD, MRCP, MRCS, DPH, QHP

Mr H.G. Hanley MD, MB, ChB, FRCS, LRCP

Mrs J.A. Hauff (succeeded Mr T.B. Williamson in February, 1967)

*Dr T. Rowland Hill MD, MB, BS, FRCP, MRCS (Deputy Chairman)

Mr H.H. Langston MB, BS, FRCS, LRCP

Mr T.L.T. Lewis MB, BChir, FRCS, FRCOG (designated successor to Sir Arthur Porritt in May, 1967)

Dr R.M. Mayon-White MD, FRCP, MB, BS, PhD, DCH (succeeded Dr T. Rowland Hill in April, 1967)

Mr G. McLachlan CBE, BCom, FCA

Mr G.A. Phalp TD, BCom, FHA

**Sir Arthur Porritt Bt, GCMG, KCVO, CBE, MA, BM, MCh, FRCS

Sir John Richardson Bt, MVO, MA, MD, BChir, FRCP

Dr K. Robson CBE, MD, FRCP

***Mr T.B. Williamson

Dr H. Yellowlees MA, BM, BCh, MRCP

Dr I.T. Field MB, BS

Dr G.R. Ford MA, BM, BCh } Joint Secretaries

---

*Died on 14th April 1967.
**Appointed Governor General of New Zealand in January, 1967.
***Retired in February, 1967 from the Joint Working Party because of illness.

CONTENTS

		Paragraphs
Foreword		
Preface		1—11
Chapter I	**Summary of main conclusions and recommendations** ...	12—15
Chapter II	**The evolution of the service**	16—22
Chapter III	**Survey of present medical advisory arrangements** ...	23—28
Chapter IV	**Management problems in the hospital and specialist service today**	29—32
Chapter V	**The key role of the clinician in administration and management—**	
	(i) at hospital level	33—39
	(ii) at regional and area level	40—41
Chapter VI	**A review of needs in certain spheres**	42
	(i) hospital beds	43—47
	(ii) organisation of out-patient and in-patient services	48—49
	(iii) review of clinical practice...	50—52
	(iv) vocational training—post graduate medical education	53
	(v) planning of services and use of resources ...	54
Chapter VII	**Towards a more sharply defined organisation of medical staff**	
	(i) the divisional system	55—57
	(ii) functions of the division	58—59
	(iii) chairmen of divisions	60—61
	(iv) composition of executive committees	62
	(v) role of executive committees	63
	(vi) some administrative aspects	64—67
Chapter VIII	**Training for medical administration and the organisation of medical care**...	68—72
Chapter IX	**Epilogue**	73—76
Appendix I	**Hospital medical staff in England and Wales: analysis by grade in terms of whole-time equivalents, 1949–1966**	
Appendix II	**Guidance issued on hospital medical advisory committees in 1953**	
Appendix III	**Extract from the Bradbeer Committee Report.**	

FOREWORD

The Joint Working Party on the Organisation of Medical Work in Hospitals in England and Wales

The Working Party was appointed in 1966, jointly by the Minister of Health and the Joint Consultants Committee, each nominating six members. It has met on 19 occasions and considered written evidence from various sources. It did not invite oral evidence but did discuss certain aspects of some problems with Mr J.B. Blaikley, Medical Superintendent and Mr A.H. Burfoot, Secretary of the Board of Governors of Guy's Hospital and separately with Dr S.D. Purcell of the Luton and Dunstable Hospital. It also had the benefit of two long discussions with Dr Philip Bonnet, then President of the American Hospital Association. The Working Party expresses its gratitude to these gentlemen for their help. It was served by Dr Ian Field, of the B.M.A. and Dr Gillian Ford and Mr R.T. Lane from the Ministry of Health and it is deeply indebted to them for the most valuable work they did in research, in drafting documents and in recording discussions.

The Working Party expects to continue its discussions on various detailed developments from the general principles with which this report is concerned.

The membership of the Working Party is set out on page (ii). Unhappily Dr T. Rowland Hill died shortly before the final draft of the report was ready, but its preparation owes much to his work. Mr T.B. Williamson retired from the Working Party in February 1967, and was succeeded by Mrs J.A. Hauff. Sir Arthur Porritt was a member up to the time of the completion of this report. The remaining members of the original Working Party were joined by Dr Mayon-White and Mr Lewis in time to have their assistance in the review of the final draft.

The views expressed in our report are those of the Working Party itself and do not purport to represent the policies of those who appointed us.

J.O.F.DAVIES
G.E.GODBER
H.G.HANLEY
J.A.HAUFF
H.H.LANGSTON
T.L.T.LEWIS
R.M.MAYON-WHITE
G.MCLACHLAN
G.A.PHALP
J.S.RICHARDSON
K.ROBSON
H.YELLOWLEES

I.T.FIELD, G.R.FORD } Joint Secretaries

Alexander Fleming House
Elephant and Castle
LONDON SE1

August 1967

First Report of The Joint Working Party

Preface

1. The terms of reference of the Working Party are:
"To consider what developments in the hospital service are desirable in order to promote improved efficiency in the organisation of medical work".

2. In setting out on its task the Working Party discussed a number of general questions covering the whole field of medical care organisation. How effective are the present administrative arrangements? What changes are desirable in the organisation of medical staff in individual hospitals? What contributions can practising clinicians make to the management and administrative arrangements of the hospital complex?

3. An interim report has now been prepared covering some of the basic elements of medical care organisation and some recommendations for changes which the Working Party believes would lead to considerable improvement in the organisation and therefore in the overall quality of clinical work in hospitals.

4. The way in which the health services and the practice of medicine have developed has left the individual hospital with the most dramatic part to play in the care of the individual. The stay of a patient in hospital is however only one event in the disease sequence. Hospitals may be involved in the care of patients before admission through the diagnostic services or out-patient departments and after discharge with follow up or rehabilitation. The links between individual hospitals, other hospitals in the same group, general practice and local authority services are tenuous and this is reflected not only in the organisation of care for the individual but in the planning of care for the community as a whole. Hospitals have tended to work in isolation from the other parts of the community health services—a situation which almost certainly means inefficient use of the costly hospital based resources. Not only are the local links insecure, but so also may be the ties with the Regional Board, particularly in the case of the larger regions. It is suspected that the result of this is that at hospital level regional policies are often not understood and at Board level there may be a real lack of accurate information and advice from the periphery on which such policies should be both based and modified.

5. While aware that a similar lack of communication may exist at other levels in the administrative structure of the health service, between for example Ministry and Regional Boards, the Working Party has concentrated in this interim report on the hospital as the fundamental specialist service unit and its immediate relationships with the other parts of the service, other hospitals in the group and with the Regional Board. Within individual hospitals and groups we have looked particularly at the contribution towards improved communications that could be made by hospital medical staffs.

