The real business of health care

THIS ISSUE CONTAINS papers that consider some of the complex issues within human resource management (HRM) in health care. In health systems the care provided has tended to be craft-based production — a trained health professional provides his or her craft for individual patients, with little need for management. Influencing the relationship between practitioner and patient has been limited by professional autonomy and the different cultures that exist among the specialised health professional groups. These differences are illustrated by Perkins et al by the results of a survey of starting and finishing undergraduate medical, nursing and pharmacy students (*page 252*).

Although health care is dominated by craft production, our health service organisations are often structured using mass production principles, such as hierarchy and specialisation; but these structures and processes only manage around the edges, without interfering with the craft production relationship between practitioner and patient.

This inability to manage the clinician–patient relationship, the real business of health care, has resulted in independent, and largely inefficient, craft production. Instead of an effective interdisciplinary care delivery model, hospital organisation and hierarchy reinforces parallel care processes that only occasionally intersect. Human resource management is complicated by care that is delivered through multiple clinical processes that only occasionally intersect, with the result that high quality care is difficult to achieve consistently.

In this issue papers by Renzaho (*page 223*) and Matthews (*page 236*) remind us of the need for cultural competence, while Prabhu (*page 265*) provides an evaluation of a volunteer program. Other HRM aspects addressed include rest during shift work (*page 246*), nurse unit managers (*page 256*), nuclear medicine technologists (*page 282*) and absenteeism (*page 271*). Additional papers continue the health professional education discussions and Johnson and colleagues provide a useful tool to assist doctors to assess their medico-legal risk (*page 339*).

In the *n=1* in this issue (*page 204*), Kathy Stiller describes a personal issue that suggests clinical practice is being tyrannised by interpretation of evidence. She reinforces the views of Sackett et al[1] of the need for the integration of best available clinical evidence from systematic research and individual clinical expertise.

This issue also contains a series of papers that were developed as a Festschrift, or a celebration publication, for Professor Ken Donald. Please see *page 301* for this collection of papers from Professor Donald's colleagues.

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1 Sackett DL, Rosenberg WMC, Gray JAM, et al. Evidence based medicine: what it is and what it isn't. *BMJ* 1996; 312: 71-2. □