about the nursing staff they seemed more reticent. Criticism of nursing care was often prefaced by comments on shortages of nurses; only 58 percent of those interviewed thought that there were enough nurses at all times, and 10 percent felt there was a shortage at night. Promptness in attending to patients, attitudes to work, individual kindnesses, and episodes of unkindness were all surveyed, and on the whole there was warm praise for Wellington Hospital nurses.

Defective communication with the patient is something that hospitals are often accused of. However it was apparent that nearly half were told all they wanted to know about their illness; 29 percent were told most of what they wanted to know and about one-quarter felt that they were not adequately informed. Some patients, mostly elderly, appeared to be indifferent, preferring not to know and trusting the doctors to do their best. Although doctor-patient liaison was good in most wards, there were some wards where only between one-third to one-half of the patients were told about their treatment by the doctors. In some wards about one-quarter of the patients had no explanation. Many patients commented on the general topic of communication, some criticising doctors for withholding information, for being too remote and for not communicating well. The patients were often confused by having several doctors in attendance and not being sure from whom they should be seeking information. Likewise family and friends in almost 20 percent of cases either received unsatisfactory or no answers to their enquiries. The workshop discussion emphasised the need for the medical staff, nurses, physical therapists and social workers to discuss together how they should keep the patient informed on all aspects of his illness—how much should be told and by whom, and that when appropriate the district nursing service should be brought in to these discussions to continue the free communication into the post-discharge period. Not only should both senior and junior medical staff be available for interviewing relatives, but where feasible printed information should be available for distribution.

This survey and others highlight the communication problems in large hospitals and the deleterious effects that poor communication can have on staff morale and patient care. An important conclusion from the survey and the ensuing workshop discussion is that if consumer research is to result in significant changes in the running of the hospital then it is essential from the outset to involve all staff including medical staff, in the research in what might be termed an action learning situation. Already this survey has resulted in a number of improvements in Wellington Hospital, and it must pave the way for other hospitals to look critically at their services.

REFERENCE

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VIEWPOINT

Maori Attitudes to Sickness, Doctors and Hospitals*

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1.

In describing the attitudes or values shown by any racial or cultural group, it is all too tempting to generalise and ignore individual differences. Stereotypes can be created and others may react to the stereotype rather than to the individual. It is strongly emphasised that every patient needs to be seen as an individual first and then perhaps as belonging to a certain cultural group. None-the-less there is a case for differing attitudes and values, dependent on culture. There is often a lack of awareness of the extent to which attitudes are shaped by factors that can be traced to the early inculcation of culture values, even though these cultural factors may remain unconscious and unspoken.

In discussing Maori attitudes to sickness, doctors and hospitals, some recognition must be given to the pressure of cultural factors—even in 1976—in situations which at first glance seem far removed from pre-European Maori settings. Before these attitudes can be explored it is necessary to know a little about the concept of tapu.

Tapu has been variously translated as sacred or religious but, means much more than that. Tapu enabled the social life of the community to be maintained—it was basis of law and order and its respect ensured the survival of a community. Any situation endowed with tapu qualities was regarded with awe and some calamity would likely occur if it were desecrated. Certain places, eg burial grounds were regarded as tapu, sometimes thing, eg weapons, were rendered tapu and often special people were regarded as tapu and therefore in positions of considerable power and perhaps isolation.

The laws of tapu had direct application to matters of health.

For the Maori of old, two main health concerns were recognised. There were accidents towards which a

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more "rational" approach was held—an approach which would not be too unfamiliar to an orthopaedic surgeon. Accidents were essentially man made and the agents causing injury readily identifiable. Sickness was a different matter. For the most part a person who was sick was considered to have a mate atua. The cause of the illness was considered to reflect an infringement by the individual against some law of tapu. Thus, the patient may well have wandered on to a tapu piece of ground, might have stepped into the shadow of a tapu person or might have paid little respect for a tribal custom that had become tapu. All sickness was regarded primarily as psychological. Thus, rather than psychiatry being a branch of medicine, in the Maori community medicine would be regarded as a branch of psychiatry.

2.