6. We believe that the recognition by hospital medical staffs of a group responsibility to the population of the district they serve and the discharge of this responsibility calls for a re-organisation of the medical staffs into a structure which emphasizes their essential interdependence in the performance of their clinical functions. The term Division in this report has been used to describe a group of specialties (or one specialty) providing a common service and with a call on the same resources. For instance it is possible to look at the surgical specialties, general surgery, orthopaedic surgery, otorhinolaryngology and others as a group with similar problems and procedures such as waiting list admissions, need for operating theatre time and anaesthetic services. It is believed that a joint approach by the medical staff forming such a division would lead to a comprehensive understanding of community needs and a more efficient use of resources in meeting those needs.

7. The divisional organisation which has been considered is discussed in this report in general terms. A lengthy exposition of the applications of this main recommendation to local situations has not been attempted since we believe that there is room for substantial variations in detail, which should be worked out in local discussion. The succeeding chapters of this report set out the supporting arguments for the need for such a change. The Working Party considers that the time has come for wide discussion of the general principles upon which its further studies will be based. Such discussion regionally and locally could lead to the formation of views both on principles and on details which would be of great help to it in its future work.

8. The Working Party now recommends to the Minister and to the Joint Consultants Committee, by whom it was jointly appointed, that its interim report should be made widely available to doctors working in hospitals. Conferences of regional representatives were convened to consider the implementation of the Platt Working Party report[1] on hospital medical staff and it is suggested that similar arrangements be made for the examination of this interim report. Initial distribution to regional representatives should be followed by discussions at regional and at group level. This should lead to an understanding of the intentions which underlie the report and to the formulation of local views and policy. It is hoped that free discussion amongst hospital staffs before too much detail is promulgated will lead to a much wider agreement than would the elaboration of a much more detailed and lengthy report which might not be available for a further year.

9. Two Royal Commissions are at the moment considering respectively medical education and local government. The Seebohm Committee is reviewing the organisation of social services of local authorities. One or all of these may produce recommendations which make it necessary for the Working Party to review issues on a wider front.

---

[1] Ministry of Health and Department of Health for Scotland, Medical Staffing Structure in the Hospital Service, London, H.M.S.O., 1961.

10. The Working Party, with other members co-opted for special subjects, proposes to continue its studies, with attention to special problems in the spheres of management of medical care, such as methods of achieving more rapid turnover in the use of hospital beds and the scope for extension of out-patient surgery. The deployment of medical staff at all levels needs to be studied in depth. It hopes to be able to produce short memoranda on such subjects which could be circulated as having the backing both of the profession and of the Health Department.

11. The Working Party has no doubt that the efficiency of the hospital service in the future depends upon the radical revision of traditional methods of organising medical work in hospitals. This process must be the outcome of local consideration and conviction rather than the imposition of detailed methods arbitrarily defined centrally.

Chapter I

Summary of Main Conclusions and Recommendations

12. Preliminary and wide ranging discussions led the Working Party to the following conclusions:

(*a*) Medical care is a single entity although it is provided from a complex of sources including hospital, general practitioner and community services. (Paragraph 16)

(*b*) The identification of problems within the complex of services and a fresh approach to them can bring about improvement without awaiting reform of the administrative structure. (Paragraph 18)

(*c*) The hospital sector is the most costly element in the National Health Service and its use of resources would be improved if its base of activity were wider than the individual hospital. (Paragraphs 19–21)

(*d*) The development of modern scientific medicine and the growth of the hospital medical team has not been accompanied by corresponding development of an appropriate administrative structure amongst clinicians. (Paragraph 19)

(*e*) Within the hospital group there is a need for a representative group of clinicians aided as appropriate by operational research to undertake a continuous review of hospital activity, to take an active part in the co-ordination and planning of services and provide effective liaison with the community services outside the hospital. (Paragraphs 19–22)

(*f*) The present medical advisory machinery is not suitable in nature and structure to meet modern requirements. (Paragraphs 23–28)

(*g*) In the face of the need for collective thinking there is nothing to be gained by the re-establishment of the old-style full-time medical superintendent. (Paragraph 33)

(*h*) General management in hospitals is a distinct function but should not be divorced from clinical policy, as these are clearly inter-related. (Paragraphs 29–32 and 38)

(*i*) The hospital has the central place in the provision of comprehensive medical care, but there are only sketchy arrangements for continuous review of its local relationships with the other medical care services. (Paragraph 40)

(*j*) An effective medical advisory machinery is essential to the policy and planning function of the Regional Board. (Paragraphs 27 and 41)

(*k*) There is a need to look at the larger regions in the hospital service and the membership and function of the statutory authorities responsible for their administration. (Paragraph 41)

13. Some examples of the particular problems which should be kept under constant review by all the clinicians practising in an area have been given. (Paragraphs 42 to 54)

14. The Working Party proposes that the organisation of medical staff in a hospital or hospital group should be remodelled on the following basis:

(*a*) Specialties falling into the same broad medical or surgical categories should be grouped together to form Divisions. (Paragraph 56)

(*b*) Each Division should carry out constant appraisal of the services it provides, deploy clinical resources as effectively as possible and cope with the problems of management that arise in its clinical field. (Paragraphs 58 and 61)

(*c*) Each Division should have an appointed chairman. (Paragraph 60)

(*d*) A small medical executive committee composed of representatives from each Division should be established. (Paragraphs 57 and 62)

(*e*) This new small medical executive committee would require an appointed chairman, with time in his contract for administrative duties. He would be an experienced clinician and should serve in this administrative capacity for five or more years. He would be the chief medical spokesman for the hospital or group of hospitals. (Paragraph 62)

(*f*) The function of the executive committee would be to receive divisional reports, consider major medical policy and planning, and co-ordinate hospital clinical activities, without controlling or limiting the clinical freedom of individuals. (Paragraph 63)

(*g*) The Divisions and the executive committee would all require appropriate supporting staff and accommodation. (Paragraph 64)

(*h*) These recommendations do not imply the disappearance of the full medical staff committee. (Paragraph 67)

15. The Working Party sees a need for training in administration:

(*a*) For chairmen of the new medical executive committees. (Paragraph 69)

(*b*) For the profession as a whole as part of a multi-disciplinary approach to the problem, a series of week-end or single day conferences. (Paragraph 70)

(*c*) For professional medical administrators. (Paragraph 71)

(i) Comprehensive vocational training schemes.

(ii) Regular opportunities for refreshment of knowledge.

Chapter II

The Evolution of the Service

16. The Working Party came early to the conclusion that it was difficult to divorce consideration of the development or efficiency of one branch of the Health Service from the other. Medical care for the individual is a single entity although it is provided by many different people in various professions. Many conditions can be treated at home with the help of specialist services provided by hospitals for general practitioners and with the support of the local authority services, such as home nursing.

17. Unfortunately, there has to date been a lack of co-ordination and communication between the three component parts of the National Health Service. Recognition of the need for continuity of care and integration of the constituent services, including the preventive services of the local authority, is widespread and seems at variance with the continuance of administrative divisions within the National Health Service.

