From the Editor ● Van die Redakteur

Are you managing?

Fourteen years ago Feinstein[1] wrote about the need for better education of doctors to make the right kind of managerial decisions. How far have we come? Making the right management decisions in family practice means managing the patient's problems optimally for the patient's wellbeing. This includes the survival of the practitioner ! How else can we achieve continuity of care? To do this we need : an attitude, a method and an ethic.

It is of no value to be the nice guy with a vague *attitude* of goodwill. This, on its own, may be very expensive for the patient. For good care, a cost-awareness attitude should be maintained constantly. This often entails our becoming the patient's advocate. Patients, as the end users of laboratory tests, operations, hospital beds, appliances and drugs, at best only partially decide which of the many options on the market are to be prescribed, if at all. Normal market forces do not operate for them as patients as they do when they want to buy a car or soap. How about fully costing your next ten scripts? When last have you protected a patient or the taxpayer from an unnecessary laboratory test or operation? How many family practitioners go through their patient's hospital accounts with them to look for incongruities and overcharging? It does happen and our patients seldom have the expertise to spot it!

We also need a *method* . Feinstein says that our ability to explain disease or to diagnose has advanced with massive strides in the last 100 years, but that our managerial decisions have often remained as they were in the 18th century, 'doctrinaire and unscientific.' Things are improving, though, as we see the emergence and implementation of various tools of management.

Weed[2] must receive much credit for stimulating the movement towards Problem Oriented Medical Records. These have been variously adapted to the needs of different primary care situations. Well used, this practice is a quantum leap towards better patient care.

Epidemiology has advanced from infectious disease epidemics to the interrelationship of all factors with all diseases. It has given us a tool to study the outcomes of our managerial decisions as well and we have learnt to explain the mechanism of many a disease process.

We need economic skills. Why is it that so many auditors and bookkeepers smile at doctors? They say we are suckers who live high and leave behind poor widows! Staff is the biggest item in any medical concern's expense account. Are we experts in the planning and use of time? This costs money in both the public and private sector. There are doctors — in the public sector, no doubt — who do Caesarian sections in 15-20 minutes and then spend two hours chatting in the tea room or along the corridor afterwards.

Cost-effectiveness per se without an *ethic*, is in many instances a barren exercise. There are examples where savings due to greater efficiency are passed on to the doctors. In the private sector it leads to greater income and in the public sector to less work for the doctors. The patient may not benefit at all. Perhaps the best example of this is to be found in firms of pathologists where machines and over-paid staff increase production and efficiency. The The increased income goes towards excessive profits and salaries and not towards lower-priced pathology tests.

So there has been some progress towards better managerial decisions in the clinical and economic fields but we still lack many answers. We still do not know what the optimal system of health care delivery is. We still don't teach managerial theory and skills as part of the basics of medicine. It remains an afterthought; something one picks up in practice. Consequently we meticulously come to a scientific diagnosis and then manage largely by intuition. We need a more scientific approach to give ongoing, effective and affordable care to our patients. We must teach ourselves and the new generations of doctors the basic sciences of management, till we are expert at both diagnosis and management. The costs in terms of human tragedy and loss of revenue resulting from mismanagement are vast compared with those of misdiagnoses. Neither of these are excusable. Let's put our efforts into reducing both.

References:

1. Feinstein AR. What kind of basic science for clinical medicine? *N Engl J Med* 1970; 283: 847-52.
2. Weed LL. *Medical records, medical education and patient care.* Chicago : Case Western Reserve University press, 1971.