When it came to sickness, the tohunga was an important person in the community. The tohunga was an extremely tapu person, set aside from common men and regarded with both respect and fear. He was so special that contamination from any ordinary person could lead to that person's immediate death. He often had special eating arrangements and, without him, no tribe would dare to venture forth in battle or even to receive a group of strangers into the pa. Thus, not only was he an expert in matters of health, but he was also an extremely powerful political figure upon whom the community depended for its spiritual strength.

In his role as a healer, the tohunga embarked on a process which many doctors would recognise in their own management of patients. His first step was to establish a diagnosis—a step which required an extremely detailed history, including a thorough knowledge of the family history. Dreams were also regarded as valuable diagnostic tools and through them, the tohunga could often discover the "hara", ie the basic infringement which had led up to the illness. Having made that discovery, he was then able to embark on a plan of treatment during which the offending spirit was removed. In this treatment process the family were very much involved with the tohunga and they assisted him in his various rituals. Their involvement was considered essential since a sickness of this nature often placed doubt on the competence of the family and indeed, continuing sickness was regarded as a blight on that family's reputation. The final phase of management included a process of rehabilitation during which the tohunga recited purification rites (whakahora) and gave a great deal of encouragement (whakanoho manawa).

3.

When the cultural attitudes shown by many Maoris to sickness and treatment today are considered, the knowledge of their cultural inheritance is often helpful in understanding the patient. It would be rare to find a patient in hospital who spoke openly about some infringement against a law of tapu but frequently there is an unspoken and an unconscious fear of some infringement against the community as a whole. On the part of the patient there may well be a restlessness as he searches within himself for some commission or omission which has led up to his illness. That attitude can easily be dismissed by a scientific approach and in its place a more logical explanation for sickness may be given. It may be explained to the patient that his jaundice is really due to a virus and not a transgression. This may partially relieve anxiety but the quest for the "real cause" may continue once the ward round is over. It is not only the patient who will be searching for the "hara" but the family also. There is for the family the possibility that they might also have been involved in some cultural offence and a certain amount of guilt is likely—especially if they are not actively involved in the treatment plan. Often the relatives of Maori patients are regarded as erratic and inconsiderate at visiting time, arriving in masses and refusing to leave when the bell rings. For the family there is a need and a desire to be involved and their presence in large numbers often reflects that desire. By helping to care for the patient they are assisting the tohunga, fulfilling the expectations of their community and alleviating their own sense of guilt. There are many ways in which families of hospitalised patients can be involved and, in these days of nursing shortages, hospitals should not be quick to turn away well intentioned families but rather, should accept pleas for involvement and perhaps arrange for a number of duties to be taken over. The opportunity should also be available for relatives to share in the various religious services which have today become part and parcel of hospital life.

Sometimes, the doctor in charge may hear that the family has requested the presence of a Maori healer or tohunga. This is seldom meant as a vote of no confidence in modern medicine or in the staff involved, but is a legitimate desire to "put right" any outstanding infringement against some law of tapu. It is an opportunity to make amends for any infringement, to ease guilt and to become involved in a process of healing that may make a little more sense than the mystical powers of digoxin or an electrocardiogram. In the latter part of last century, Parliament passed the Tohunga Supression Act which in effect outlawed the tohunga. Perhaps in those days the act was necessary but, in 1976, there is obvious room for co-operation between medical practitioners and Maori healers. A good tohunga will not presume to have a cure for cancer or diabetes and will seldom insist on the disruption of existing treatment. He will however, be in a better position than the average medical practitioner to give an opinion on the possible psychosocial factors operating.

4.

In considering cultural attitudes to health, the role of the family is crucial in Maori circles. Ill health reflects on the family and the rest of the community will hold that family responsible for any harm which comes to one of its members. Up until recent times the muru raid was common following death. If there were any semblence of neglect, then neighbouring tribes and families took it upon themselves to plunder the family of the deceased, removing all valuable articles from them as a type of "punishment" for negligence. The family concerned could not retaliate and could only hang their heads in shame as the raid proceeded.