18. Reform of the present administrative system would require legislation and this always takes time. Many of the problems which arise in such a personal, humane and conservative complex of services will inevitably be present under any system of organisation of medical care. It is fruitless at the present moment to consider how efficiency might be promoted only in a hypothetical National Health Service under a unified administration. If these problems are distinguished and analysed now, a fresh approach to them may bring about improvement without awaiting legislative reform.

19. In 1967 it is possible, while recognising the strength and achievements of the system which has developed, and on the whole has worked reasonably well since 1948, to see its main weaknesses particularly those which threaten the efficiency of the hospital based services, the most costly elements of the National Health Service. Before 1948 hospital specialist services were available only in certain areas in the country. Since 1948 these have been planned on a national scale and there has been increasing specialisation because of the technological complexity of modern scientific medicine. These factors have nearly doubled the size of the hospital medical team (see Appendix I) but there has been no corresponding evolution of an administrative structure among the clinicians with the ability and authority to deploy medical skills. The present planning policy of the Health Service is based on the theory of a district general hospital providing comprehensive area specialist services for a population, usually between 100,000 and 200,000, which receives home care to an increasing extent from grouped medical practices. The inadequacy of the links that exist at the moment between preven-

Unable to display this page

more usually the arrangements were adapted to local needs from the recommendation made in H.M.C.(48)1 that committees representative of the different groups of staff concerned should act as advisers of the Management Committee on their sphere of the hospital's work. The committees were to be constituted by the staff and not appointed by the Management Committee. No official constitution has ever been devised, but R.H.B.(53)91 offered general advice, and also proposed that the committees should interest themselves in various specific subjects (see Appendix II). In these early documents there was no mention of the participation of junior medical staff, and until very recently most committees have probably been representative only of the consultant grade.

24. The memorandum R.H.B.(53)91 also suggested that medical advisory committees could valuably undertake periodic discussion of a systematic review and statistical analysis of the clinical work of all departments in the hospital, thus helping to maintain a high standard. Initiation of discussion of clinical details in cases of special interest might be helpful, provided there was no clinical interference in individual cases and the consultant in charge retained sole responsibility. The object of all this was to be the maintenance of as high a standard of medical care as possible throughout the group.

25. The general advice may be useful, but omits important possibilities such as:
postgraduate education and staff training;
study of bed use as well as allocation;
the use of treatment facilities, e.g. operating theatre organisation;
out-patient clinical organisation and waiting time;
the development and availability of diagnostic services;
perhaps most important of all, co-ordination *within the hospital group* and liaison with extra-hospital services, especially general practice.

26. It is now apparent that these arrangements are, in general, far too vague. Effective presentation and use of statistical information has to date been rare. If the service is to achieve maximum effectiveness, authorities must have improved review and planning machinery, and be better able to obtain the views of clinicians. Planning authorities may then be better equipped to perceive hitherto unrecognised needs, and to assess medico-scientific developments. While certain kinds of regional clinical services have evolved under the National Health Service, others, for example epidemiology, genetics and toxicology, have not developed in this way and yet are necessary as consultative services to practising clinicians.

27. Since 1948 hospital medical committees have tended to drift away from the mainstream of management which at group level is largely non-medical. Thus "clinical management" tends to be regarded as remote from the general management of a hospital, medical care being thought to have little administrative content. In fact, practically every clinical decision affects the administrative running of the hospital. It is not too soon to redefine the problem of the administration of medical care services, and to design a system that will produce a better solution of the management problems involved.

28. For very many years the question of hospital administration has produced over generalized and emotional debate often clouded by the question of whether or not the chief administrators should be medically qualified. A number of questions need reconsideration. What is meant by medical administration? How important should be the clinician's contribution to management? How can the clinician's participation in management be made more effective?

Chapter IV

Management Problems in the Hospital and Specialist Service Today

29. The hospital service is the most complex, sophisticated and costly sector of the medical care services. Its general policies and the effectiveness of the way these are carried out have an influence far beyond the immediate confines of what is normally conjured up by the word "hospital". In any large scale enterprise the problem of management has many facets and the hospital service is no exception. Problems of management proliferate in an organisation with many branches, many functions, and many specialties. Opportunities for failure of communication abound in such situations.

30. The management task in the hospital sector, as it affects the hospital based consultant and his junior staff, is to ensure the smooth and economic running of the procedures concerned with diagnosis, treatment and care of in-patients and out-patients. In addition the hospital provides domiciliary consultative and diagnostic services direct to general practitioners. The present arrangements for integrating "care"—including diagnosis, treatment and after-care—are inadequate.

31. Constant awareness of the effect of one action on others is essential for efficient management. Any scheme of administration is likely to be inefficient if it fails to provide the means for mobilising the full consciousness of clinicians about the effect of their individual actions on others than the patient. Since medical factors play a decisive role in a very high proportion of all important general policy decisions, clinicians must be enabled to play a continuous and leading part in the management arrangements for the complex of hospital and associated institutions, which provide the comprehensive medical care service for the population.

32. This may be all too obvious to those who have to manage the affairs of hospitals, but we believe that many clinicians fail to appreciate fully the importance of their role in management problems. It was the realisation of this lack of appreciation that caused the Working Party to suggest to the Ministry of Health that the document "Management Functions of Hospital Doctors" (1966) be printed and circulated to all hospital medical staff.

Chapter V

The Key Role of the Clinician in Administration and Management

(i) At Hospital Level

33. At the outset of the National Health Service, reaction to the previous system produced a policy which avoided a hierarchical structure; consultants were to be on equal clinical footing, with equal rights and privileges. This policy has perhaps been taken too far, ignoring modern needs. Thus an ill-defined medical advisory organisation has developed which does not provide effectively for management problems. These require a corporate approach which precludes the re-introduction of the erstwhile medical superintendent.

34. The committee set up by the Central Health Services Council on the internal administration of hospitals, reporting in August, 1954, suggested the main content of medical administration (see Appendix III). In 1967 it is obvious that the apparently comprehensive list is too imprecise to define the elements of the management problem or plan the future. The role of any medical executive committee must include emphasis on forward planning and creative thought if both manpower and capital resources are to be deployed to the greatest advantage.

35. The organisation of clinical functions is an activity distinct from the general management of hospitals, but each affects the other and decisions cannot be made in either field without regard to the other. The situation will not be solved by providing an administration predominantly medical in character, assuming incorrectly that clinicians can only communicate on such issues with administrators who are medically qualified. A medical man engaged in general management would be acting in an entirely non-medical capacity.

36. Many important hospital administrative matters require direct medical attention only from those in the clinical services concerned. For example, the use of operating theatres must be governed by generally accepted rules, but once these rules are established to the satisfaction of the surgical team, routine supervision falls to the theatre superintendent, usually a senior nurse, in consultation with anaesthetists, surgeons, the bacteriologist, the physicist, and the general administration. The hospital engineer and the cleaning staff also have their several functions. This is the stuff of general administration, and with smooth management the senior medical staff will not become involved unless there is some divergence from agreed policy. However, it has been suggested that much of the daily administration is carried out by medical staff, including junior staff, almost without their being aware of it, and that more training in this field would result in greater efficiency.

37. Discipline is an important part of medical administration, but in a good hospital is not a particularly difficult problem. Clearly it is for consultants to correct their housemen in clinical matters—major social misdemeanours bring

in the general administration operating within agreed standing orders or policy, Discipline of senior medical staff poses more difficult problems; again it is a matter for corporate policy and can only be dealt with effectively by colleagues. For example, if a consultant insists on working when he is too ill to do so, there is certainly an important general administrative issue, but the chief administrative officer, whether medical or lay, acts only in consultation with the chairman of the medical advisory committee. Memorandum H.M. (61)112, (November, 1961) which was agreed with the profession, sets out the two-stage process—a preliminary informal step leading, if necessary, to a more formal inquiry.

38. Again, there is a range of problems which need corporate medical consideration and for which a strengthening of medical administration is necessary. It is simple to lay down standing orders or rules governing admission to a hospital bed. But is the whole medical process as it is deployed for the benefit of each individual patient effective? Is it achieving the best possible results? How efficient is the co-ordination of general, specialist and after-care services as it relates to an episode of illness? The answers to these questions are sought all too infrequently, and too often an individual consultant engages in his own immediate and highly responsible tasks without seeking or even having a ready opportunity, to discover how they fit into the general pattern of the hospital.

39. This highlights the shortcomings of management arrangements on predominantly medical issues. What is required, particularly in larger hospitals, is better co-ordination of policy deriving from clinical interest within specialties and within related specialties, and a more effective means of producing and maintaining collective medical responsibility in such co-ordination of policy. At present the process within hospitals, and in fact in the medical care services generally, seems to be too narrow in its outlook.

(ii) At Regional and Area Level

40. Although the hospital has the central and most dramatic part in medical care arrangements, it is only a part of the broad based social welfare service each part of which must co-ordinate its functions with the others if anything like integrated action is to be achieved. Some areas have active, functioning, maternity and psychiatric liaison committees with representatives from each of the different sectors providing care. However, co-operation between the local authority and hospital services is uneven and both services suffer in consequence. Still less is there sufficient opportunity for general practitioners to express their views on the best deployment of specialist services for the population as a whole. Nothing exists at the hospital or group level for examining the waiting lists for particular diagnoses (for example tonsils and adenoids, hernias, cataract, certain of the paediatric conditions) with the practitioners who are the source of referral. Equally, there is often no machinery for the consultants and general practitioners to consider jointly how to make use of hospital facilities for postgraduate education.

41. The Regional Board is the authority which plans hospital services. Recently teaching hospitals have become more involved with the service requirements of the areas around them. Present evidence suggests that circumstances which dictated the size of the regions in 1947 have been modified since and that there is a real need to look again at the larger regions and see how far it is practical to reorganise them, as happened in 1959 in the South West Metropolitan Region. However, the Regional Boards, whatever their size, cannot efficiently carry out their principal functions of planning unless they can rely on an effective medical organisation mobilising the skill and wisdom of the practising clinicians at service level, and we propose looking at this in more detail later.

Chapter VI

A Review of Needs in Certain Spheres

42. The following paragraphs give some important examples of the particular problems which should be kept under review by all the clinicians practising in an area and for which a different administrative machinery may be necessary.

(i) Hospital Beds

Flexibility of arrangements.

43. There is inefficiency in the use of beds in hospitals. Without reasonable flexibility some wards become chronically over-crowded, while others are permanently underfilled. The development of specialisation and the tradition that consultants have a fixed number of beds completely and permanently at their disposal, have tended in many hospitals to make for inflexibility in the deployment of beds. With the increase in number of consultants and the present lack of a system for continuous review it is difficult to achieve a satisfactory policy for the admission and movement of patients to make the best use of all beds, unless there is exceptional goodwill between all members of the staff. A number of investigations undertaken in recent years have suggested that at any one time a substantial number of hospital beds are occupied by people who could have been discharged at an earlier date, who would be more appropriately cared for in a long stay ward or in welfare type accommodation as provided by local authorities, or need never have been admitted at all. A recent Ministry survey of 6,000 self-care patients who were ambulant and able to wash, dress and feed themselves indicated that 1,321 were being retained in hospital for other than medical reasons.

Occupancy.

44. A number of factors may lead to a patient being retained in hospital for longer than necessary and the pursuit of high bed occupancy as an end in itself is certainly one of these. The bed occupancy figure alone cannot be used as a measure of efficient bed use, but in spite of much public comment in recent years, this fact is still insufficiently appreciated. Administrators, and members of Hospital Management Committees and of Boards, often tend to give undue weight

to occupancy figures. As a result, patients may occasionally be kept in hospital for longer than necessary out of a misplaced desire to improve occupancy figures regardless of the adverse affect on turnover and actual bed use, and with no consideration for the desire of the patient to return home as quickly as possible.

Improved bed management.

45. Some consultants, in order to prevent allocation of a bed to a patient with a chronic illness who might "block" it for a long period, have adopted the practice of retaining a patient who could have been discharged, until the bed can be filled by a patient with an "acute" illness. This misuse could be prevented by improved arrangements for transfer of patients with chronic illness not requiring the same facilities to other accommodation. While it is appreciated that the necessary alternative accommodation is not available in all areas, improved bed management on a group basis and better liaison between hospitals and local authorities, such as could be achieved through an effective executive committee of the medical staff, could do much to improve the position.

Emergency arrangements

46. Arrangements for emergency admission can be a major cause of inefficient use of beds, particularly in hospitals where these are made on a rigid "firm" and specialty basis and each unit keeps some of its beds empty to take possible emergencies. Such arrangements result in far more beds being kept empty than would occur if a system of beds for common use or a special admission ward were available. Another instance is the way in which obstetric beds are kept empty for patients who may be admitted in labour. A certain amount of bed wastage here is inevitable, but it can be reduced by different hospital staffs co-ordinating their admissions so that one hospital when full, may have assistance from another hospital nearby where there are empty beds. The most important requirement is an agreed area plan for maternity work with a recognised booking policy, well understood by hospital and home care services.

47. It will be necessary to prepare a separate paper to deal comprehensively with the problems of effective bed use and the contribution which could be made by efficient medical management in this field, but some indication of this has been given above. The use of 5-day wards, overnight hostel facilities and out-patient treatment units are among the many other measures which could lead to improved bed use, and which could be investigated and exploited by an active executive committee of medical staff.

(ii) **Organisation of Out-patient and In-patient Services**

Planning in advance

48. There is good reason to believe that patients spend longer in hospital than is necessary because planning of their requirements is not carried out in advance. For example, they may have to lie in bed awaiting X-ray examination because at short notice the X-ray department cannot provide an appointment. Many forms of X-ray examination are nowadays elaborate and preliminary preparations have

to be made. While individual administrators may tackle this problem with zeal there is a tendency to leave this too much to chance; a better medical organisation would keep the issue fresh and make timely adjustments. The practical problems might be eased further by employing an efficient and possibly expanded secretariat who could co-ordinate new and previous examinations and procedures before the actual date of admission, in co-operation with the general practitioner. Such a secretariat would need adequate permanent accommodation within the hospital.