Likewise, it was not uncommon for a visiting group to claim the body of a deceased person and bury him among their own dead. It was considered a mark of respect to the deceased person but also a further reflection on the lack of confidence they had in the family who had let that particular person die. In warfare, it was particularly important to recover the bodies of decreased warriors as soon as possible least they be desecrated and insulted.

Having regard to these latter customs, it is not surprising that the death of a Maori patient in hospital can lead to a great deal of anxiety among the relatives. As soon as news of death is received, the local marae will immediately be made ready to receive the body and to cater for large numbers of visitors who may come to pay their respects. If the body is not on the marae when the visitors arrive, accusations of negligence on the part of the immediate family could be made. The visitors have come not only to see the next of kin but also to address the body itself. It thus becomes a matter of urgency for the family to take possession of the deceased relative. The question of autopsy is sometimes raised. Reluctance for such a procedure usually stems from the urgent desire to reclaim the body rather than an abhorrence of post mortem. If, for instance, the person had died on a Friday and an autospy request would require the body to remain in the hospital until Monday, seldom would permission be given. On the other hand, the relatives may feel much easier if some assurance can be given that the autopsy will take place shortly and that the funeral proceedings will not be delayed. For the bereaved family, there are both unconscious and conscious reasons why the body should be claimed and watched over up until the time of burial. The doctors duty does not end when the patient has died, but should continue until the body has been respectfully returned to the bereaved family.

The concepts of tapu and the perception of illness as an infringement against tapu are central to much of the anxiety and depression which surround the Maori patient while in hospital. Family involvement at times of illness is likewise a very traditional and culturally necessary attitude which must be recognised in the management of the whole patient and not just his impaired organ.

Management and the Medical Profession*

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INTRODUCTION

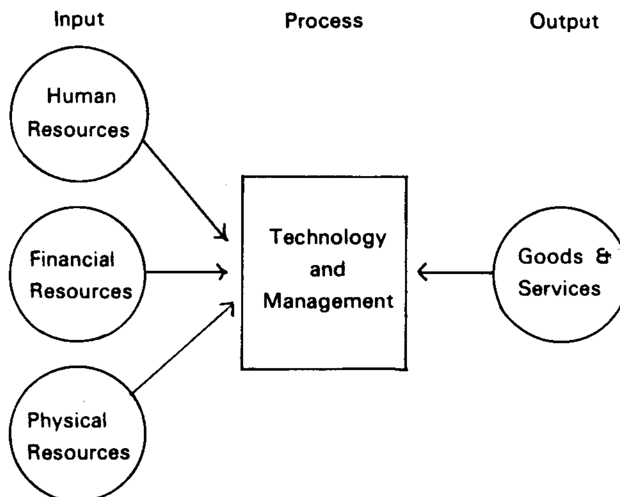
Management is getting things done through people. This is one of the simplest and yet most accurate definitions of management. It rightly emphasises two of the most important aspects of management: "getting things done", achievement of results, and "through people", because achievement is only possible through people, the most important resource. By implication, good management must mean getting things done within the constraints of limited resources and time. After all, anybody can manage if both resources and time are unlimited.

This leads to another definition of management which may describe it more accurately. Management is the efficient utilisation of human, financial and phsyical resources in an organised effort towards common goals.

RELEVANCE OF MANAGEMENT TO THE MEDICAL PROFESSION

It may well be asked at this stage what has all that got to do with the medical profession?

I shall illustrate the relevance first of all by means of an Input/Output model:



So far as the medical profession is concerned the output is, of course, health care. The input is as shown in the diagram. The relevant technology is medicine. In a broad sense, the provision of health care is no different from the provision of goods and services. It requires input of resources, it requires technical know-how in the form of medicine, and it requires managerial know-how which welds the technology and the inputs together in order to provide health care.

The other reason management is important to doctors is that all doctors, like other professional groups, have two jobs: the technical or professional one directly related to his profession, and the non-technical one which may be loosely described as administration or management. This is true regardless of one's present or future position, whether in private practice on his own, or in a group practice, or employed in the public sector. The proportion of time he spends on each of the two jobs, namely technical and managerial, will obviously depend upon his position.

By and large, medical education and training have concentrated on providing doctors with the knowledge and skill necessary for their first job, but they are left on their own to

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