Records

49. It is not uncommon for some hospital departments to refuse to release their own records, including X-rays, for inclusion in the general record files because it is feared that this might lead to their loss. Such an attitude can lead to unnecessary duplication both of records and of investigations, including some which involve added exposure of the patient to radiation, and can produce complications in medical care. The Tunbridge Committee report[3] underlines the principle of availability of records between departments and between hospitals.

(iii) Review of Clinical Practice

Variation in practice

50. The normal therapeutic regime for quite common conditions will vary considerably between one hospital and another, or between one consultant and another in the same hospital. The treatment of hernia well demonstrates the wide differences in the length of stay of the patients in different hospitals, or under different consultants in the same hospital. This is a material point, for over one million patient days are used a year for patients with hernia, and these patients also suffer a mean waiting time of 15·6 weeks.[4] Moreover, absence from work may precede admission, with consequent loss of earnings to the patient and in manpower to the nation.

Specific examples of variations

51. Further examples where, at the present time, clinical practice and opinion differ in a variety of situations are the treatment of varicose veins and after-care in meniscectomy; tonsillectomy; and fenestration. A specific instance concerns the after-care of meniscectomy patients at a certain hospital where the average length of stay was 13 days. Because of the length of the waiting list some patients were referred to another hospital with more available operating theatre time, where the operation was carried out by the members of the medical staff from the general hospital. Five years later it was realised that the average stay at the second hospital was 18 days, while the length of stay at the general hospital remained the same. This chance finding in the preparation of a paper then led

---

[3] Ministry of Health: Central Health Services Council: Standing Medical Advisory Committee. The Standardisation of Hospital Medical Records, London, H.M.S.O. 1965.

[4] Ministry of Health, and General Register Office, Report on Hospital In-Patient Enquiry for the year 1963—Part I, Tables, London, H.M.S.O., 1967.

to the appropriate action. No-one at present has the specific duty to suggest what may be done in such circumstances or even to institute appraisal of current practice.

52. The medical staff must have means of being made aware of the implications of clinical developments which at first sight do not seem to affect more than one specialty, but often have implications for many. Outstanding examples of this are recent developments in cardiac resuscitation and laboratory automation procedures.

(iv) Vocational Training—Postgraduate Medical Education

53. The whole of the medical staffing structure at the present time still appears to be based on the requirements of four decades ago, and the Working Party believes that this now needs critical reappraisal. Because of the pattern of medical staffing, and the apprenticeship character of much vocational medical training, no hospital nowadays can afford not to be a teaching hospital in some sense. With the development of postgraduate medical centres and emergence of the need of a centralised policy for vocational training of the specialties—to say nothing of making the best use of junior medical staff—it would seem important to develop machinery to keep the complex needs of vocational training and postgraduate medical education before the consultant staff as a whole. It is no exaggeration to say that the morale of the junior staff depends very largely on their consciousness that their problems are fully understood by their consultant colleagues. Training requirements have changed radically and the new needs must be met by hospitals hoping to attract and retain junior staff, despite the considerable cost in time and effort which this will involve on the part of consultant staff. This will need to be taken into account in determining establishment. Some areas have instituted day release arrangements for junior staff, but the feasibility of this varies not only between hospitals but between specialties in the same hospital. It is important to develop machinery which will take account of the needs of individual junior doctors and the continuing education of the general practitioner, and will guide and co-ordinate all postgraduate activities.

(v) Planning of Services and Use of Resources

54. There has hitherto been very little general oversight of the pattern of different services offered by a given hospital. Nowadays most consultants have marked specialist interests. Unless there is deliberate planning there can be no certainty that the replacement of a retiring consultant will in fact provide the kind of specialist activity that will complement the current pattern of the hospital as a whole. A decision to make a completely new specialist appointment to the hospital staff may not be accompanied by a careful analysis of the effect that this is likely to have on operating theatre time, out-patient clinics, nursing staff, etc. Bitter experience may in certain places have improved the position in this regard when a changeover of staff is due to occur, but there should be machinery to evaluate what is necessary. There are no doubt detailed arguments about how many beds the new man will inherit and where they will be and so on; but there

is reluctance to examine afresh what kind of appointment is wanted, what special interest is lacking, or in the case of teaching hospitals, what the University would like to see from the point of view of teaching. Even the bed allocation may be decided by habit rather than with regard to the greatly changed value of the bed as a unit.

Chapter VII

Towards a More Sharply Defined Organisation of Medical Staff

(i) The Divisional System

55. The preceding paragraphs attempt to describe and define the medical content of hospital administration at the service level. It is not disputed that many of the duties described are competently carried out today by medical advisory committees and their chairmen or by medical superintendents where this post still exists. Chairmen and medical advisory committees are, however, busy clinicians. The advisory machinery was designed (R.H.B. (53) 91, see Appendix II) to ensure representation of the whole consultant and specialist medical and dental staff of the hospitals concerned, of general medical and dental practitioners on the staff and of those in practice in the area and of medical officers of health. Since then time has passed and views have changed, and such a committee, while democratic, is cumbersome and unwieldy for the manifold duties it has to carry out, ranging from major policy considerations to more routine medical matters affecting possibly only one or two specialties. An immediate objective must be to develop more specific constitutional arrangements, which will encourage on an area basis, and subsequently regionally, the building up of the collective thinking of the consultant medical staff of the hospital and specialist services, to provide a firm basis for policy making. Only in this way can the organisation of medical care be founded on scientific observations and related to perceived needs.

56. It seems to the Working Party that no matter how the hospital sector of the health service is organised, the medical efficiency and the organisation of clinical functions of each individual hospital, large or small, is a problem unique to that hospital. In order to find the structure in which such appraisal of the hospital's function would be feasible, the Working Party found it necessary to look closely at the basic medical organisation of the hospital service. The "firm" system as it operates at the moment has something to be said for it within a limited field, but members of the "firm" do not necessarily have the opportunity —nor always the will—to communicate with colleagues within the same broad sector of activity and having similar or related organisational problems. For example all the surgical specialties tend to have lengthy waiting lists and make demands on anaesthetic services and theatre time. *Taking the district general hospital complex as the basic unit it is suggested that the grouping together of specialties would allow an organised approach to many of the problems which medical staff should be facing and so establish effective medical administration in*

hospitals. Some of the specialties fall naturally into single or composite groups within either broad medical or surgical categories. Others—such as neurosurgery—represent both medical and surgical interest. The number and size of specialty groups or "Divisions" would be influenced to a great extent by the size and pattern of the existing group hospital services. Divisions might be formed from the medical specialties, the surgical specialties, the laboratory services, radiology and radiotherapy, psychiatry, obstetrics and gynaecology or some combination of specialties deriving from a specific development at a particular hospital. The division would include all the consultants and their junior staff and would meet regularly to review its work. Suitable information could be placed before the meeting covering work done, results, facilities required and any question of mutual assistance. In such a system the substantial contribution of junior staff—especially registrars—to the organisation of the work could be more fully recognised. One of the present frustrating factors for many capable young doctors is undoubtedly their lack of opportunity to influence the management of their own work in order to improve efficiency.

57. The Working Party examined the theoretical application of the divisional system to two areas. In one the natural grouping of specialties gave rise to six divisions and in the other to nine. One of these exercises was applied in a region which already had a system whereby clinicians are grouped together. There is no written constitution for these groupings but they represent the working arrangements for clinicians in an area to come together for discussion.This region was therefore conditioned to grouping by specialties and accepting one member as spokesman for the rest of the group. This small number of *services* or *divisions* would result in a small number of representatives and it is suggested that these should form an *executive committee* which would be less cumbersome than the present medical advisory committee.

(ii) **Functions of the Division**

58. The functions of a "division" have been indicated in a general way in paragraphs 42 to 53; namely the review of hospital bed usage against the background of community needs, the organisation of out-patient and in-patient services, the review of clinical practice, vocational training and postgraduate medical education. Under these broad main headings will be included the study of data on waiting lists, out-patient waiting times, time spent in hospital by patients awaiting operation or investigation and supervision of medical records. The use of resources, manpower, both medical and ancillary, and equipment will need to be considered by divisions and the optimum use of these worked out. This will involve liaison with other divisions and with non-medical groups. Liaison activities with other divisions and with other departments and committees within the hospital group, with general practitioners and with medical officers of health, to name only a few, will form an important part of the division's duties. Postgraduate activity should cover both informal inservice training schemes for junior staff with more formal clinico-pathological conferences and programmes for all the doctors practising in the area (including those in general practice and local

authority service). Association with the other community services, particularly home nursing, should make possible the integration of care for groups such as the very old and the very young and should also lead to the development of policy on subjects such as out-patient surgery, early discharge after delivery, and rehabilitation.

59. The Working Party has not attempted to define the method of co-ordination with nursing administration, but it seems that the nursing organisation envisaged in the Salmon Report[5] would fit in conveniently with what it has proposed. It is obvious that the chairman of the executive committee would need to work as closely with the chief nursing officer as he would with the administrator.

(iii) **Chairmen of Divisions**

60. The divisions would each require a chairman who should be appointed by Boards of Governors in consultation with appropriate consultant staff, and by Regional Boards in consultation with Hospital Management Committees and consultant staff. The duties of the post should be recognised in the holder's contract. The internal divisional organisation would be a matter for each specialty or group and no doubt would depend on what the chairman could himself undertake.

61. Some idea of the functions of divisions has been outlined but it is not easy to lay down a single pattern for each division and its chairman. Most of the division's administrative effort would be devoted to appraising the need it is fulfilling, the success it is achieving in its objects, and coping with the problems that arise. Obviously it is essential that the division be supplied with data relevant to these functions—such as statistical information on admissions and discharges, waiting lists, out-patient waiting times, and autopsy findings. Regular meetings of the division should be presented with information of this nature collected and processed in collaboration with the non-medical administrative staff. Certain divisions might find it profitable to organise some kind of inservice reappraisal. The presentation of reports to the executive committee from the division might be a duty delegated by the divisional chairman to another member of the division.

(iv) **Composition of Executive Committees**

62. The executive committee would be composed of representatives from the divisions. There would also be a chairman, appointed in the same way as the chairman of a division, who would occupy the position for a period preferably of 5 or more years, who might later return to wholly clinical practice. The chairman of the executive committee would not necessarily be the chairman of a division. The Working Party recognises that a mistaken selection might be made and therefore this should be subject to annual renewal. The duties of such a post would be different from those of the chairman of the present medical

---

[5] Ministry of Health and Scottish Home and Health Department, Report of the Committee on Senior Nursing Staff Structure, London, H.M.S.O., 1966.

advisory committee in as much as he would have wider scope, organised assistance from colleagues, less involvement with day-to-day details of clinical work, some executive powers and appropriate recognition of the duties of his post in his contract. Such a post could only be filled by an experienced clinician.

(v) Role of Executive Committees

63. The executive committee and its chairman would receive and consider reports put to them by the divisions, review major issues of policy and planning, and co-ordinate the medical activities of the hospital as a whole. In this structure the executive committee is seen as a source of authority behind the chairman who would of course be the hospital's (or group of hospitals') chief medical spokesman during his term of office. It is believed that persons of such inclination and aptitude are to be found amongst hospital consultants and that the chairman's duties would be in no way inconsistent with the recognised rights and privileges of the other serving consultants. One of the built in duties associated with such a role, whether it be called "Chief of Staff" or "Chairman of the Medical Executive Committee" could well be the presentation of a bi-annual or quarterly report to the medical staffs as a whole, meeting as a full medical committee. The chairman, if he is not a member of the Hospital Management Committee, should attend its meetings.

(vi) Some Administrative Aspects

64. Since both the "chief of staff" and the chairman of divisions will be actively engaged in management they must be provided with the essential apparatus of medical administration such as suitable office accommodation and supporting secretarial staff. Consultants holding office in divisions, whether as chairman or in any other capacity, would be unlikely to average more than one or two sessions a week on administrative duties. The chairman of the executive committee might need to devote three or four sessions a week to this work.

65. Such an organisation should be developed from existing arrangements rather than generally introduced in a uniform pattern on a certain day. The Working Party is aware that any preconceived pattern of services is unlikely to be applicable to the large number of very small hospitals. Nevertheless of the 333 non-teaching hospital groups in England and Wales in 1966 only 35 had less than 500 beds. It is suggested that at least a modified form of the full divisional system might evolve in areas where the total consultant staff shared by the group number no more than twenty or thirty.

66. The Working Party believes that such a system would provide the machinery for a sharper perception of the problems of planning and evaluation of medical care, and for better co-ordination with general practice and local health authority services. Some consultants will be relieved of attendance at committees where the subject matter may be barely relevant to their duties or interests, but the administrative burden falling on a few will prove to be greater than before. Nevertheless, we believe that this is work that must be done, that assistance must be provided for those who do it, and that time must be made for it.

67. Notwithstanding these proposals there is no reason why the full medical staff committee as at present constituted should not continue to meet as before.

Chapter VIII

Training for Medical Administration and the Organisation of Medical Care

68. The re-organisation into a divisional structure with an executive committee can only be effective if arrangements are introduced for appropriate training to be made available to clinicians selected to fill special roles and if the profession as a whole accepts the need for change and understands the working of the new structure and its objective. A planned training programme will be required to achieve this and will have to include special courses for clinicians appointed as medical executive committee chairmen and a continuing series of general conferences and seminars suitable for the main body of clinical staff.

69. The detailed content and the duration of courses for prospective medical executive committee chairmen will need to be considered outside the present discussions, but the Working Party consider that preparation for this important role should include the study of the organisation of medical care as a whole, as well as instruction in the principles of administration and the application of modern management aids and techniques. Experimental courses along these lines should be devised. There should also be regular opportunities during their period of service for chairmen to meet colleagues with similar responsibilities to provide fresh thinking.

70. The education and training of the main body of the profession poses different problems, and the organisation, on a regional basis, of weekend or single day seminars or conferences would appear to offer the most practical solution likely to achieve some success. The Working Party emphasises, however, that the clinical staff of hospitals is by no means the only group of National Health Service employees in need of this assistance, and that the greatest benefit to participants and to the service is most likely to be derived from a multi-disciplinary approach. This could include hospital administrators, doctors and other administrators on the headquarters staff of Regional Hospital Boards or the Ministry of Health, and doctors and others engaged in other branches of the service, as well as the group of clinicians working in a hospital with which the Working Party is primarily concerned. The new structure proposed for the organisation of medical work in hospitals can only be fully effective if it is closely related to the organisation of medical care as a whole and if there is a basic identity of outlook in common between the various branches of the service. Among doctors, participation in these general conferences and seminars should not be restricted to the senior or established members of the profession in the hospital service, but should include a proportion of doctors from the junior grades, and from general practice and public health.

71. Elsewhere in this report, emphasis is placed on the need for a much closer integration of the three main parts of the service and comments are made on the nature and quality of administration at central and regional level. The impact of the professional medical administrator on the general running of the service and therefore indirectly on the efficiency of medical work in hospitals is very great, and it seems appropriate to include a few general comments on the training requirements for this group of doctors in this Report. The organisation of medical care in this country on a national basis, with increasing emphasis on the concept that the total medical care of the patient requires the integrated co-operation of services inside and outside hospital, now more than ever before calls for high quality in recruitment to the ranks of professional medical administrators. With continuing trends in this direction, administrative medical officers at all levels have a need for a common basic training which will fit them for a career not as "personal doctors", caring for individual patients, but as specialists in the administration of community medical care concerned with practising medicine in relation to populations and groups. Training for such a role must include postgraduate experience in the hospital service and/or general practice, and a study of epidemiology, statistics and other subjects appropriate to the practice of this type of administration. At present there is a regrettable lack of properly organised vocational training for professional medical administrators other than those required for the services of local authorities. Until this is remedied and there is some improvement in the career structure and the status of these administrators, the present shortage of suitable applicants for this type of work seems likely to continue. There is a need for organised initial training courses and for regular refresher courses for these doctors. There has been systematic training for the Diploma in Public Health for nearly a century, but this Diploma has been related to one particular field of medicine and is not fitted to the requirements of the hospital service or general practice. It is known that the General Medical Council is reviewing the regulations governing the Diploma.

72. The Working Party thinks that the pattern of training needs more detailed examination, and proposes to return to this subject at a later date. It feels that a common basis of training for administrators in any branch of the health services could be devised which would encourage interchange between them and be consistent with the requirements of any likely pattern of administration in the future.

Chapter IX

Epilogue

73. Medical advisory machinery in the hospital service has performed a useful function since 1948. Nevertheless statistical and other sources of information now delineate the community's need in depth and detail never possible before. This sharper perception of problems of planning and of evaluation of medical care services demands a higher efficiency than that of which the existing machinery is capable.

74. The Working Party assumes that the present rapid trend towards grouped general practice with attached local authority nursing and other staff will continue, and will be planned within the district of a general hospital, so as to form a health service unit or complex of which the district general hospital and the postgraduate medical centre associated with it are the focus. Although reference here and elsewhere is to the district general hospital, it is still true in many, if not most, centres that the district general hospital is dispersed over several units. In such conditions it is still possible to organise the several units as one, and unnecessary to await concentration on one site. A divisional organisation is the logical development for the district general hospital, whatever pattern of hospital staffing emerges as a result of present negotiations between the profession and the Health Departments or of recommendations made by the Royal Commission on Medical Education. The number of divisions would relate to the services provided by the district general hospital, and these in turn are influenced by the geography of the area and by other practical considerations such as the optimum size of the hospital unit. The Working Party is not in a position to define either the minimum or maximum size of a population that should be served in this way—that is by the district general hospital in association with group practice and local health authority centres—but this complex would only exceptionally be found where the population numbers less than 100,000 and is more likely to approach, or even exceed, 200,000 in larger urban communities. It is not suggested that such a complex should stand alone. There will be sharing of some highly specialised services between neighbouring groups as part of a regional pattern. This raises a further problem of administration which has exercised the Working Party.

75. There must be doubt as to the effectiveness of the regional administration when its span of control covers too many units or medical care complexes such as we have described. Also it may well be that the actual constitution, membership and function of the statutory administrative authorities themselves will shortly come under review, though they are outside our remit. Aside from the possibility of reconstitution of these authorities there is a need for special qualifications in members of such bodies, or inclusion of members with expertise in the techniques of large scale management in professional and scientific fields.

76. The Working Party believes that the suggestions made in this report, covering as they do only the service level of hospital organisation, will, if implemented with goodwill and understanding, provide more effective management of the medical care services found in hospitals than exists at the moment. Moreover it is believed that such an organisation could be readily assimilated into the basic structure of a fully integrated service.

Appendix I

Hospital medical staff in England and Wales: Analysis by grade in terms of whole-time equivalents 1949–1966

Grade	1949	1950	1951	1952	1953	1954	1955	1956	1957	1958	1959	1960	1961	1962	1963	1964	1965	1966
All staff: Total	11,735	12,595	13,391	13,917	14,055	14,605	14,923	15,391	15,696	15,941	16,033	16,584	16,932	17,557	17,971	18,346	18,905	19,541
Consultant	3,488	3,828	4,197	4,520	4,639	4,823	4,935	5,055	5,171	5,371	5,322	5,460	5,698	5,868	6,049	6,201	6,912	7,136
Medical assistant	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	7	398
Senior hospital medical officer	1,106	1,070	1,238	1,343	1,518	1,560	1,601	S.h.m.o. — with allowance 1,619	1,609	1,612	1,530	656	590	625	618	617	174	134
Senior registrar	1,430	1,510	1,401	1,133	1,020	983	952	S.h.m.o. — without allowance 983	1,008	949	931	872	885	788	715	659	514	396
Registrar	1,523	1,736	1,706	1,974	2,120	2,304	2,409	2,519	2,630	2,726	2,787	925	940	1,000	1,048	1,140	1,206	1,245
Junior hospital medical officer	401	422	492	468	476	502	567	604	620	653	673	2,984	3,093	3,347	3,530	3,755	3,970	4,186
Other staff	378	330	293	252	108	86	37	37	36	16	40	709	681	662	673	608	463	181
Senior house officer	797	938	1,329	1,514	1,675	1,763	1,873	1,962	2,068	2,155	2,315	27	18	23	35	36	33	25
House officer	2,613	2,761	2,735	2,713	2,500	2,585	2,551	2,614	2,553	2,458	2,436	2,476	2,560	2,710	2,835	2,982	3,279	3,489
												2,475	2,468	2,534	2,469	2,348	2,347	2,351
Paid staff: Total	11,735	12,540	13,339	13,811	13,865	14,335	14,684	15,108	15,404	15,632	15,762	16,295	16,638	17,231	17,623	17,949	18,441	19,041
Consultant	3,488	3,796	4,161	4,458	4,517	4,662	4,778	4,888	4,990	5,154	5,132	5,261	5,477	5,637	5,803	5,946	6,626	6,835
Medical assistant	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	7	397
Senior hospital medical officer	1,106	1,064	1,232	1,337	1,507	1,552	1,593	S.h.m.o. — with allowance 1,610	1,599	1,604	1,522	656	590	625	618	617	174	134
Senior registrar	1,430	1,500	1,393	1,116	998	945	915	S.h.m.o. — without allowance 935	963	924	908	864	878	785	713	656	511	394
Registrar	1,523	1,733	1,705	1,968	2,105	2,281	2,389	2,475	2,595	2,682	2,758	905	921	976	1,017	1,103	1,148	1,176
Junior hospital medical officer	401	422	492	468	474	492	567	604	620	653	673	2,949	3,064	3,309	3,505	3,716	3,924	4,119
Other staff	378	326	293	239	94	59	33	33	33	15	33	708	681	662	673	608	463	181
Senior house officer	797	938	1,328	1,512	1,673	1,760	1,859	1,949	2,054	2,143	2,300	20	11	10	9	6	6	6
House officer	2,613	2,761	2,735	2,713	2,499	2,585	2,551	2,613	2,550	2,457	2,436	2,457	2,550	2,694	2,835	2,977	3,274	3,487
												2,475	2,467	2,533	2,451	2,320	2,308	2,312
Honorary staff: Total	...	55	52	106	190	271	239	284	292	309	271	289	294	325	348	397	465	500
Consultant	...	32	36	62	121	161	157	167	181	217	190	200	221	231	246	255	286	301
Medical assistant	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	1
Senior hospital medical officer	...	6	6	6	11	9	8	S.h.m.o. — with allowance 9	9	8	8	—	—	—	—	—	—	—
Senior registrar	...	10	8	17	22	37	37	S.h.m.o. — without allowance 48	46	26	23	8	7	3	3	3	3	2
Registrar	...	3	1	6	16	23	20	43	35	44	29	20	19	24	31	37	58	69
Junior hospital medical officer	...	—	—	—	2	10	—	—	—	—	—	35	28	38	26	39	46	67
Other staff	...	4	—	13	14	28	5	4	3	1	6	—	—	—	—	—	—	—
Senior house officer	...	—	1	2	3	3	13	13	14	12	14	7	7	13	26	30	27	19
House officer	...	—	—	—	1	—	—	1	3	1	1	20	11	16	—	5	5	2
												—	1	1	18	28	39	39

Appendix II

Guidance issued on hospital medical advisory committees in 1953

A memorandum issued in 1953[6] suggested that committees should concern themselves with:

(*a*) Developments in the scope of a hospital's work, such as the formation of new departments, or extensions and modifications in existing departments;

(*b*) allocation of beds;

(*c*) criteria to be followed in deciding upon the admission of patients on the waiting list;

(*d*) arrangements to be adopted for emergency admissions;

(*e*) procedure for dealing with complaints involving medical or dental staff;

(*f*) procedure for making appointments of junior medical or dental staff (within the framework of such central guidance as has been given, e.g. in relation to registrars);

(*g*) types of medical and dental equipment and supplies to be obtained;

(*h*) care of medical and dental records;

(*i*) economies to be sought both generally and in relation to such matters as prescribing, use of X-ray films, etc;

(*j*) control of infection in hospitals;

(*k*) recommendations of members of the staff to serve as members of the Board of Governors or Hospital Management Committee;

(*l*) the organisation of such activities as clinical demonstrations or maintenance of a medical library.

The memorandum went on:

'Another function which is not at present usually exercised by such committees but which the Minister thinks would, if exercised, produce results of the greatest value, is the systematic review and analysis of the clinical work of the staff. If the results of the work of all departments were regularly reviewed and where practicable subjected to statistical analysis and brought before the full committee at its periodical meetings, discussion of the results would, in the Minister's view, assist all the staff in achieving and maintaining a high standard of clinical work. Suitable opportunity for discussion of the clinical details of cases of special interest might also be provided. No question of clinical interference in the conduct of individual cases would arise; this would remain the sole responsibility of the consultants in charge of the particular cases. The object would be discussion and review of clinical results with the object of ensuring as high a standard of medical care as possible throughout the group.'

---

[6] Ministry of Health, Medical Committees in Hospitals and Hospital Groups, 1953 (RHB (53)91, HMC (53)85, BG (53)87).

Appendix III

Extract from the Bradbeer Committee Report

The Committee set up by the Central Health Services Council on the Internal Administration of Hospitals, which reported in August 1954[7] suggested the following as the main content of medical administration:

(1) continuous advice to the governing body on the best use of the available beds and all other facilities for patients;

(2) co-ordination of the work of medical departments and matters of medical administration arising therefrom;

(3) liaison work on medical matters with the Regional Board, the Local Health Authority, the local Executive Council, the Coroner, etc.;

(4) medical supervision and control of admissions and discharges;

(5) the survey of waiting lists and the action to be taken to meet varying pressures on different departments;

(6) departmental supervision and co-ordination of medical auxiliaries;

(7) medical aspects of the almoners' work;

(8) the medical arrangements to cover the smooth-running of the out-patient clinics, appointments system, casualty department, etc.;

(9) supervision of medical equipment and medical supplies, in co-operation with the chief pharmacist;

(10) medical records;

(11) hospital discipline involving patients;

(12) discipline of junior medical officers;

(13) general supervision of the health of the staff;

(14) notification of infectious diseases; co-ordination of measures to prevent the spread of infection within the hospital and the investigation and control of any outbreaks of epidemic disease or cross-infection within the hospital, in association with the local authority where necessary;

(15) supervision of any area service provided by the hospital, e.g., obstetric flying squad, blood transfusion service where appropriate.

---

[7]Ministry of Health: Central Health Services Council. Report of the Committee on the Internal Administration of Hospitals, London, H.M.S.O., 1954.

Printed in England for Her Majesty's Stationery Office
by McCorquodale Printers (Crewe) Ltd.

Dd.136290 K40 1/68 90895 401.

Published by
HER MAJESTY'S STATIONERY OFFICE

To be purchased from
49 High Holborn, London W.C.1
423 Oxford Street, London W.1
13A Castle Street, Edinburgh 2
109 St. Mary Street, Cardiff CF1 1JW
Brazennose Street, Manchester 2
50 Fairfax Street, Bristol 1
258-259 Broad Street, Birmingham 1
7-11 Linenhall Street, Belfast BT2 8AY
or through any bookseller

Printed in England

PRICE 2*s.* 9*d.* NET

S.O. Code No. 32-538